Manchester City Council
Report for Information

Report to: Audit Committee - 15 February 2022

Subject: Internal Audit Assurance Report 2021/22

Report of: Deputy Chief Executive and City Treasurer / Head of Internal Audit and Risk Management

---

Summary

The Internal Audit Section delivers an annual programme of audit work designed to raise standards of governance, risk management and internal control across the Council. This work culminates in the Annual Head of Internal Audit Opinion and an Annual Assurance Report.

This report provides an update of progress on the agreed audit plan 2021/22; additional work assigned to the audit service and copies of the audit opinions issued in the period November 2021 to January 2022. A progress update on the period prior to this was included in the Audit Assurance report presented to Committee in November 2021.

Recommendations

Audit Committee is requested to consider and comment on the Internal Audit Assurance Progress Report.

Wards Affected All

Contact Officers:

Name: Carol Culley
Position: Deputy Chief Executive and City Treasurer
Tel: 0161 234 3506
E-mail carol.culley@manchester.gov.uk

Name: Tom Powell
Position: Head of Internal Audit and Risk Management
Tel: 0161 234 5273
E-mail tom.powell@manchester.gov.uk

Name: Richard Thomas
Position: Deputy Head of Internal Audit and Risk Management
Tel: 0161 455 1019
E-mail richard.thomas@manchester.gov.uk

Background documents (available for public inspection): The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of the background documents are available up to four years after the date of the meeting and can be accessed on the Council website:

- Internal Audit Assurance Report (Audit Committee November 2021)
- Review of Effectiveness of Internal Audit (Audit Committee September 2021)
- Annual Fraud Report (Audit Committee September 2021)
- Internal Audit Plan 2021/22 (Audit Committee March 2021)

Internal Audit Assurance Report

1 Introduction

1.1 The work of internal audit is a key part of the Council's overall assurance framework which is described in the Annual Governance Statement and in the Head of Audit and Risk Management Annual Opinion. This report provides an update on work following our previous report in November 2021.

1.2 Most of the planned work is underway with final reports, draft reports and fieldwork completed on 51% of audit assignments, 29% in fieldwork or planning, and 7% due to commence as planned in March 2022. Of the total plan 11 reviews (13% of planned outputs) have been deferred to the first quarter of 2022/23 for a number of reasons set out in section 2.4.

1.3 Audit work is prioritised in areas of highest risk and where changes have been made to policies, strategies and systems. These factors alongside pressure across the organisation since the start of the year in driving covid response and recovery; in managing resource reductions and capacity to deliver on key priorities; and in the delivery of substantial organisational change are all reflected in the opinions and findings of audit work. Whilst this report does note areas for improvement there remains positive management engagement and commitment to agree actions and address areas of identified risk.

1.4 Appended to this report are:

- Appendix One: Delivery status of the annual audit plan 2021/22
- Appendix Two: Executive summaries November 2021 to January 2022
- Appendix Three: Basis of Audit Assessments (Opinion/Priority/Impact)

2. Audit Programme Delivery

2.1 The following is a summary of progress against the 2021/22 audit plan.

Audit Status	**Audit Plan Status**	**Delivery %**
Final Report / Assignment Complete	36	43%
Draft Report	2	3%
Fieldwork Completed	4	5%
Fieldwork Started	15	18%
Planning	9	11%
Not Started	6	7%
TOTAL	**72**	
Deferred to Quarter One 2022/23	11	11%

2.2 Audits classed as 'not started' include year returns such the Annual Statement and Register of Strategic Partnerships where the timing of completion related to year end processes and could not start earlier. This block also includes audits where planning is at an early stage and where it is expected that the final completion and reporting of audit work will be concluded in April 2022.

2.3 The overall delivery of the plan has been impacted by need for urgent audit support on further, unanticipated Covid related grants linked to the Omicron variant from late 2021, as well as increased demands from Government for grant related data to be submitted for their assurance purposes and to be used in national data matching exercises. These were not anticipated in the original, approved audit plan or in the update provided to Audit Committee in November 2021.

2.4 As with previous schemes Internal Audit supported the design and delivery of the covid grant schemes for payment, providing timely assurance over planned payments and undertaking the review and investigation of applications made in error or as the result of attempted fraud. This is expected to continue, albeit on a reducing scale, throughout 2022. Work was reallocated across the team to accommodate these additional demands, but this has meant that four school audits and three audits originally allocated to an officer who was unavailable due to long term sickness absence could not be delivered in the year. Of the 11 deferred audits, four have been rescheduled following initial planning in response to developments in services or changes in project timescales and commitments and where it was more appropriate to reschedule these for delivery later in the year. The details of these are set out below.

Audit Title	**Rationale**
Neighbourhoods - Flare Replacement	Timing change moved to 2022/23 agreed with client linked to changes in project scoping and timescales
Core Financial Systems – Assurance Mapping	Timing change as this work will follow on from the outcome of current SAP process mapping work which will enable the planned assurance work to progress more efficiently and avoid duplication
Our Town Hall Work Packages and Payments (2nd tranche)	Timing change to expand on review in 2021/22 – client requested delay to 2022/23 due to commitments in quarter one.
Youth Services	Timing change due to changes in service staffing and planned changes in service delivery model required scope to be updated and agreed with client. Work to be included in audit plan for delivery in quarter one 2022/23.

Audit Title	Rationale
Assurance Health checks: Church of the Resurrection Charlestown Primary School Oswald Road Primary School Abraham Moss High School	Resources focused on Omicron grant processes in 2021/22. Agreed with clients to start Quarter 1 2022
Traded Services Regulatory Services Major Projects Assurance	Deferred to Quarter 1 2022 – impacted by audit staff absence in 2021/22 Major projects work will also be informed by assurance obtained from the current Future Shape review of the capital programme.

2.6 Outputs include audits and briefing notes, as well as advice, guidance and support to management where captured in formal reports. It includes counter fraud investigations where a formal was report issued but does not include all casework outcomes.

2.7 In March 2021, to manage the resource pressures and uncertainty resulting from Covid, we opted for a '6+6' plan with the intention for a formal mid-year review of the strategy and plan in October. This approach enabled tighter scope focus in the first six months and allowed time to re-assess and build greater detail into the second half of the year.

2.8 The sections below describe the progress against the agreed annual audit plan 2021/22 and the deliverables to year end.

3 Resourcing and Plan

3.1 The proposed structure, budget and role profiles for the Internal Audit service review are complete. In recognition of changes that are also now being proposed across the wider audit and risk management division, the advice of the HR&OD Service is to align formal staff engagement and consultation across all teams and to complete the redesign across all services at the same time. Work is being finalised to confirm the proposed structures and roles across for those teams so that formal staff and trades union consultation can begin. It is anticipated that this process will enable matching and recruitment to posts from April 2022.

3.2 For internal audit, the current resource is 12 staff in post. To support capacity, the placement of an officer within the team has been extended through to the end of March and it is hoped they will be successful in securing a permanent role. The proposed structure, which is subject to staff consultation, comprises 15 planned posts. An option is also being progressed to secure funding for a fixed term post to assist with the high volume of investigations and other work linked to Covid grants. It is the assessment of the Head of Audit and Risk Management that this will provide sufficient resource for the delivery of an effective risk-based audit plan for 2022/23. A further update on progress will be

provided to Audit Committee in the Annual Internal Audit Plan report scheduled for March 2022.

3.3 To support the audit team, the Deputy Head of Audit and Risk Management and his audit management team are holding regular welfare and update meetings to review pressures and agree the allocation of work to ensure that priorities, demands and deadlines are realistic and achievable. The team is working flexibly from the office, from client sites and from home and this has been positive for morale and mutual support as reflected in feedback from the recent staff survey. Training opportunities are also being progressed with officers being supported in a range of activities liked to personal and service development plans.

3.5 There continues to be an impact on resources arising from staff absence due to Covid and other illness, with a need to reallocate and reschedule work. This includes one officer suffering from long term absence since September 2021. The position and the resultant risks to the delivery of the annual audit plan is being actively managed and the team continue to demonstrate their flexibility and adaptability in responding to these challenges. We continue to gather assurances from alternative sources, such as the outcome of the Peer Review, through active involvement in the Council's Future Shape Programme and engagement in a range of officer working groups and boards.

3.6 Salford City Council ICT audit team are progressing work across our ICT assurance portfolio and this is largely progressing in line with agreed plans. In conjunction with the Director of Capital Programmes, we also commissioned an external consultant to undertake a review of programme and cost management arrangements across the capital programme and highways services. Whilst this was not a formal audit, it was used to support a September 2021 report to Resources and Governance Scrutiny Committee and the findings and conclusions from this work has fed into our assessment of assurance. This work and the recommendations from the review have also been considered as part of a review of the Capital Programme being undertaken as part of the Future Shape Programme and we will consider the assurances from all of this work in the annual audit opinion.

4 Children's Services and Education

School Financial Health Checks

4.1 We have finalised a limited assurance school audit report for All Saints Newton Heath) and two have been issued as draft (Peel Hall Primary School and Divine Mercy). As reported to Audit Committee in November all final audit reports in the year to date have resulted in limited assurance opinions. We recognise that school control frameworks have been impacted by the disruption caused by Covid19 but it is critical that Governors and Headteachers ensure that that essential governance and control systems are fit for purpose and comply with Schools Financial Regulations. We are emphasising this requirement as part of the process of collating School Financial Value Standards (SFVS) returns which are required for onward reporting from the Council to the Department for

Education May 2022.

4.2 The reasons for the issues arising in school audit reports have been discussed at Audit Committee and raised with education and finance colleagues at the quarterly Schools Assurance meetings. It has been agreed that a circular with input from Internal Audit will be issued to schools from the Director of Education reminding them of the need to ensure the completion of all key financial controls and reconfirming what the minimum key controls need to be. This will include a focus on procurement, bank reconciliations and other areas that are essential to good financial management in schools.

4.3 Following the success of presentations to a Business Managers conference in November consideration is also being given as to whether remote sessions can be set up with Business Managers and Head Teachers around particular areas of risk such as high value procurement.

4.6 We have also completed a financial health check audit at the Education Leadership Trust during the quarter and have started but not yet completed fieldwork on their safer recruitment arrangements. We plan to use the terms of reference developed for the safer recruitment audit to complete a similar piece of work for schools in quarter four.

Foster Care payments

4.9 We are in the process of planning our audit of Foster Care payments. This audit was added to the plan in-year following concerns over potential duplicate payments identified in a previous audit of children's placements and subsequent confirmation of actual cases where duplicate payments had been found and reported to the fraud and irregularity audit team. We will be using data analytic techniques when undertaking this audit work, to enable us to identify any cases where we suspect duplication of payments may have occurred, and to establish the root cause of these. The outcome of this work will be reported to Audit Committee on completion.

5 Adults Services

Client Financial Services – Appointeeships

5.1 We issued a final report for our audit of Appointeeships within Client Financial Services. This resulted in a limited assurance opinion. The audit identified inconsistencies over the handling of cash in area offices, where client's personal allowances are being administered. Some of this has been caused by pandemic restrictions and need for paperless workarounds, however we identified process improvements that are needed to maintain an effective system of control and achieve greater efficiency.

Direct Payments

5.2 We have an audit of direct payments on the audit plan but in our initial meeting with the Assistant Director of Adults Services to scope the work, it

was confirmed that they had commissioned the Greater Manchester Health and Social Care Partnership to complete a review of the current Personal Budgets offer in June / July 2021. This work resulted in a report which identified the need for improvements in several areas, with 22 recommendations being made.

5.3 Issues were raised in relation to policy, assessments, indicative budgets, support planning, payment, Personal Assistant training and the review process. The proposed approach to address issues identified in the review is to establish a Project Team to deliver the improvements with the Assistant Director of Adults Services acting as the Senior Responsible Office (SRO).

5.4 Having reviewed this report and resultant recommendations we consider it is likely that these would have formed the core of planned audit work we would have performed. Rather than duplicate this work we have noted the low level of current assurance highlighted by the externally commissioned work and confirmed that there is now a detailed plan to address them. We have agreed that Internal Audit work will be deferred to 2022/23 to focus on a review implementation of the agreed recommendations to verify improvement and provide assurance that the issues raised are being addressed.

Technology Enabled Care

5.5 We have issued a final report for our audit of technology enabled care during the quarter and provide a reasonable audit opinion over the effectiveness of controls in operation. We identified several areas of good practice however our assurance opinion was tempered by concerns regarding the absence of contracts with some service users and the lack of a robust testing scheme once care equipment had been installed.

5.6 The service is currently experiencing a period of rapid change. There is an increasing amount of technology available, which provides the opportunity for the service to expand its offer to citizens. At the same time, there is a mandate from the Better Outcomes Better Lives (BOBL) programme to increase the uptake and usage of digital technologies. Together this has led to a renewed focus and impetus to the service and a commitment to realise the potential of technology to both increase the scope and scale of the offer and improve outcomes for citizens.

Better Outcomes Better Lives

5.7 We have completed the fieldwork for our audit of the governance arrangements in place for the Better Outcomes Better lives programme in Adults Services and a report is in the process of being drafted.

Adults Management Oversight and Supervisions

5.8 We are in the process of completing the fieldwork for our audit of management oversight and supervisions in Adult Services. Fieldwork for this audit should be completed over the next couple of weeks.

6 Corporate Core and Information Governance

6.1 Positive assurance can be taken from the Local Government Association Peer Review and resultant Feedback Report that has been published on the Council website. This review took place in November and December 2021 by an experienced and qualified peer review team who considered the following five themes critical to the Council's performance and improvement.

- Local priorities and outcomes
- Organisational and place leadership
- Governance and culture
- Financial planning and management
- Capacity for improvement

6.2 The feedback report was positive and noted the City's inherent assets of ambition, drive and innovation, that the Council is 'first rate', strong and determined with a national reach and is a positive and proactive partner across the City and across Greater Manchester Combined Authority. The report reflected the strength of leadership, governance, and financial stewardship; and a culture of internal challenge reflected in positive comments regarding public engagement, community-based service delivery models and member scrutiny. The OurManchester approach was recognised as integral to the Council's ways of working and the review team saw evidence of this operating in practice.

6.3 The report includes a wide range of other positive observations but rightly highlighted areas for ongoing focus. These recommendations include the need to sustain focus in priority areas including equality, housing and homelessness, neighbourhood working and children's services; noting that to deliver on the ambitious agenda for the Council and City means that capacity and capability needs to be subject to ongoing review. The report is to be presented to Executive on 16 February and this will guide future action planning and response. From an Internal Audit perspective we will consider the review as part of audit planning for 2022/23 and will monitor progress in addressing these recommendations as sources of additional governance assurance.

Information and ICT

6.4 As reported in November 2021 we have continued to support several key Council projects that have a core ICT element. Work on an audit of Vulnerability Management started in January 2022 and we are planning an Information Governance audit, which will be centred on assurance over the area of privacy notices. An audit of the effectiveness of operational controls over ICT device replacement is underway.

Core Systems

6.5 Following Government announcements we supported the initiation of local processes for two further business grant schemes, the Omicron Hospitality and Leisure Grant; and the top-up to Additional Restrictions Grant funding. We have engaged with the required post payment assurance process now specified by BEIS and the exercises being run by the National Fraud Initiative and will consider whether any further assurance in this area is required as part of our annual audit planning for 2022/23. Work will be required in this area until

at least June 2022 and investigations into allegations of fraud or error will continue throughout next year. We have also supported the reconciliation processes required by BEIS and led by Corporate Finance obtaining positive assurance over the payments made under the wide range of business support schemes.

6.6 Grant certification work was completed in relation to a further European grant (Zero Carbon Cities) in line with required timescales. Positive assurance was obtained as no issues were identified as a result of this work. We are also supporting the Synergy Project in providing a formal Statement of Expenditure, following advice on record keeping that we previously issued.

6.7 A further payment recovery exercise has been commissioned through Internal Audit; reviewing standard payments made by the Council from 2019 to 2021. The previous exercise led by Internal Audit with support from finance colleagues reviewed five years of payment data and returned approximately £380k back to the Council. We are working with Finance to explore how the use of other software solutions and the emergent project for the replacement of the core financial system (SAP) can be utilised to further minimise the risk of duplicate or overpayments.

6.8 In January we plan to begin audits providing assurance over the operation of two core financial systems; payroll and debt recovery.

7 Neighbourhoods; Growth and Strategic Development

Housing Operations – Governance Arrangements

7.1 Housing Operations, formerly known as Northwards Housing Limited, came back under Council control on 5 July 2021. This was agreed by Executive in January 2021 to achieve financial and strategic benefits. Senior Management Team have overseen the transition through the Council's Future Shape programme. This covered multiple aspects of the transition, but the overriding priority was to ensure that residents continued to receive a seamless service. Previous reviews performed by external consultants, including a due diligence review, highlighted that the governance arrangements needed revision, therefore this aspect was included in the 100-day plan with the establishment of new governance arrangements.

7.2 To begin a programme of audit work with Housing Operations, we completed a review of the developing governance and oversight arrangements and issued a report in January 2022, with a reasonable assurance opinion and agreeing four recommendations for improvement. This report acknowledged that significant consideration had been given to setting up governance structures which will provide a line of accountability and community engagement from tenant and resident groups through the proposed advisory committee and to the Council's Scrutiny and Executive. The proposals align with wider Council Governance arrangements and with Housing Regulations and Standards, documented in the 2021 Social Housing White Paper.

7.3 We found that the key themes of the White Paper had formed the foundations of the governance arrangements and that these will be incorporated into the new Resident Charter, which will become a focal point of the committee. We confirmed the commitment to create a Resident Charter, giving tenants the opportunity to influence the development of key performance indicators (KPIs) that are meaningful to them.

7.4 Although the proposals are not yet fully developed, we noted that there are some elements of the governance documentation and approach that could be enhanced and have made four recommendations regarding committee documentation and membership, ownership of the risk register and finalising the approaches to gathering performance data and reporting requirements.

Housing Operations - Approach to Empty Homes and Voids

7.5 Approximately 290 of the former Northwards properties are currently empty for a variety of reasons; including those in works, in decant and waiting for capital investment. The Housing Operations service wants to use the move back to the Council as an opportunity to develop a new strategy for these properties.

7.6 In addition to monetary loss, there are clear links to homelessness, with high numbers of citizens in temporary accommodation and the need to bring properties back into use quickly, and to address anti-social behaviour associated with vacant properties. An improved void strategy would also support Manchester's Housing Strategy and Residential Growth Strategy, as well as the Council's Housing Affordability Policy Framework. An efficient and effective approach to minimising void properties will optimise the use of social assets, maximise rent and revenue income, improve the wider asset management regime and is reputationally beneficial. We have agreed the terms of reference for this audit and are currently finalising our fieldwork, with the aim to produce a final report in March 2022.

Victoria North (formerly Northern Gateway)

7.7 Following a directorate level risk workshop we facilitated in December 2021, internal audit have liaised with the programme to understand current risk exposure and gather sources of assurance. We are assured that regular progress reports on this significant joint venture are reported to the Economy Scrutiny Committee and for year end we plan to review project risk registers, board papers and other internal reports, and produce a briefing note to summarise the governance position and highlight any areas of concern that may warrant specific management focus or scope for audit review.

Traffic Signals Maintenance Grant

7.8 Internal audit has liaised with the project to ensure grant certification is timely and compliant with stipulated grant terms and conditions. The initial timescale was to sign a declaration supported by a review of documentation, to the team leader of the Smart Transport Team in the Department for Transport no later

than 31 December 2021. This was assuming the grant spend had been committed by 31 March 2022. The deadline for grant certification has now been revised and a new deadline of 30 September 2022 has been published. Audit will recommence its certification assurance early in September to meet this revised timeframe.

8 Procurement, Contracts and Commissioning (PCC)

Factory Project Assurance

8.1 We have recently agreed the Terms of Reference and have commenced a review of the arrangements in place to ensure the effective management of work packages for the Factory project. This work will focus on controls to ensure work is clearly defined and allocated to support the management of delivery; systems and processes are in place to assess work against time and quality standards; payments are made in line with prices agreed; and there are suitable controls over any variations and work package progress and delivery is reported to key stakeholders and used to inform decision making. We will report on the findings of our review in the annual audit opinion.

Follow Up Review – Children's Placements

8.2 Work is underway on a review of progress in the implementation of recommendations made as part of our Review of Placement Finding Activities audit in 2021. We have met with the service to discuss progress and improvements made to address the risks identified as part of our audit and are currently reviewing evidence provided by the service to support the progress described. On completion we will issue a follow up report to highlight the progress made and position in terms of overall exposure to risk in this area.

Carbon Reduction in Procurement

8.3 We are undertaking work to determine the arrangements in place to support carbon reduction through sustainable procurement. Through discussions with key officers, a review of corporate guidance and a walkthrough of recent procurements where this was applied, we will seek to provide assurance that there are clearly defined roles, responsibilities, and expectations and corporate procedures and guidance support the delivery of carbon reduction through procurement.

Contract Management – Adult Social Care

8.4 We issued a Terms of Reference and planned to undertake a review of the contract management arrangements for the Homecare Contract in quarter four. However, a recent response from the Directorate explained that due to the heightened response around Omicron, hospital discharges and associated pressures in the community, coupled with workforce shortages, the service would not be able to respond to an audit at this time. We will discuss alternative sources of assurance or arrangements to reschedule this audit with senior officers in March 2022.

Waivers and Contract Extensions

8.5 In December we issued the final report for our review of waivers and contract extensions. The key findings of this audit were reported to Audit Committee in November and having agreed management responses this was issued with a reasonable assurance opinion.

9 Counter-Fraud and Investigations

Proactive

9.1 Work is continuing into quarter four on the review and refresh of counter fraud policies and ensuring they meet the accessibility criteria for published documents on the intranet. These include the Council's Counter Fraud Strategy and Policy; Anti-Money Laundering; and Anti-Bribery and Tax Evasion polices. The Whistleblowing Policy has been externally reviewed by the whistleblowing charity Protect and the Internal Audit have also arranged staff training for officers across the Council to further develop awareness and capabilities of key services in dealing with potential allegations of wrongdoing. The service are also supporting Legal Services with a revision of the Social Media Policy.

9.2 Work is underway to refresh and update counter fraud policies within schools and improve general awareness across this sector via a programme of fraud assurance assessments.

9.3 A Counter Fraud Training workshop was undertaken with Housing Operations to support colleagues in understanding anti-fraud and corruption policies, including money laundering, and how the whistleblowing process works.

Reactive

Corporate Cases

9.4 Internal Audit have received 50 referrals of potential fraud or irregularity during the year to date. Of these 9 were considered whistleblowing allegations made either anonymously or from a named source and have been handled under the Whistleblowing Policy and Procedure.

9.5 The nature of this work has remained consistent including concerns raised in several key risk areas including staff conduct, contractor conduct and performance, ethics and behaviours, employee compliance with procedures and theft from schools.

Other Investigations: Business Grants, Council Tax Reduction Scheme and Housing Tenancy

9.6 During 2021/22 Internal Audit have received 46 referrals of potential fraud or irregularity in relation to the Covid19 Business Support Grants. This is an increase of two from November 2021. Due to the values involved this portfolio

remains a key area for investigation and cases are being progressed positively in line with BEIS requirements.

9.7 A total of 59 referrals of fraud or irregularity in relation to the Council Tax Reduction Scheme have been received in the year to date. This is an increase of 27 cases since November and highlights the impact of the return to a more business as usual approach across the revenues service. There have been 36 referrals received in relation to Housing Tenancy and Right to Buy. These figures are broadly in line with previous years.

9.8 The Director of a company was sentenced at Crown Court in December, after previously pleading guilty to offences under the Theft Act 1978. This followed a joint investigation with Trafford MBC which established an exemption from business rates valued at £57k had been dishonestly obtained (£27k of which related to Manchester City Council). The individual received a 14- month custodial sentence, suspended for 18 months and ordered to pay costs of £5,091.

10 Recommendation

10.1 Audit Committee is requested to consider and comment on the Internal Audit Assurance Progress Report.

Appendix One: Audit Status, Opinions and Business Impact 2021/22

Audit Area	Audit Status	Assurance Opinion	Council Impact
Childrens' and Education Services			
St Bernard's Primary School	Final Report	Limited	Low
Benchill Primary School (Follow Up)	Final Report	Partially Implemented	Low
St Matthews High School	Final Report	Limited	Low
St Margaret's Primary School (Follow Up)	Final Report	Partially Implemented	Low
Lily Lane Primary School (Follow up)	Final Report	Partially Implemented	Low
Collyhurst Nursery	Final Report	Limited	Low
Martenscroft Nursery	Final Report	Limited	ow
St Phillips CE Primary School	Final Report	Limited	Low
Children's Quality Assurance Framework	Final Report	Substantial	High
Peel Hall Primary School	Final Report	Limited	Low
Planning for Permanence (follow up)	Final Report	Partially Implemented	High
Divine Mercy Primary School	Draft Report	Set at Final	
Safer Recruitment in Schools	Fieldwork		
Special Educational Needs (local offer)			
Supervisions			High
Elective Home Education	Planning		Medium
Schools Assurance Mapping	Not Started		Medium
Service front door: assessment & access			High
Health and Care (Adult Services)			
Supported Living – Technology Enabled Care	Final Report	Reasonable	Med

Audit Area	Audit Status	Assurance Opinion	Council Impact
Client Financial Services - Appointeeships	Final Report	Limited 🟠	High
Better Outcomes Better Lives	Fieldwork Complete	Set at Final	High
Health and Social Care: Assurance Framework Review	Fieldwork		High
Adults Services Quality Assurance Framework			High
Adults Supervisions and Management oversight			High
Payment System Assurance (Adults)	Planning		High
Multi Agency Safeguarding - Front Door			
Direct payments (Adults)			High
Corporate Core			
VCSE Grant Expenditure	Final Report	Substantial 🟢	Low
Our Town Hall- Allocation and Management of Work Packages and Delivery.	Final Report	Reasonable 🟡	High
Capital Programmes (commissioned)	Final Report	Assurance Review	High
URBACT C-Change Grant	Grant Certified	Certified 🟢	Low
URBACT ZCC Grant	Grant Certified	Certified 🟢	Low
Interreg ABCitiEs Grant	Grant Certified	Certified 🟢	Low
Synergy Grant – file review	Briefing Note	N/A	Low
ICT Assurance Mapping	Briefing Note	N/A	Low
Irish World Heritage Centre	Briefing Note	N/A	Low
Estates – Service Review	Briefing Note	N/A	Low
Omicron related covid grant schemes (additional work). Design and Pre-Payment Assurance Checks	Complete	Assurance checks	High
Covid grant schemes Government assurance submissions	Complete	Collation of assurance	High
Covid grant schemes Government assurance submission (additional work)	Complete	Collation of assurance	High

Audit Area	Audit Status	Assurance Opinion	Council Impact
Covid grant schemes Government – coordination of data matching for new schemes (additional work)	Fieldwork	Set at Final	Medium
Joiners Movers Leavers			High
ICT Hardware Asset Management			High
Payment Card Industry - Compliance			High
Information Governance Privacy Notices			Medium
Debt Recovery and Write Offs			High
EYES System– Education / Early Years			High
Climate Change – emissions calculation	Not Started		High
Annual Governance Statement 2022			Low
Register of Significant Partnerships 2022			Low
Neighbourhoods; Growth and Development			
Disabled Facilities Grant: Certification	Grant Certified	Certified 	Medium
Highways Maintenance Grant	Grant Certified	Certified 	Medium
Culture Recovery Fund Grant – part 1	Grant Certified	Certified 	Low
Highways Compensation Events	Final Report	Reasonable	Medium
Housing Operations – Governance	Final Report	Reasonable	Medium
Highways Programme and Project Assurance	Briefing Note	N/A	High
Housing Operations – Audit needs assessment	Briefing Note	N/A	Low
AVRO Hollows - Tenant Management Organisation	Draft Report	Set at Final	Medium
Housing Operations – Void and Empty Properties	Fieldwork Complete	Set at Final	Medium
Culture Recovery Fund Grant – Part 2 (additional work)			
Victoria North (Northern Gateway)	Planning		High
Estates Planning – Asset Management Plan			High
Data Analysis - Single Person Discount			Medium
Taxi Licensing			Medium
Procurement, Contracts and Commissioning			
Supplier Due Diligence	Final Report	Reasonable	High
Waivers and Contract Extensions	Final Report	Reasonable	Medium

Audit Area	Audit Status	Assurance Opinion	Council Impact
Children's Placements	Final Report	Partially Implemented	High
Carbon Reduction in Procurement	Fieldwork complete	Set at Final	Medium
Factory Project Assurance	Fieldwork		High
Contract Management – Adult Social Care			High
Social Value Compliance	Planning		Medium
Frameworks – Selection and Award	Not Started		Medium

Appendix Two: Audit Report Executive Summaries (Opinion Audits)

The following Executive Summaries have been issued for the audit opinion reviews finalised since November 2021 and as requested by Audit Committee are attached below for information.

Reference in Appendix	Audit Title
A	Waivers and Contract Extensions
B	Technology Enabled Care
C	Housing Operations Governance
D	Client Financial Services - Appointeeships
E	Supporting Families Programme
F	All Saints Newton Heath Primary School
G	Children's Placements (follow up review)

Internal Audit Report 2021/22

Corporate Services – Integrated Commissioning and Procurement

Use of Waivers and Extensions

Distribution - This report is confidential for the following recipients	
Name	**Title**
Peter Schofield	Head of Integrated Commissioning and Procurement, Responsible Officer
Tom Wilkinson	Deputy City Treasurer, Accountable Officer
Mark Leaver	Strategic Lead – Integrated Commissioning
Paul Murphy	Group Manager, Procurement
Councillor Craig	Leader of the Council
Joanne Roney	Chief Executive
Carol Culley	Deputy Chief Executive and City Treasurer
Fiona Ledden	City Solicitor
Simon Livesey	External Audit (Mazars)

Report Authors		
Senior Auditors	Rebecca Crowther Erica Corbett	0161 234 1603 0161 234 5285
Lead Auditor	Clare Roper	07940 410849
Deputy Head of Audit & Risk Management	Richard Thomas	07971 227687

Draft Report Issued	30 November 2021
Final Report Issued	15 December 2021

Executive Summary

Audit Objective	Assurance Opinion	Business Impact
To provide assurance that there is compliance with the new procedural framework for waiver and contract extension requests.	Reasonable	Medium

Sub objectives that contribute to overall opinion	Assurance
Appropriate action is being taken to address earlier audit recommendations made regarding the use of waivers.	Reasonable
There is compliance with waiver and contract extension requirements across directorates.	Limited
There is evidence of scrutiny and challenge over waiver requests and contract extensions.	Reasonable

Key Actions (Appendix 1)	Risk	Priority	Planned Action Date
The ICP Team should systemise the process for submitting and approving waiver and contract requests	Significant	6 months	31 May 2022
The ICP team should work with Legal Services to simplify the Constitutional wording around contract authorisations.	Significant	6 months	31 May 2022

Assurance Impact on Key Systems of Governance, Risk and Control		
Finance	Strategy and Planning	Resources
Information	Performance	Risk
People	Procurement	Statutory Duty

1. Audit Summary

1.1. We completed a review of waiver arrangements shortly after the move to an electronic approval process in 2020, to confirm the suitability of the revised approach and to ensure early compliance. This review is a continuation of that work; providing assurance that the revised process is embedded, complied with and working well across the Directorates and that there is

continued scrutiny and challenge over contract extension and waiver requests. Given the inherent financial, legal and reputational risks associated with waivers and contract extensions, the area is classified as having a medium business impact.

2. Conclusion and Opinion

2.1. We are able to provide a **reasonable** level of assurance over compliance with the current procedural framework for waiver and contract extension requests.

2.2. Whilst completing this we discovered a number of wider issues that were beyond the initial planned scope of this audit. This review examined compliance with the Council's Constitution which details the parameters of officer authority. In assessing compliance with the current regulations, we found that the aspects of the Constitution were unclear and were not user friendly and we can see that this has led to confusion around delegated powers. The current governance system is too restrictive in some areas and does not always enable the most appropriate signatories or levels of sign off to be achieved. Whilst this audit did identify non-compliance with the current framework, we did not find the level or nature of the approvals tested to be inappropriate or unreasonable. This audit found issues with compliance that were Council wide, and whilst the Integrated Commissioning and Procurement (ICP) team are the contact officers for the audit it is important to note that the waiver reports are completed by officers across the Council, and that issues have been found in all directorates.

2.3. This audit demonstrates the need for a review of the levels of decision making within the Constitution and reaffirms the importance of forward planning that ICP and management are continuing to improve. We recognise that there are elements of decision making and accountability being reviewed as part of the Future Shape programme, and have integrated this into our recommended actions, namely that proposals are presented formally to the Commercial Board for consideration. Within this we consider that there is an opportunity to further develop the consistent use of terminology such as direct award, waiver, contract variation and contract extension. This is important as the term waiver is often interpreted negatively as an exception to procurement rules whereas there are genuine, appropriate and permissible reasons why a direct award of contract may be the most positive solution for the Council.

2.4. Action has been taken to address audit recommendations arising from the previous piece of work in this area, such as strengthening intranet guidance to address accessibility issues and improve content. Our sample testing confirmed the electronic approval process was used across all directorates and the paperless system established as standard practice. We also recognise the ICP team's continued effort to improve forward planning and commissioning pipelines to reduce the number of waiver requests. This is significant progress from that noted in previous audit work and there is a more robust system in place with a good general understanding of future contract and procurement needs.

2.5. Ongoing work is required to strengthen the process for submitting, recording, scrutinising and approving waivers and contract extensions. The log that we were provided with did not contain the evidence we would expect of approvals, scrutiny and challenge over waiver requests and contract extensions, or evidence of ICP consultation and oversight, prior to submission to the Deputy Chief Executive and City Treasurer (DCE&CT).

2.6. Clarity is needed on the contract authorisations prescribed by the Constitution, as three of 14 sampled waiver reports and three of six sampled extension reports did not have the correct signatures (summarised in Appendix 1). As noted above, it is the view of Internal Audit that the majority were appropriate senior-level approvers, but they were not roles named in the Constitution as permitted to sign-off these reports.

2.7. Although the paperless submission process is embedded, there are remaining compliance issues to address across the directorates with regards to waiver and contract report completeness. Our test sample found waiver and extension reports with information missing, including three with no supplier details. Three of the six contract extensions were signed off after the previous contract had lapsed. Half of waivers appeared to have been signed off after the expected contract commencement date listed on the waiver application (we note that the contract may not have commenced on the date recorded).

2.8. In summary, whilst the audit scope focused on compliance, rather than recommending actions to drive compliance with the current framework we consider that a review of delegations and permissions would be more appropriate and on that basis have concluded the audit with an overall assurance opinion of reasonable.

3. Summary of Findings

Key Areas of Strength and Positive Compliance

3.1. The ‘How to Buy’ guide and Code of Practice for Waivers were readily available on the intranet, with references to guidance and quick links on the procurement home pages. A quick search of the word ‘waiver’ on the intranet returned guidance, report templates and the procurement home page.

3.2. The Code of Practice for Waivers had been amended to state that Executive Members should be consulted prior to submission and that waivers above £50k must be sent via Procurement. This guidance is in line with the recommendations made in the previous audit review on the use of waivers.

3.3. The Head of ICP confirmed that all waivers over £50k were reviewed by the team prior to approval by the DCE&CT, in line with the Constitution. The waiver template (over £50k) requires authors to confirm that the request has been agreed by the Head of ICP prior to submission.

3.4. All 14 waivers and six contract extensions tested were submitted and processed using the paperless system.

3.5. Work was being undertaken by ICP to improve forward planning and reduce the number of urgent and unplanned procurement requests, as well as requests for waivers and exceptions. ICP continues to provide advice to service areas on appropriate alternative procurement routes where possible, in an effort to reduce the number of waivers and have refused requests.

3.6. The report templates have been updated since the time of our fieldwork and are now available and accessible. The waiver request form has been standardised to allow for one report template to be used for waivers above and below £50k.

3.7. Of the 14 waivers tested, all had exemption reasons in line with the Constitution. Seven were requested because only one contractor could provide the works or services required to deliver the contract, six were due to urgency and one was a combination of urgency and only one contractor being able to provide works.

3.8. In all service areas apart from Capital Programmes, waiver and contract extension requests were submitted by the report author, contract manager or Senior Responsible Officer, who were subsequently listed as the department contact on the waiver log. Capital Programmes procurement requests were submitted by the Commercial Performance and Compliance Team, whose manager was listed as the department contact. In all cases, the named officer was a relevant point of contact for queries and completed reports.

Key Areas for Development

3.9. Three of the 14 waivers and three of the six contract extensions tested did not have the correct level of authorisation in line with the Council's Constitution. In all cases the required SMT member signature was missing. Two of these waivers were signed by non-SMT members, however there is no provision in the Scheme of Delegation for members of SMT to delegate their authority to sign waivers above £50k or contracts above £250k. All six reports were filed as complete and authorised, despite not having Constitutional approval. We note that the majority of these were directors who are at an appropriate level.

3.10. We found that challenge and scrutiny from approving officers with regards to the timeliness, reason for and content of waivers was often not documented. Of the 14 waivers tested, we saw evidence of one instance of challenge from an authorising officer, who queried Executive Member notification and agreement from ICP. We saw limited evidence of challenge where important information was missing from reports or incorrect levels of approval had been sought. Of the six waivers requested due to urgency, five of these were due to framework expiry, however we saw no evidence of challenge or feedback regarding lack of preparation or failure to re-tender. We acknowledge that the challenges of Covid – 19 are likely to have impacted on these issues during the selected time period. We discussed with the ICP team other levels of scrutiny that have occurred but are not documented at each level of review before signing off the final report, as well as the ongoing work being done to improve forward planning.

3.11. The Code of Practice for Waivers states that waivers should not be sought retrospectively. Seven of the 14 tested waivers were approved after the expected contract commencement date outlined on the form. Three of the six contract extensions tested were authorised after the extension commenced. Discussions with ICP indicated that they did not consider this to be a significant risk as waiver reports are often submitted with an expected start date which can change or there might be some exceptional reasons why approval was not sought by relevant parties beforehand. Additionally, we note there are controls to prevent purchase orders being raised without contract authorisation and that for larger contracts Legal Services confirm there is approval before signing. Whilst there are compensating controls in place, we consider it is important that realistic planned commencement dates are used on waivers and that the time required to obtain approvals should be taken into account by directorates with support from ICP in their advance planning.

3.12. Our testing showed that the waiver and contract extension log showed little improvement in data clarity to that seen in our previous audit work. The log contained several direct awards, contract variations and further competition reports in the waiver section. These were not labelled as such and it was unclear from the log how many of each request type had been processed. Our full sample of 26 reports selected from the waiver log contained only 14 waivers. We had concerns that the true position on waiver use was unknown and may be overstated, however we have been told since completing our work that the log is intended for wider contractual requests and that ICP hold their own records for all waivers as well as flagging waivers on the directorate contract registers.

3.13. In one case relating to a £70k waiver request, a service was advised by ICP to seek approval from an officer who was not an SMT member. This is not compliant with the current rules outlined in the Constitution; whereby SMT and DCE&CT approval would have been required.

3.14. The Code of Practice for Waivers contained references to the European Union, EU regulations and EU procurement thresholds. These are no longer relevant and should be updated in line with the Public Contracts Regulations.

3.15. The ‘How to Buy’ Guide and Code of Practice for Waivers did not advise users of the requirement to complete all fields of the request template and there was no reference to Social Value or Carbon, as recommended in the previous audit. Of the 14 waivers tested, Social Value information was omitted from two and budget impact/supplier recommendation omitted from four. ICP have confirmed this will be updated.

3.16. There had not been an update to Commercial Board on the use of waivers as of the August 2021 meeting, as per a previous audit recommendation. It is noted that a scoping document was presented by the ICP team which intends to improve forward planning and reduce future numbers of waiver requests. We were told that a progress report to Commercial Board will be presented to a forthcoming board.

3.17. A review of SAP identified gaps in the supporting records as we could only locate related purchase orders (POs) for seven of the 14 waivers tested. Of these, only three had the appropriate procurement documents attached in line with the Council's Financial Regulations. We found POs for four of the six contract extensions and of these, only two had the appropriate signed documents attached.

4. Management Comments

Our additional discussions with ICP raised several wider issues with waivers. ICP do not agree that all waivers are inherently risky and consider that they are incorrectly described in the Constitution as a way to bypass normal rules. They advised that a more accurate description is direct award, that is a valid approach in certain situations and that, with appropriate justification, contains no more risk than something competitively procured. Whilst waivers may not be the optimal situation if services planned ahead, they can still be justified and appropriate in relevant circumstances. ICP wish to change the Constitution to reflect that for lower value (under UK threshold procurements), there are three potential procurement routes - quotes, tendering or direct award - which Procurement must be consulted on beforehand (they advised that this is not always the case at present). Internal Audit agree with these points and consider that greater clarity in this terminology and framework will enable ICP to focus their support and challenge in areas where waivers are used but where tendering would have been the most appropriate or appropriate procurement route.

ICP have advised that there is insufficient clarity on approvals and that whilst the approvals sought have not always been in line with the Constitution, they have been appropriate and relevant and sought from the people who should be held accountable (relevant Directors). At present, Education, Public Health, ICT and Highways Directors are not authorised to approve waivers over £50k and extensions over £250k for their respective areas as they are not SMT members. ICP are currently working with Legal Services to address how the Constitution can be improved and this will include approvals. We support this approach.

Some of the extensions sampled have since been competitively procured which has addressed some of the issues picked up in the audit testing. ICP are restarting the Introduction to Financial and Contract Management half day training course for Raising the Bar from October 2021 and are currently doing sessions with management teams to cascade information.

Internal Audit Report 2021/22 **Adults Social Care** **Technology Enabled Care**

Distribution - This report is confidential for the following recipients	
Name	**Title**
Jane Downs	Independent Living Service Manager, Responsible Officer
Karen Crier	Assistant Director Manchester Local Care Organisation, Accountable Officer
Gaynor McGinty	Service Manager for Integrated Contacts & Technology Enabled Care
Daniel Thompson	Community Equipment Team Manager
James Williams	Strategic Lead Commissioner (ASC)
The final report will also be issued to the following recipients	
Councillor Midgley	Executive Member Health and Care
Joanne Roney	Chief Executive
Carol Culley	Deputy Chief Executive and City Treasurer
Fiona Ledden	City Solicitor
Bernadette Enright	Executive Director Adult Social Services
Simon Livesey	External Audit (Mazars)

Report Authors		
Senior Auditor	Sonal Vasta	6333
Senior Auditor	Peter Gallagher	5247
Lead Auditor	Emma Maddocks	5269
Deputy Head of Audit & Risk Management	Richard Thomas	1019
Head of Audit & Risk Management	Tom Powell	5273

Draft Report Issued	23 November 2021
Final Report Issued	04 January 2022

Executive Summary

Audit Objective	Assurance Opinion	Business Impact
To provide assurance over the effectiveness of controls in operation for provision of technology enabled care.	Reasonable	Medium

Sub objectives that contribute to overall opinion	Assurance
Arrangements for installation, repair, maintenance and return of the equipment	Reasonable
Reliability and testing of new types of technology prior to roll out	Reasonable
The monitoring and response from activated equipment	Substantial
Invoicing and collection of fees related to monitoring and response services	Substantial

Key Actions (Appendix 1)	Risk	Priority	Planned Action Date
Management should determine an approach to addressing the historic and ongoing absence of contracts during the Covid-19 pandemic.	Significant	6 months	Completed
Management should identify which equipment is not regularly tested by users and contact them to ensure that it is still in working order.	Significant	6 months	June 2022

Assurance Impact on Key Systems of Governance, Risk and Control		
Finance	Strategy and Planning	Resources
Information	Performance	Risk
People	Procurement	Statutory Duty

1. Audit Summary

1.1. The Community Alarm and Technology Enabled Care Team provides a monitoring service to over 4,000 service users to support them in maintaining independence. In 2019/20 this resulted in over 165,000 emergency activations of equipment, each of which required some form of action. The service helps to deliver outcomes which matter to citizens, maximising independence, keeping healthy, and staying safely at home. The team manages referrals, arrangements for installation, monitoring equipment, and in some cases the on-site response.

1.2. The Better Outcomes Better Lives (BOBL) programme has identified that technology needs to be embedded in every stage of a citizen's journey. Technology is a key component of a blended approach to care delivery within a holistic and strengths-based assessment framework.

2. Conclusion and Opinion

2.1. We can provide **reasonable** assurance over the effectiveness of controls in operation for the provision of technology enabled care (TEC). We identified areas of good practice particularly:

- management's commitment to improve the service as part of the BOBL programme;
- the control centre ensuring 24-hour service provision;
- external independent accreditation covering various aspects of the service (including assessment, installation, monitoring, performance, and response of TEC); and,
- achievement of key performance indicators for monitoring and response.

However, our assurance opinion was tempered by concerns regarding the absence of contracts with service users and the lack of a robust testing scheme once equipment had been installed.

2.2. The service is currently experiencing a period of rapid change. There is an increasing amount of technology available, which provides the opportunity for the service to expand its offer to citizens. At the same time, there is a mandate from the BOBL programme to increase the uptake and usage of digital technologies. Together this promoted a renewed focus and impetus to the service and has the potential to both increase the scope and scale of the offer to improve outcomes for citizens.

3. Summary of Findings

Key Areas of Strength and Positive Compliance

3.1. The increased focus on the service as part of the BOBL programme was evident. The intention of this work is that "we will create a cultural shift amongst the health and care workforce which will increase the uptake and usage of existing digital technologies (including TEC); and we will embed this cultural change in order to future proof the growth of digital solutions."

3.2. Although still in the early stages, actions have already been taken to start this process:

- A working group has been established, with initial meetings having already taken place with key business stakeholders. This group is aware of the need to formally set out its scope and priorities to operate effectively.
- The new Lead Commissioner has set out a high-level timeline of ongoing activity and has instructed the service to delay ordering and testing new equipment pending an assessment of the commissioning strategy and a review and evaluation of existing, and piloted, equipment.
- Reports were produced to identify which Learning Disability, Hospital, and, Integrated Care Teams are most utilising TEC. This report provides details of the number of Support Plans and TEC applications, which will enable targeted support to be provided to improve take up.
- TEC Champions have been identified to promote TEC and to support colleagues on the best utilisation of it, and the expectations of a 'champion' are clearly defined. Records have been produced identifying what support these champions have provided (including which teams the support was provided to), which will help identify where further support and training would be most beneficial.
- TEC spotlight presentations have been provided; demonstrating and explaining the TEC offer currently available. These hour-long presentations included case studies, details of the benefits of TEC, what TEC services are available, and the role and support available from TEC champions.

3.3. The primary system used is provided by Tunstall, a leading UK TEC provider, and detailed information from them about the equipment they provide in this field is readily available. We also identified some good practice in the various pilot schemes for new equipment being run. We found evidence of realistic consideration of scope, baseline for current activities, pilot objectives, approach, qualitative and quantitative outcomes recorded, and formal reporting via project closure reports.

3.4. As part of our audit we tested a sample of 20 applications for TEC, of these we identified that 12 requests that progressed to installation all were provided in line with the customer (or next of kin) requests. All the equipment installed, where there was a service element, was tested on-site, confirmed to be working by the Community Alarm and TEC Control Centre which monitors the equipment, and was recorded as such on the Piper Network Controller (PNC). We were also advised that where the installation was pre-arranged (as opposed to a response to equipment failures or faults) the equipment was tested and confirmed working by the control centre, prior to leaving the depot, as well as being tested on site.

3.5. As a 24 hour, 7 days a week service it is essential that robust business continuity plans are in place to ensure service provision. The service has a business continuity arrangement for Tunstall Response (the provider of equipment), to cover the monitoring in the event of major equipment failure or evacuation.

3.6. Where there was a monitoring (or monitoring and response) service for the equipment installed we reviewed the call records on PNC. The system automatically recorded all calls, and time stamped them. These were

reviewed as part of the supervisions/1-2-1 of control centre officers and supporting records of the calls used for these supervisions were maintained.

3.7. The service receives annual external accreditation from the representative body for technology enabled care (TEC) services, the TEC Services Association (TSA) and is considered compliant with various standards and service delivery modules of its quality standards framework. Part of this process involves the monitoring of key performance indicators and in each case the service met or exceeded the standards required. These KPI's included, time to answer calls, quality control checks, user satisfaction and response times (where service provided was monitor and response). We have taken assurance from this external accreditation and have not repeated testing in these areas; however, we did confirm that call time and response time were met for our sample.

3.8. Where a service had been set up on LAS and a Care Package Line Item (CPLI) had been created, ContrOCC enabled timely billing to users. In nine of ten of our sample, accurate bills were issued promptly. Our sample included cases where:

- a service came to an end the records were amended to stop the billing process;
- a balance was outstanding, an arrears letter was sent, and payment was subsequently received; and
- the customer was also receiving homecare, but the expenditure of this service was offset against the homecare costs due to the service user's financial assessment. (This case was also going through the process for Section 117 of the Mental Health Act, where if the service remained in place this would be paid via health budgets not the service user.)

Key Areas for Development

3.9. Our audit work identified that there were no contracts in place with service users for newly installed equipment. Management confirmed that during the early stages of the Covid-19 pandemic a decision was made that contracts would not be agreed and signed with service users on installation; to minimise the infection risk to both the service users and those installing the equipment. At the time of our audit this was still the case, and there were no plans in place to agree them retrospectively, or to restart agreeing contracts at installation.

3.10. The welcome pack provided to customers advises them that they need to test the equipment (where appropriate) every month to ensure that it remains in working order. In our sample it was clear that this was not happening as only one such test had taken place, and then only once, since the equipment had been installed. There was no evidence of the Community Alarm and TEC Team having followed up the absence of such tests.

3.11. There was no single process for identifying, trialling, and commissioning new equipment. Although there was some good practice in the pilot schemes, other equipment was tested and commissioned elsewhere without any formal records of the equipment's impacts. Given the amount of new technology in

use or being considered, we found that the TEC Brochure had not been updated in over 2 years, and as such we consider it out of date.

3.12. Although there were examples of detailed and comprehensive recording of activity at the installation stage (e.g. notes detailing why installations had been declined, and installations postponed and subsequently completed) we identified a pattern of recording issues at this stage of the process. Our testing identified:

- An instance where LAS was not updated, a CPLI was not created and so the service user was not charged (at £4.68 per week) for over four months.
- Equipment declined at installation not updated in the Elms system which records where work is required.
- Two instances of installations were not updated on Elms, which due to their nature we were unable to determine if they had been installed or not.

3.13. During our site visit we confirmed that although equipment was held in a secure office, it was stored where there was space available, rather than in a managed and organised way. Its location in part relied on staff knowing where it had been put. In discussion with officers on site it was clear that they were aware of the need to improve stock control, particularly with regards to storage, management, write-offs, and reconciliations. In mitigation, it should be noted that the equipment used, whilst relatively expensive, was of no financial value outside of the technology enabled care environment (see appendix 2 for a list of equipment available). We were also informed that there were plans in place to co-locate all the MEAP service. Given there is already a stock control system and processes in place for the community equipment team (also in MEAP) the plan was for the TEC equipment to be managed using this system.

Internal Audit Report 2021/22

Growth and Neighbourhoods

Housing Operations (Northwards) Governance

Distribution - This report is confidential for the following recipients	
Name	**Title**
David Ashmore	Director of Housing Operations (Responsible Officer)
Fiona Worrall	Strategic Director Neighbourhoods (Accountable Officer)
Angela Raftery	Assistant Director of Housing Operations
Councillor Akbar	Executive Member for Neighbourhoods
Joanne Roney	Chief Executive
Carol Culley	Deputy Chief Executive and City Treasurer
Fiona Ledden	City Solicitor
Simon Livesey	External Audit (Mazars)

Report Authors		
Auditor	Erica Corbett	35285
Deputy Head of Audit & Risk Management	Richard Thomas	41019
Head of Audit & Risk Management	Tom Powell	35273

Draft Report Issued	17 December 2021
Final Report Issued	28 January 2022

Executive Summary

Audit Objective	Assurance Opinion	Business Impact
To provide assurance over the proposed governance arrangements	Reasonable	Medium

Sub objectives that contribute to overall opinion	Assurance
The proposed Northwards housing board, including membership, roles and responsibilities and function(s), aligns with wider Council governance arrangements.	Reasonable
The alignment of governance arrangements with housing regulations and standards.	Reasonable
Arrangements for consideration and making of decisions.	Reasonable
Risk and performance management arrangements (including resident satisfaction and local accountability).	Reasonable
Appropriate reporting arrangements and escalation routes.	Limited

Key Actions (Appendix 1)	Risk	Priority	Planned Action Date
Improvements to governance documentation and membership composition.	Significant	6 months	31 July 2022
Clarity of committee involvement and ownership of the risk register.	Significant	6 months	31 July 2022
Documented approach to performance and data.	Significant	6 months	31 July 2022
Documented approach to reporting requirements.	Significant	6 months	31 July 2022

Assurance Impact on Key Systems of Governance, Risk and Control		
Finance	Strategy and Planning	Resources
Information	Performance	Risk
People	Procurement	Statutory Duty

1. Audit Summary

1.1. Housing Operations, formerly known as Northwards Housing Limited, came back under Council control on 5 July 2021. New proposed governance arrangements were included in a 100-day plan with the establishment of a 'Board' (proposed title – Northwards Housing Services Advisory Committee), chaired by the Executive Member of Neighbourhoods.

1.2. This Advisory Committee will be responsible for overseeing the delivery of housing services and management of the Council's housing stock. A shadow board is currently in place. Internal audit agreed to review the developing proposals to ensure they align with current housing regulations and fit with wider Council governance arrangements.

2. Conclusion and Opinion

2.1. We can give a **reasonable** assurance opinion over the proposed governance arrangements.

2.2. Significant consideration has been given to setting up a new governance structure which will provide a line of accountability and community engagement from tenant and resident groups through the proposed advisory committee and to the Council's Scrutiny and Executive. The proposals align with wider Council Governance arrangements and with housing regulations and standards, documented in the 2021 Social Housing White Paper. We found that the key themes of the White Paper have formed the foundations of the governance arrangements and that these will be incorporated into the new Resident Charter, which will become a focal point of the committee. From interviews and meetings, we confirm and endorse the commitment to create a Resident Charter giving tenants the opportunity to influence the development of key performance indicators (KPIs) that are meaningful to them.

2.3. Although the proposals are not yet fully developed, we found elements of the governance documentation and approach that could be enhanced and have made four recommendations regarding committee documentation and membership, ownership of the risk register and finalising the approaches to gathering performance data and reporting requirements.

3. Summary of Findings

Key Areas of Strength and Positive Compliance

3.1. The proposed governance structure provided a line of accountability and community engagement from tenant and resident groups through to the proposed advisory committee, and Council's Scrutiny and Executive. Reports will be presented to the Communities and Equalities Overview and Scrutiny Committee, allowing citizens a greater say in Council matters by holding public inquiries into matters of local concern. The advisory committee will make recommendations for decision to the Executive Committee.

3.2. The proposed composition of the committee is sufficient to ensure adequate oversight and challenge and the terms of reference (ToR) outlines the purpose, membership, arrangements, conduct and responsibilities.

3.3. Meetings were proposed to be held every two months, led by a formal agenda, which is sufficiently frequent to allow regular oversight of progress and effectively undertake roles and responsibilities. Dates of meetings will be scheduled to be included in the Council's annual timetable of meetings and to fit in with other Council reporting schedules. Meeting quorum requirements have been set in line with Rule 15 of the Council Procedure Rules and it has been acknowledged that this must include a mix of both elected members and resident representatives, to ensure an optimum balance.

3.4. The committee will be administered by Commercial Governance and Directorate Support and meetings and decision making will be subject to the Council's procedure and political balance rules. The committee will have to abide by regulations around publication of agendas, right of attendance and access to information; papers must be available in a timely manner to enable full and proper consideration. All committee members must sign and adhere to the Council's Member Code of Conduct (which also applies to co-opted members) and this is supported by the Council's Standards Committee and Whistleblowing procedures.

3.5. The Government Social Housing White Paper sets out draft measures for tenant satisfaction which have been used as a starting point for the new Resident Charter, a focal point for the committee. This will be incorporated into new key performance indicators developed with tenant's input. Our interviews and document review showed that the resident voice and working collaboratively with local communities will be a key focus of governance arrangements. The terms of reference also include consideration of environmental investment and community safety.

3.6. Structures are being developed to support and underpin the committee's remit to ensure the tenants voice is heard. The Council is engaging with a range of partners and tenants. There will be an escalating hierarchy of resident engagement and influence and work on a new Engagement Strategy is supported by the Resident Charter.

3.7. Whilst the committee will not have decision making powers, under the Council's Constitution this enables the co-opted residents to have voting rights for matters discussed and ensures that the chair can be the Executive Member regardless of which ward they serve. An advisory committee is a recognised authority for receiving information and advice on subject matters and feeding these into other decision making. Substantive decisions will be taken in line with the Council's Constitution either at executive level or via delegated authorities. The Director and Deputy Director of Housing Operations also intend to attend the committee as officer representatives.

3.8. Directorate and Corporate level risk registers are maintained centrally and accessible by Directorate Management Teams, who are responsible for the quarterly review and refresh and escalation of high-level risks to the Corporate Risk Register, as required. The risk management framework and associated policy / practices are developed by Audit and Risk Management, who also facilitate risk workshops. The Directorate register includes current Housing Operations risks.

3.9. We note that some of the national regulation and guidelines is intended for Housing Associations, especially those relating to potential concerns about financial stability and sustainability. We can take assurance on these matters through the established budgetary control mechanisms operating within the Council, that housing operations have adopted.

Key Areas for Development

3.10. The expectations of the role and how the Council will support co-opted members has not been made clear. A document should be available clearly outlining the role description/profile, person specifications and tasks. Development of this has commenced since the time of our fieldwork.

3.11. There is a need to ensure that appropriate training is in place for committee members and tenants, so that they can contribute fully to the governance and oversight of services and provide appropriate challenge where necessary. There should also be clear succession planning in place.

3.12. In terms of committee membership, little consideration appears to have been given to required skills and behaviours. There was no agreed or documented objective analysis of required skills (e.g. skills matrices). We appreciate the desire from members for the recruitment to be constituency-based but this does not negate the need to have the right skills around the table to govern effectively. We note that the committee meetings will be open to the public and documents available therefore all ward members and tenants will have an opportunity to attend meetings. Development of this has commenced since the time of our fieldwork, in line with recruitment.

3.13. Whilst there have been discussions around reflecting diversity in the community, proposals for how this will be achieved are unclear. The under-representation of some groups within wider society (younger people, women, people in paid work and black and minority ethnic groups) on boards is one of the bigger challenges facing governance in the housing sector. Research suggests that smaller and diverse boards perform better, however there continues to be barriers to achieving board diversity, including: inadequate advertising and search; role and person specifications not reflecting broader competencies, transferable skills and relevant experiences; and competing pressures for adding expertise (although this last point has been covered by the proposal for additional independent members with housing expertise). The committee should monitor the diversity and seek to redress any imbalances. Proposals have been made for evening meetings and additional digital recruitment to expand coverage, both of which have received a good response from residents.

3.14. Given the key focus of the tenant's voice, we recommend that the numbers of tenants and members are equal. We appreciate that numbers on the advisory committee must be balanced and reasonable, given the associated administration involved, and levels of interest expressed in taking up these voluntary roles. There is a risk that the actual number of tenant representatives fall short of expectations, requiring a rethink of how to attract and then maintain the optimum level of influence.

3.15. The proposed maximum term of two years for co-opted residents does not reflect general good practice and we would recommend that this is extended to reduce

associated administration. We note this was also raised by members at Resources and Governance Scrutiny Committee. Since the time of our fieldwork this has been amended to a minimum term of 2 years.

3.16. Proposals could improve in terms of the Council's Code of Corporate Governance commitments of clearly setting out objectives and publishing information to show progression toward objectives. Good governance is dynamic and involves continuous evaluation and review. There should be proposals in place to ensure that arrangements are regularly reviewed to ensure that they continue to meet the Council's governance needs and have in place mechanisms to improve services and ways of measuring when they have improved.

3.17. The ToR states that the committee will 'have oversight of the risk register for the housing service' however it is not clear what form this will take. The documentation should be more explicit about the role of the committee in relation to the risk register and any intentions for tracking and reporting on risks. Committee members need to have a clear understanding of the status of priority risks, whether they are being properly managed and controlled, and have robust contingency plans should risks materialise.

3.18. The Government White Paper includes a key focus on greater transparency of performance data for residents and the general public. The ToR states the purpose of the committee as 'responsible for overseeing the delivery of the housing services', 'including the monitoring of the performance of all housing functions and the engagement of residents in the effective delivery of services' however it has not yet been clearly set out how this will be achieved.

3.19. The ToR states that the committee will 'Provide reports to the Council's Executive and to relevant Scrutiny Committees', however this does not clearly set out what reporting is expected and we were told that there would be no specific feedback from the committee as a matter of course. Reporting requirements should be defined in the ToR. The service should also ensure that tenants are able, on an annual basis, to hold a scrutiny review of the whole service and report to elected members so that the service has proper oversight and accountability.

3.20. The National Housing Federation (NHF) 2020 Code of Governance sets out standards that housing associations, their boards and the wider sector should seek to attain; protecting the interests of the communities they serve. The code's checklist provides a self-assessment tool covering 166 individual compliance actions, however we note not all of these are applicable to the Council's housing operations and the accountability and expectations of the committee are different to that of housing providers. It would be considered best practice to, as a minimum, ensure relevant parts of the NHF Code are covered.

Internal Audit Report 2021/22

Corporate Core, Client Financial Services

Client Financial Services - Appointeeships

Distribution - This report is confidential for the following recipients	
Name	**Title**
Simon Finch	Head of Service, Responsible Officer
Helen Wright	Accountable Officer
Duncan Morton	Service Manager
The final report will also be issued to the following recipients	
Councillor Midgley	Executive Member
Joanne Roney	Chief Executive
Carol Culley	Deputy Chief Executive and City Treasurer
Tom Wilkinson	Deputy City Treasurer
Fiona Ledden	City Solicitor
Simon Livesey	External Audit (Mazars)

Report Authors		
Senior Auditor	Bethan Booth	801 36697
Lead Auditor	Emma Maddocks	234 5269
Deputy Head of Audit & Risk Management	Richard Thomas	455 1019
Head of Audit & Risk Management	Tom Powell	800 35273

Draft Report Issued	07 December 2021
Final Report Issued	10 January 2022

Executive Summary

Audit Objective	Assurance Opinion	Business Impact
To provide assurance over the effectiveness of systems in place for managing customers' accounts where the Council act as an Appointee.	Limited	High

Sub objectives that contribute to overall opinion	Assurance
Policy and procedures, including key roles and responsibilities, are in place and clearly defined.	Reasonable
Accounts are appropriately set up, subject to regular review and escalated where required.	Reasonable
Payments made to clients are appropriate and securely handled in line with the appointeeship agreement.	Reasonable
Management assurance and reporting is effective, and actions identified to ensure client monies are protected is addressed in a timely manner.	Limited
Arrangements for any cash handling are appropriate.	No

Key Actions	Risk	Priority	Planned Action Date
Reintroduce the use of receipts to support the handover of cash to clients.	Critical	3 months	1 January 2022
Review of the pre-paid card monthly statements by CFS officers to verify withdrawals have been in line with the amounts loaded onto the cards by CFS and to verify that balances are not building on the cards.	Critical	3 months	31January 2022
Strengthen arrangements for ensuring the timely transfer of clients from appointeeships to deputyships once they meet the criteria to be changed, specifically to ensure that the necessary application is completed and approved	Significant	6 months	1 March 2022

within the Council and sent to the DWP in a timely fashion.			
Undertake a review of the current management information produced by the CFS Service Manager to establish if it can be used to support case management by the team and, whether it can be used to provide upward assurance to senior management. If the information is useful for case management then expectations should be communicated to the team around how they should use this information when received. If the information is not considered useful in its current form for supporting delivery consideration should be given to amending the information produced.	Significant	6 months	1 April 2022
Controls over the safe logs at Local District Offices should be strengthened to ensure they are clear and concise, and supported by a specimen signatory list.	Significant	6 months	31 January 2022
The importance of the ASOs altering their routes for cash withdrawals should be reiterated.	Significant	6 months	1 February 2022

Assurance Impact on Key Systems of Governance, Risk and Control		
Finance	Strategy and Planning	Resources
Information	Performance	Risk
People	Procurement	Statutory Duty

1. Audit Summary

1.1 Client Financial Services (CFS) provide financial management, managing welfare benefits and payment of living costs on behalf of vulnerable adults who lack mental capacity to deal with this themselves.

1.2 As an Appointee the Council is legally responsible for the management of the finances of on behalf of vulnerable adults. CFS are responsible for the management of welfare benefits.

1.3 This audit focused on the appointeeship agreements as these are not subject to the same level of external review and scrutiny when compared to deputyships.

2. Conclusion and Opinion

2.1. Overall, we can provide a **Limited** audit opinion over the effectiveness of systems in place for managing customers' accounts where the Council act as an Appointee. The main reason we are unable to provide a higher level of assurance is the lack of effective controls applied to cash handling, which may have been a result of Covid restrictions / workarounds, but these now need to be reviewed. We have made two critical and four significant risk recommendations which are outlined in our summary of findings below and are described in more detail in Appendix 1.

2.2. Three of our recommendations are specific to strengthen control around cash handling and the delivery of cash to CFS clients. We were particularly concerned over the controls for personal allowance withdrawals.. This was however not the case for several of the withdrawals we examined; varying amounts were withdrawn with no documentation to fully support these variations. We also identified that significant balances had built up on some pre-paid cards.

3. Summary of Findings

Key Areas of Strength and Positive Compliance

3.1. There are detailed and comprehensive procedures in place to provide guidance to officers over the process to be followed.

3.2. Pre-paid cards and pin numbers are stored separately, with pin numbers being held on a card master spreadsheet which is maintained by CFS on the network drive, with access limited to only CFS officers. The cards are held in the safe at the relevant district office to which only two officers have access.

3.3. There is a waiting list in place for cases to be allocated a CFS officer to ensure caseloads are not excessive and enable officers to have comprehensive oversight of their cases.

3.4. An Income and Expenditure assessment is completed for all clients to identify the amount of personal allowance they can receive. Our testing confirmed this had been undertaken for all clients in our sample.

3.5. Monthly bank reconciliations had been undertaken and our testing of a sample of two months of bank statements per client identified only one difference of insignificant value.

Key Areas for Development

3.6. We made ten recommendations overall with two of these being identified as a critical risk, four as significant risk and the remaining four as moderate risk.

3.7. Receipting arrangements for cash payments to clients are insufficient and do not support clear and transparent cash distribution. A clear audit trail documenting movement of cash is important; if disagreements and/or discrepancies occur, these will require investigation. Complete and auditable records serve to safeguard client monies and to protect Council officers handing cash.

3.8. We identified nine instances from a sample of 22 cash withdrawals where the withdrawal amount was not in line with the client's personal allowance and there was no documentation to support these variations.

3.9. There are delays as a result of COVID within the Council both by CFS staff and Social Workers in completing relevant documentation to ensure appointees are moved to deputyships when they reach the relevant savings threshold.

3.10. Whilst management information is comprehensive and produced monthly by the CFS Team Manager and shared with team members, it has not been defined how this should be used operationally within the service so use of it by the team to support their work is quite limited. It is also not currently used to support any upward assurance to senior management.

3.11. Safe logs are in place at District offices however, it is often difficult to identify who has taken the pre-paid cards or cash from the safe as entries on the logs are just signatures, there is no specimen signature list to support them.

3.12. Admin Support Officers (ASO's) do not alternate their route for withdrawals which increases the risk of theft or attack of the ASO officers if it is known that they will be in a particular location on a particular date.

Internal Audit Report 2021/22

Children's Services

Troubled Families Programme Audit

Distribution - This report is confidential for the following recipients	
Name	**Title**
Julie Heslop	Strategic Head of Early Help, Responsible Officer
Joanne Dalton	Strategic Lead for Early Help and Interventions
Ed Haygarth	Troubled Families Lead
The final report will also be issued to the following recipients	
Councillor Midgley	Executive Member
Joanne Roney	Chief Executive
Carol Culley	Deputy Chief Executive and City Treasurer
Tom Wilkinson	Deputy City Treasurer
Fiona Ledden	City Solicitor
Paul Marshall	Director of Children's Services
Simon Livesey	External Audit (Mazars)
Sarah Horseman	Head of Audit and Assurance, GMCA
Damian Jarvis	Audit Manager, GMCA

Report Authors		
Senior Auditor	Bethan Booth	801 6697
Lead Auditor	Emma Maddocks	234 5269
Deputy Head of Audit & Risk Management	Richard Thomas	41019
Head of Audit and Risk	Tom Powell	35273

Draft Report Issued	19 October 2021
Final Report Issued	25 October 2021

Executive Summary

Audit Objective	Assurance Opinion	Business Impact
To provide assurance over local systems designed to support the delivery of the Supporting Families Programme (formerly Troubled Families) – that they are sufficient and demonstrate compliance with the key requirements and standards of the updated Greater Manchester audit framework.	Reasonable	Medium
To reflect the changing nature of the delivery model, seek to gain assurance over the following areas: • The response to the impact of the Covid-19 pandemic on service delivery. • The extent to which the Local Authority is responding appropriately to the self-assessment findings of the Early Help Systems Guide that was completed in 2020/21. • Continued focus on the role of partner organisations.	Reasonable	Medium

Assurance Impact on Key Systems of Governance, Risk and Control		
Finance	Strategy and Planning	Resources
Information	Performance	Risk
People	Procurement	Statutory Duty

1. Audit Summary

1.1. In 2017/18 it was agreed that Greater Manchester Local Authorities would receive the remainder of the Troubled Families Funding through the GM Reform Investment Fund and would no longer operate under the Payment by Results model (PbR). To reflect this change, it was also agreed that Greater Manchester (GM) Local Authorities would not take part in the national PbR spot check process.

1.2. GM introduced a bespoke audit process in 2018/19 to provide the necessary assurances to the Ministry for Housing, Communities and Local Government (MHCLG) that GM Local Authorities were meeting the minimum expectations of the national programme. This approach has seen a shift away from a data focussed verification of successful PbR claims, towards an emphasis on quality assurance processes and local decision making.

1.3. This report provides the necessary assurance to GMCA over Manchester's use of Supporting Families funding, in line with the agreed Audit and Monitoring framework. We have validated delivery of the Early Help offer against each of the 10 key 'Supporting Families' process areas, including the role of partner organisations.

2. Conclusion and Opinion

2.1. Overall, we can provide **Reasonable** assurance that local systems designed to support the delivery of the Supporting Families Programme are sufficient and provide effective levels of compliance with the key requirements and standards of the updated Greater Manchester audit framework.

2.2. We have RAG-rated seven of 10 process areas as 'green' and three 'amber', as detailed below: -

- Supporting Families-eligibility was not determined up-front at the referral stage, but rather after the interventions were complete. We have not raised a formal recommendation as this was identified in our previous review. Management advised that they ask practitioners to base their offer on providing the right support according to need, rather than Supporting Families criteria or a 'tick box' exercise.
- There had been no formal documenting of the lessons learnt as a result of the COVID pandemic.
- Whilst the self-assessment had been carried out, results analysed and top priorities identified, there was no formal action plan to monitor onward implementation.

2.3. Full details of our findings and opinions for each of the 10 key Supporting Families process areas can be found in Appendix 1.

2.4. In regard to the impact of COVID 19 on service delivery, we have been able to confirm that a number of adaptations have been put in place to ensure service continuity, including use of virtual meetings, social distanced visits, and use of a parenting line.

2.5. The results of an officer survey were published in June 2020, exploring the impacts of COVID 19. The majority of responders felt that it had been difficult to develop a relationship with new families during COVID; where there was an existing relationship, these were easier to maintain. During our audit we spoke to an Early Help Practitioner (EHP) from the North and Central offices and they didn't feel that COVID had affected their ability to develop and maintain relationships. They confirmed they delivered Early Help using available

technology and identified that they felt service users were more open via a telephone meeting, rather than a face to face.

2.6. Whilst officers and management can explain the adaptations the council has put in place and can articulate the impact of COVID 19, a formal lessons learnt exercise has not been carried out.

2.7. The Council has completed the self-assessment from the Early Help systems guide and priority areas of future focus have been identified, although these need to be documented and monitored.

2.8. We contacted several partners who work alongside the LA and asked if they felt supported acting as the Lead Agency in interventions. We can confirm all partners felt that they were adequately supported.

3. Recommendations and Management Responses

3.1. We identified two moderate level recommendations as detailed below: -

- Lessons learnt from operating under restrictions caused by the pandemic should be identified and captured. These should be used to help inform the future operation of the Early Help Team.

  A report was taken to Children's Leadership Team (CLT) summarising the findings of our EHSG and this included several next steps. Whilst strategic leads are sighted on the EHSG this was not pulled into an action plan. This is helpful guidance and management will produce an action plan for the refresh of the EHSG due before the end of 2021.

- An action plan should be formally developed to monitor progress in the priority areas identified through the self-assessment.

Early Help welcomes the positive feedback on our response to Covid-19. Management also accepts the recommendation to pull together a 'lessons learned' document and agree this would be a useful approach.

Final Internal Audit Report 2021/22

Children's and Education Services

School Financial Health Check: All Saints Newton Heath Primary School

Distribution - This report is confidential for the following recipients	
Name	**Title**
John Sharp	Headteacher
O Wadsworth	Chair of Governors
Lilian Barlow	School Business Manager
The final report will also be issued to the following recipients	
Councillor Bridges	Executive Member for Children and Schools
Joanne Roney	Chief Executive
Carol Culley	Deputy Chief Executive and City Treasurer
Tim Wilkinson	Deputy City Treasurer
Fiona Ledden	City Solicitor
Paul Marshall	Strategic Director, Children's and Education Services
Simon Livesey	External Audit (Mazars)

Report Authors		
Senior Auditor	Bethan Booth	801 36697
Lead Auditor	Emma Maddocks	234 5269
Deputy Head of Audit & Risk Management	Richard Thomas	455 1019
Head of Audit and Risk Management	Tom Powell	800 35273

Draft Report Issued	15 November 2021
Final Report Issued	1 December 2021

Executive Summary

Audit Objective	Assurance Opinion	Business Impact
To provide assurance to the Local Authority and Governing Body over the adequacy, application and effectiveness of financial control systems operating at your school.	Limited	Medium

Sub objectives that contribute to overall opinion	Assurance
Allocation of financial roles and responsibilities	Limited
Long term financial planning, budget approval and monitoring	Reasonable
Key financial reconciliations	Limited
Expenditure, specifically purchasing and payroll	Limited
Income collection and recording	Limited

Summary of Key Actions	Risk	Priority	Planned Action Date
Roles and responsibilities should be amended so that one member of staff cannot approve, purchase, and pay for orders to ensure that there is appropriate segregation of duties. Responsibility for reconciling debit card transactions should also be completed independently, not by the card holder.	3 Months	Critical	11.11.2021
An Operational Financial Procedural Manual should be developed, and the Scheme of Delegation updated, to cover all key financial systems and controls.	3 Months	Critical	11.12.2021
The Amazon account should be closed as this allows the school credit. Any form of credit account is not allowed as per the school's Financial Regulations.	3 Months	Critical	Not Accepted
Quotations should be obtained and where necessary a tendering exercise completed for all transactions over £2000.	3 Months	Critical	25.11.2021

The Head Teacher should review the bank reconciliation monthly.	6 Months	Significant	11.11.2021
The Head Teacher should review the payroll reconciliations monthly and document this review. Payroll reconciliations should be dated and signed by both the School Business Manager and the Head Teacher.	6 Months	Significant	11.11.2021
The School Development Plan should be extended to a three-year plan and it should also clearly link the priorities to the school budget.	6 Months	Significant	25.11.2021
All debit card purchases should be approved in advance. The card should always be stored in the safe when not in use	6 Months	Significant	25.11.2021
Official school purchase orders should be raised on FMS and should be signed by an authorised signatory, in advance of the purchase being made with the supplier.	6 Months	Significant	11.11.2021

Assurance Impact on Key Systems of Governance, Risk and Control		
Finance	Strategy and Planning	Resources
Information	Performance	Risk
People	Procurement	Statutory Duty

1. Audit Summary

1.1 The 2021/22 Internal Audit plan included an allocation of time to complete financial health checks at a sample of Local Authority maintained schools. All Saints Newton Heath was selected as part of this programme of audits, due to elapsed time since the last audit review. This review was completed remotely due to Covid19 restrictions.

2. Conclusion and Opinion

2.1. We provide **limited** assurance over the adequacy, application and effectiveness of financial control systems operating at the school. The main reasons we are unable to provide any higher assurance at this stage is the lack of financial procedures and non-compliance with the School's Financial Regulations in two key areas. The School has a credit account with Amazon which contravenes the Financial Regulations directive that Schools should not take out any kind of credit facility. We also saw no evidence in the sample of higher value purchases tested, of no quotes or tenders being obtained to ensure best value is achieved. More detail is provided on these issues plus further significant and moderate risk recommendations in Appendix 1.

3. Summary of Findings

Key Areas of Strength and Positive Compliance

3.1. There is an approved budget in place, with evidence of Governor engagement in setting and approving budgets, which had been submitted to the Local Authority in line with agreed timescales.

3.2. There is regular reporting on budget monitoring to both the Finance Committee and the Governing Body.

3.3. The school operations are mostly cashless, with minimal cash collection and therefore the risk of loss and misappropriation of money when handling cash and the associated administration has been reduced.

3.4. School advised there are only two members of staff who have a key to the safe; the Head Teacher and The School Business Manager, however as the Business Manager has been working from home, the office assistant now has a key to the safe. These keys are taken off site each evening.

Key Areas for Development

3.5. We have made four critical and five significant recommendations to help improve governance, risk management and financial control at the school, specifically relating to the following issues:

- The need to amend allocated responsibilities to staff around the key financial controls to ensure segregation of duties are in place and that no one member of staff can approve, order, and pay for goods or services.
- A financial procedures document needs to be developed alongside the revisions to the Scheme of Financial Delegation, to ensure appropriate allocation of roles and responsibilities for the key financial control systems.

- The Amazon Business should be closed as it is a credit account and therefore in contravention of the Schools Financial Regulations.
- Controls over bank reconciliations need to be improved to ensure the Headteacher reviews the completed reconciliations and statements are date stamped on receipt. The person completing the bank reconciliation should not be the debit card holder, to ensure independent oversight and review of debit card transactions.
- The School development plan should be expanded into a three-year plan with clear links to the budget.
- Payroll reconciliations should be independently reviewed by the Head Teacher following completion.
- Arrangements for use of the school debit card should be improved to ensure timely approval and to ensure that appropriate records are retained to support each purchase.
- Purchasing controls should be improved to ensure compliance with the Schools Financial Regulations and the Scheme of Financial Delegation for all purchases. In particular purchases must be approved in advance of the purchase being made with the supplier, there should be appropriate separation of duties and that for all purchases over £2,000 (except where a legitimate exemption applies) three quotations are obtained or an appropriate tendering exercise is completed.

Internal Audit Report 2021/22

Children's Services

Follow Up Audit: Placement Finding - Review of Core Processes

Distribution - This report is confidential for the following recipients	
Name	**Title**
Adele Ion	Head of Provider Services, Responsible Officer
Paul Marshall	Strategic Director of Children and Education Services, Accountable Officer
Sean McKendrick	Deputy Director Children's Services
Alex Jones	Commissioning Service Manager
The final report will also be issued to the following recipients	
Councillor Bridges	Executive Member
Reena Kohli	Directorate Head of Finance
Joanne Roney	Chief Executive
Carol Culley	Deputy Chief Executive and City Treasurer
Fiona Ledden	City Solicitor
Simon Livesey	External Audit (Mazars)

Report Authors		
Lead Auditor	Clare Roper	35264
Deputy Head of Audit & Risk Management	Richard Thomas	41019

Draft Report Issued	20 January 2022
Final Report Issued	8 February 2022
Audit Objective	**Overall Implementation Status**
To provide assurance over the implementation of audit recommendations agreed in response to the audit of Placement Finding – Review of Core Processes issued May 2021.	Partially Implemented

1. Audit Summary

1.1 During 2020/2021 Internal Audit undertook an audit review of Children's placements to provide assurance over current arrangements and controls within CPT (Centralised Placements Team) and Contracts and Commissioning to support placement finding activities.

1.2 Based on the work undertaken we provided a limited assurance opinion and made the following number of recommendations for improvement, with agreed target dates for implementation between 30 September 2021 and 30 November 2021.

Priority	Accepted	Rejected
Critical	0	0
Significant	4	0
Moderate	0	0
Minor	0	0

1.3 To provide assurance to the Accountable Officer, Strategic Director of Children and Education Services, SMT and Audit Committee we undertook a follow up audit to confirm whether the exposure to risk had reduced.

1.4 This was not a full repeat review of the operation of placement finding processes but rather an assessment of progress made with the implementation of the agreed audit recommendations.

2. Conclusion and Opinion

2.1 Our review of progress against these recommendations shows one recommendation is implemented with the remaining three classed as being partially implemented at this time. As a result, we therefore conclude there is a partial reduction in the overall risk exposure, based on evidence of progress being made, however actions are not fully complete and exposure to risk remains. We will continue to engage with the service to gain further updates on progress and the findings from Internal Audit's upcoming review of foster care payments will also be taken into consideration in any status updates.

2.2 The original recommendations and current confirmed status are attached at Appendix 1.

2.3 An explanation of recommendation prioritisation and follow up assurance is attached at Appendix 2.

2.4 Based on the work completed and assurance obtained, we will include the reported status of these actions in our update reports to SMT and Audit Committee.

Appendix 1: Status Update

Recommendation 1 (Significant)

The Service Lead should work with the various Team Managers on how the current development work being undertaken can seek to include and address the compliance issues identified in audit testing. The C&C Service Plan could be used to identify actions and track progress.

Additional actions could include:

- A review of templates to remove any fields which are not required and provide prompts of instances when certain sections (e.g. approvals) are required.
- Improvements around the evidence trail of approvals particularly in relation to high cost placements and uplifts which take the cost per week over original approval requirements.
- The inclusion and communication of any expectations over timescales for the completion of certain tasks for instance the updating of Liquid Logic and setting up of Child Looked After (CLA) payments.
- Revisions to the setup of the CPT Tracker to make use of auto populated fields to minimise the manual input required from officers.
- Consideration to the introduction of a matching form for external placements.
- Systems for identifying and chasing Individual Placement Agreements (IPA) which have yet to be returned by the provider.

Internal Audit Assessment:

Discussions with the Head of Provider Services and Commissioning Service Manager and a review of documents provided by the service identified that numerous improvements have been made following our review. This has included the following:

- Work has been undertaken to update policies and pathways so there is greater clarity over key tasks.
- There is a new duty officer system (officer is now on duty for the whole week as opposed to a single day). This has had a positive impact on the effectiveness of the team and freed up much needed capacity for non-duty officers to complete other tasks, such as investigating payment related issues.
- The CPT team now has a permanent manager in post providing consistency in approach to quality assurance. The CPT manager is co-located with the Fostering Manager so there is more open communication between teams.
- A daily placement meeting takes place to provide work focus and prioritisation. This is now more integrated with the fostering team and is attended by the fostering duty manager, and the duty senior social worker who work together to ensure the safe placement of a child.
- Weekly case overview meetings take place between the placement officer

and their manager. Monthly supervisions also take place and the tracker for the individual placement officer can be used to provide oversight and assurance.

- The service has worked with the Performance, Research, and Intelligence (PRI) team to streamline the previous CPT tracker and this was relaunched in October 2021 to make it more beneficial for users. There is now a tab for each officer, facilitating prioritisation of individual placements officer workloads and helps them to track individual children placements more easily.
- 'Stop the Clock' days have been introduced following the change to the duty system. This has increased capacity, allowing officers not on duty extra time to focus on important tasks. This is classed as 'protected time' and has various focuses which includes updating Liquid Logic (LL), setting up payments and Care Package Line Item (CPLIs) etc.
- IPAs are now built into LL which allows for greater monitoring and tracking of IPAs.
- Delegated approval has been given to Service Leads and Heads of Service for placements up to a value of £4,400.

We consider this recommendation to be **implemented**.

Recommendation 2 (Significant)

The Commissioning Service Manager should enhance the current controls in place to make the process around Individual Placement Agreements (IPAs) more efficient. This should consider:

- Expectations around issuing IPAs following a placement and ways of ensuring these timescales are met.
- How it can be easily determined when an IPA has not been returned by the provider.
- Expected timescales over chasing non returned IPAs along with any forms of escalation to be applied.
- Varying signatory requirements on the IPAs in accordance with the cost of the placement.

Internal Audit Assessment:

Following a meeting with the Head of Provider Services and Commissioning Service Manager we were informed that IPAs are now on Liquid Logic which has improved the overall controls and visibility of the IPA position. The service regularly runs reports showing which IPAs have yet to be finalised and signed.

The process for finalising IPAs has also improved since the time of the audit and a new procedure manual for the completion of this task has been produced. Outstanding IPAs are monitored and discussed as part of permanence clinics and external residential panels which has involved checks that they are completed and signed.

The service considers that there has been significant progress in relation to the completion and quality of IPAs since the audit and there is now a greater

understanding and awareness of expectations across the wider workforce. However, there is recognition that they are still not where they want to be in terms of the completion and finalisation of IPAs and from January 2022 this will be a task allocated to the relevant CPT officer, as part of their tasks before handover to colleagues in the Contract and Commissioning and Social Worker Teams. We confirmed this was identified as an ongoing risk in the Commissioning Performance Report dated December 2021. This provided further detail that due to the ongoing absence of the CPT officer given responsibility for this task, the remaining officers within CPT will take responsibility for issuing IPAs for the placements they make from January 2022.

The sign off process has been confirmed and the Deputy Director has allowed sign off for placements by the Service Leads and Heads of Service under £4,400.

Other developments being progressed from January with a view to improving the timely finalisation of IPAs includes; the service looking to put a freeze on provider payments in cases where they have not returned a signed IPA; and trialling the use of the provider portal within ContrOCC with a view to wider roll out if successful.

Whilst there is a 360 Quality Assurance Tool template for use by Commissioning and Contract Officers for site monitoring visits, confirmation of a signed IPA for each child placed with the provider is not an area of assessment which could be added.

At this time, we therefore consider the status of this recommendation to be **partially implemented.**

Recommendation 3 (Significant)

The Commissioning Service Manager with the support of officers from Finance should determine how management information and reports can be used to more promptly to identify and act on:

-outstanding unpaid invoices which require resolution.

-unbilled care received.

-instances where payments are being made to multiple carers for a single child.

-Other potential overpayments to carers/providers.

This should then be produced regularly and shared with relevant officers to allow for these cases to be addressed. Work should also be undertaken with providers to ensure they are billing correctly to facilitate payment, i.e. one invoice per child and this should include all costs related to the placement (accommodation plus any support costs).

Internal Audit Assessment:

Bi-weekly steering group meetings are now operational and attended by Finance and Commissioning colleagues to review outstanding payments/placements without CPLIs. Our discussions with the Head of Provider Services confirmed that this has significantly improved the issues previously identified regarding payments to providers/carers. Established business as usual processes now include weekly

touch points between Team Manager Commissioning and Team Manager Children's Finance. This identifies any duplicate CPLIs, open CPLIs with no invoices and placement endings. This information is reported on a weekly basis to the strategic lead of children's finance and into the DCS budget report.

To facilitate the additional work required, the service also introduced a dedicated post for tracking internal foster carer payments which continues to have a positive impact; there is now extra capacity to investigate payment anomalies and work with social workers to provide support to ensure placements are processed correctly and in a timely manner. In addition, internal foster carers have confirmed that having a point of contact for payment queries has helped and finance colleagues have noted a positive impact on the number of over and under payments. The change made to the Duty System described earlier has also helped to provide the capacity needed to identify payment issues more quickly. Greater use of the Conversation Tool function within ContrOCC is also being encouraged, to allow issues with provider invoices to be resolved more quickly.

We understand there remain some longstanding queries which are being investigated. We note that the Finance Team Leader previously involved with the weekly meetings and reviewing payment queries has recently changed roles. The service acknowledges that finance input continues to be required and we therefore support the continuation of this resource from finance to reduce the risk of slippage or loss of momentum in identifying and resolving payment issues.

We reviewed several recent update reports which incorporated the topic of placement payments. The Internal Payment Report dated 14 December 2021 highlighted what is working well and current worries, the position reported was consistent with the Finance Report Provider Services. Whilst reporting indicated most historic issues have been resolved there are still issues in terms of missing placements, as a placement plan cannot be added onto LL retrospectively. If there is no gap in placements, they can only be added under the cost tab 'non-service provision' resulting in two carers being paid for the same period. Similarly, there is an issue with temporary placements; these sit parallel to the primary placement therefore both carers are paid for the same period, as the primary placement has not been closed. We were informed that further work is being progressed to try and reduce the instances of such cases going undetected. Other notable cases of concern and blockages were highlighted, including Special Guardianship Orders (SGO) discharge cases, over 18 discharge and missing care packages. We understand from discussions with the Head of Provider Services and Commissioning Service Manager that this aspect of payments is outside the responsibility and scope of the commissioning service and accountability sits with social care teams and finance. A coordinated approach is therefore required to ensure controls are sufficient to reduce the exposure to risk in this area.

The service acknowledged that some incidents can slip through and currently, whilst management information is used to track placement ends for over 18s, checks to ensure payments are not being made to multiple carers for a single child have not yet been developed. Further work is therefore needed to determine how the use of system data can be used to identify such cases. The service confirmed this was beyond the scope and responsibility of the commissioning team and therefore the action will need to be taken forward by finance.

Work has also been undertaken with a view to reducing the long standing age debt issue, an external consultant has been commissioned and work to be completed by the end of the financial year. Work on this has commenced and internal reporting has increased with analysis produced and shared monthly. We reviewed the spreadsheet with the position as at 30.11.21 this showed:
-current position.
-position one month ago.
-change between current and one month ago.
-invoice age profile (£ and invoice count).
-newest and oldest invoice date.
-lowest and highest value invoice.
A summary and more detailed breakdown are provided showing invoices noted as "on-hold". We were also provided with a ContrOCC Working Timeline spreadsheet which included a high-level activity plan consisting of 7 tasks to be completed each week with the spreadsheet used as a tool to record the status of tasks. These were:
-review current aged debt invoice report.
-rerun the on-hold invoices report on a weekly basis.
-review a cohort of the on-hold invoices.
-investigate issues.
-identify solutions to fix issues.
-identify area of ContrOCC that needs to be addressed.
-work with colleagues and providers to get invoice issues resolved.
From a review of the spreadsheet, we determined that each task is colour coded as being completed or ongoing. We did note that there were some actions which had not been assigned a colour therefore the completion of this task on a timely basis could not be confirmed; step 2 (w/c 28.11.21) and step 1 (12.12.21). It was not clear from this who was assigned responsibility for each of the actions. The spreadsheet includes an issues tab which showed 9 key issues including:
-no CPLI for period being invoiced.
-incorrect rates.
-discounts/historic framework rates.
Whilst we are able to describe here the positive developments made in strengthening payment controls since our last audit, we also intend to use the findings of our upcoming audit of Foster Care Payments to provide additional assurance through the use of data analytic techniques, to identify any cases where we suspect duplication may have occurred.
As such we currently consider this recommendation to be **partially implemented**.

Recommendation 4 (Significant)

The Commissioning Service Manager in conjunction with Social Work Managers should consider current placement closedown processes and how the risk of payments to more than one carer for the same child and period could be identified in advance, to prevent significant repeated overpayments. This should include ceased arrangements and transfers in internal foster carers, Special Guardianship Orders, extra allowances, and other costs. Once the correct process is determined this should be reflected in the Fostering, Post 16 and Residential workflow diagrams which have been produced recently.

Internal Audit Assessment:

Our discussions with the Head of Provider Services and Commissioning Service Manager confirmed that closedown processes have been improved and LL reports can be used to enable the tracking of this information. Data can also be filtered by placement type allowing for more specific monitoring. The service has discussed the closedown issues with the supervising social workers who are now more versed in picking up these issues (there was recognition from the service that despite the improvement of supervising social worker QA functions accountability sits with the child's social worker). Sessions have also been held around payments to communicate what needs to happen enabling officers to be more proactive and to reduce the risk of placements not being closed following a placement end. Updated procedure notes covering CPT closure and case note alert to social workers and commissioning have been shared with managers through service managers meeting and SW, this has also been communicated through the broadcast sheet. As described in the updates above for other recommendations, a Specialist Business Support officer has been tasked with ensuring placement plans and payments are set up on a timely basis (internal foster care placements) by the allocated Children's Social Worker. This involves the identification of inhouse placements and checking of LL to confirm Placement Plan (PP) and CLA payments are raised in a timely manner, if not completed a further email is sent offering support/attach any guidance of use. This work also aims to identify any issues preventing PP/CLA payments being raised – e.g.: foster carer does not have approval status required/other child placed with the carer on the system no longer placed.

Work is also being undertaken to review unplanned endings and the resultant process and work sitting behind introducing the child to the carer to reduce the instances of placement breakdown to determine whether there are any issues regarding training and matching. This is seeking to develop the culture within the workforce which ensures our children have a positive introduction to a placement. This also provides a QA function to ensure appropriate tasks have been undertaken.

A further development planned from January 2022 is the completion of monthly 'dip sampling' reviews. This approach has been agreed with the Deputy Director and we were informed would include a review of Permission to Accommodate (PTAs) and IPAs for placements. We have not yet seen any further detail regarding the scope of the planned 'dip sampling' reviews.

We consider the status of this recommendation to be **partially implemented**.

Appendix Three: Basis of Audit Assessments (Opinion/Priority/Impact

Level of Assurance	Description
The level of assurance is an auditor judgement applied using the following criteria	
Substantial	Sound system of governance, risk management and control. Issues noted do not put the overall strategy / service / system / process objectives at risk. Recommendations will be moderate or minor.
Reasonable	Areas for improvement in the system of governance and control, which may put the strategy / service / system / process objectives at risk. Recommendations will be moderate or a small number of significant priority.
Limited	Significant areas for improvement in important aspects of the systems of governance and control, which put the strategy / service / system / process objectives at risk. Recommendations will be significant and relate to key risks.
No	An absence of effective governance and control is leaving the strategy / service / system / process open to major risk, abuse or error. Critical priority or a number of significant priority actions.

Priority	Assessment Rationale
The priority assigned to recommendations is an auditor judgment applied using an assessment of potential risk in terms of impact and likelihood.	

Critical	Significant	Moderate	Minor
Actions < 3 months	Actions < 6 months	Actions < 12 months	Management discretion
• Impact on corporate governance • Life threatening / multiple serious injuries or prolonged work place stress • Severe impact on service delivery • National political or media scrutiny • Possible criminal or civil action • Failure of major projects • SMT required to intervene. • Statutory intervention triggered. • Large (25%) impact on costs/income • Impact on the whole Council.		• Some impact on service governance • Some risk of minor injuries or workplace stress • Impact on service efficiency • Internal or localised external scrutiny • Procedural non compliance • Impact on service projects • Handled within Service • No external regulator implications • Cost impact managed at Service level • Impact on Service or Team	

Impact	
Impact is the auditor assessment of criticality of the strategy / service / system / process being audited to the achievement of the Council's priorities and discharge of functions and duties in the following areas. This is described in the Audit Terms of Reference	
Strategic Objectives	Key Partnerships
Safety and Welfare	Finance and Resources
Corporate Risk	Key Service Fulfilment
Organisational Change	Statutory Duty