Flintshire Internal Audit

Progress Report

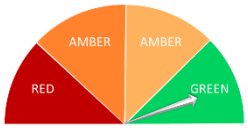
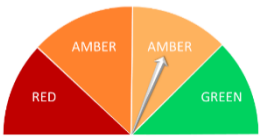
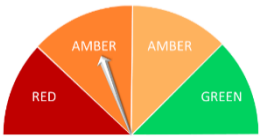
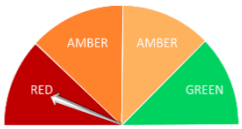
January
2025

CYNGOR
Sir y Fflint
Flintshire
COUNTY COUNCIL

Contents

Levels of Assurance – Standard Audit Reports Appendix A

The audit opinion is the level of assurance that Internal Audit can give to management and all other stakeholders on the adequacy and effectiveness of controls within the area audited. It is assessed following the completion of the audit and is based on the findings from the audit. Progress on the implementation of agreed actions will be monitored. Findings from **Red** assurance audits, and summary findings from Amber Red audits will be reported to the Governance and Audit Committee.

Level of Assurance	Explanation
Green – Substantial 	**Strong controls in place (all or most of the following)** • Key controls exist and are applied consistently and effectively • Objectives achieved in a pragmatic and cost effective manner • Compliance with relevant regulations and procedures • Assets safeguarded • Information reliable Conclusion: key controls have been adequately designed and are operating effectively to deliver the key objectives of the system, process, function or service.
	Follow Up Audit: 85%+ of actions have been implemented. All high priority actions have been implemented.
Amber Green – Reasonable 	**Key Controls in place but some fine tuning required (one or more of the following)** • Key controls exist but there are weaknesses and / or inconsistencies in application though no evidence of any significant impact • Some refinement or addition of controls would enhance the control environment • Key objectives could be better achieved with some relatively minor adjustments Conclusion: key controls generally operating effectively.
	Follow Up Audit: 51-85% of actions have been implemented. All high priority actions have been implemented.
Amber Red – Some 	**Significant improvement in control environment required (one or more of the following)** • Key controls exist but fail to address all risks identified and / or are not applied consistently and effectively • Evidence of (or the potential for) financial / other loss • Key management information exists but is unreliable • System / process objectives are not being met, or are being met at an unnecessary cost or use of resources. Conclusion: key controls are generally inadequate or ineffective.
	Follow Up Audits - 30-50% of actions have been implemented. Any outstanding high priority actions are in the process of being implemented.
Red – Limited 	**Urgent system revision required (one or more of the following)** • Key controls are absent or rarely applied • Evidence of (or the potential for) significant financial / other losses • Key management information does not exist • System / process objectives are not being met, or are being met at a significant and unnecessary cost or use of resources. Conclusion: a lack of adequate or effective controls.
	Follow Up Audit - <30% of actions have been implemented. Unsatisfactory progress has been made on the implementation of high priority actions.

Categorisation of Actions	Actions are prioritised as High, Medium or Low to reflect our assessment of risk associated with the control weaknesses
Value for Money	The definition of Internal Audit within the Audit Charter includes 'It objectively examines, evaluates and reports on the adequacy of the control environment as a contribution to the proper economic, efficient and effective use of resources.' These value for money findings and recommendations are included within audit reports.

Final Reports Issued

Appendix B

The following reports and advisory work have been finalised since the last Governance and Audit Committee. Action plans are in place to address the weaknesses identified.

Project Reference	Portfolio	Project Description	Audit Type	Level of Assurance	New Actions		
					High	Med	Low
28-2024/25	S&T	Parc Adfer	Risk	Amber Green	0	1	1
33-2023/24	SS	Deprivation of Liberty Safeguards Adults (DoLS)	Risk	Amber Red	3	5	0
23-2023/24	H&C	Tenancy Enforcement / Support	Risk	Amber Red	1	5	0
05-2023/24	CE	Management of Community and Recreation Assets	Risk	Red	3	2	0

Audit Assurance Summary for 2024/25

Appendix C

Portfolio	Number of Reports & Assurance						Priority & Number of Agreed Actions			
	Red	Amber Red	Amber Green	Green	Advisory / Grant - No Opinion Given	In Total	High	Medium	Low	In Total
Corporate	1					**1**	3	2		**5**
Education & Youth			1			**1**	0	4	2	**6**
Governance			1			**1**			1	**1**
Housing & Community		1	1		1	**3**	1	7	0	**8**
People & Resources										
Planning, Environment & Economy		1	1		1	**3**	2	7	1	**10**
Social Services		1				**1**	2	5		**8**
Streetscene & Transportation		1	1		1	**3**	0	6	1	**7**
Cross Cutting Portfolio's										
Total	**1**	**4**	**5**		**3**	**13**	**8**	**31**	**5**	**44**
External Audits		1			1	**2**	2	1	0	**3**
Total	**1**	**5**	**5**	**0**	**4**	**15**	**10**	**32**	**5**	**47**

Footnote:	
Red Assurance:	Corp - Management of Community and Recreation Assets
Amber Red Assurance:	H&C - Health and Safety Risk Management; PEE&E - Climate Change, Environmental Sustainability and ESG; SS- DOLs and H&C Tenancy Enforcement / Support

Amber Red Reports Issued

Appendix D

Social Services – Deprivation of Liberty Safeguards Adults (DoLS) – 33–2023/24

Background

The Deprivation of Liberty Safeguards (DoLS) is the procedure prescribed in law when it is necessary to deprive a resident of their liberty who lacks capacity to consent to their care and treatment to keep them safe from harm.

A deprivation of liberty happens where someone is under continuous supervision and control and is not free to leave, and the person also lacks the ability to consent to these arrangements.

This review will focus on Adult DoLS and does not include Community DoLS.

The Deprivation of Liberty Safeguards (DoLS) Team is made up of the Safeguarding Unit Service Manager. The Adult Safeguarding Manager and Deputy Manager (Senior Practitioner/Approved Mental Health Professional), 3 full time Best Impact Assessors (BIA) (1 agency). 4 Administrators, 1 of whom maintains the Action First cases.

Year	Carry Forward from Previous Year	Cases Received In Year	Cases Completed in Year	Cases outstanding
2021/22	SS unable to provide this information	465	444	SS unable to provide this information for the past
2022/23		574	463	
2023/24		607	509	
2024/25 (as at 4/9/2024)		358	121 current caseload	237

Of the 358 applications, 72 (20%) were due to expire within the next 90 days.

The Deprivation of Liberty Safeguards (DoLS) can only be used if a person is in hospital or a care home. Care homes or hospitals must ask the Council if they can deprive a person of their liberty. If a person is living in another setting, including in supported living or their own home, it is still possible to deprive the person of their liberty in their best interests, via an application to the Court of Protection.

There are three types of application:-

- **Standard applications** - If care home or hospital staff complete a standard application, then the assessments required must be completed within 21 days from the date the assessors were instructed by the Supervisory Body being FCC.
- **Urgent applications** – A care home or a hospital can grant itself an urgent authorisation to deprive a person of their liberty if required before a standard authorisation can be obtained. They must simultaneously apply for standard authorisation (if not already done). Where the managing authority has given itself an urgent authorisation and applies for a standard authorisation, the assessors must complete the assessments within five days of the date of instruction.
- **Further applications** - When an existing DoLS authorisation is coming to an end, and the managing authority concludes the authorisation needs to continue, a further authorisation should be requested.

The Managing Authority is the care establishment. Most care establishments fall within the independent sector, however where the Council is the Managing Authority the distinction between Managing Authority and Supervisory Body is that the Managing Authority is overseen by Flintshire County Council's Regulated Services and Resources. This means the County Council's Managing Authority responsibilities falls under the jurisdiction of regulated care provider services which is distinctly different to the Supervisory Body which falls under the jurisdiction of Flintshire County Council's Safeguarding and Commissioning Service.

There are six assessments which must take place before the Council can give standard authorisation. The service has external and internal assessors to decide whether authorisation can be given. The stages of assessment are captured within PARIS.

The Deprivation of Liberty Standards (DoLS) ensures such people are protected if those arrangements deprive them of their liberty. Arrangements are assessed to check they are necessary and, in the person's best interests. Authorisations can be valid for up to one year. The restrictions should stop as soon as they are no longer required. Standard authorisations cannot be extended. If it is felt that a person still needs to be deprived of their liberty at the end of an authorisation, the managing authority must request another standard authorisation (or renewal). Representation and the right to challenge a deprivation are other safeguards that are part of DoLS.

Management information is submitted to Healthcare Inspectorate Wales, and an annual report is produced jointly by HIW and the Care Inspectorate Wales.

The review focused on:

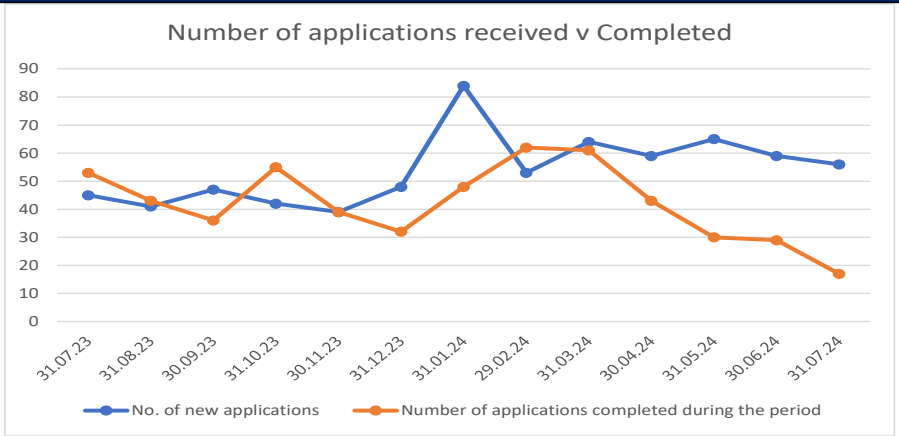
- Review adequacy of policies and procedures in relation to DoLS. Review of training logs to ensure relevant training has been rolled out and refresher training is undertaken.
- Review of authorisation and decision-making processes, including how this is evidenced and communicated.
- Review how objections are received, processed, and responded to by the Supervisory Body.
- Review reporting available which shows compliance with legal and regulatory framework, determine where reporting is shared and escalated to.
- Detailed testing of management controls, management information and reporting to ensure oversight of the DoLS population for 2022-23 and 2023-24.

KEY to DoLS terms		
Managing Authority	**Care Home or hospital**	**Timescales**
Standard Authorisation	The authority to legally hold someone in a care home or hospital under DOLs.	The Managing Authority must complete a request for a Standard Authorisation up to 28 days before the person is due to arrive
Supervisory Body	A Local Authority or a Welsh Health Board in Wales. A Local Authority in England.	The Supervisory Body must then arrange for the person to be assessed within 21 days of receiving the application.
Urgent Authorisation	A Managing Authority can deprive a person of their liberty for up to seven days.	It is expected that the assessments are completed within 7 days of allocation or sooner if requested by the Supervisory Body.
Standard Authorisation	The authority to legally hold someone in a care home or hospital under DOLs.	They should arrange an assessment within 21 days of receiving the application.

Areas Managed Well

- Staff are DoLS trained, Best Interest Assessors (BIA) receive annual refresher training in line with legislation.
- The decision making process and authorisation of DoLS is recorded using the Paris system.
- The Supervisory body has a clear process when objections are received and from the testing carried out they had been processed and responded to in line with legislation.
- Lessons learned exercises take place following the more complex challenges of a DoLS case.
- Annual PI's are captured from the Paris system and submitted to Welsh Government detailing the DoLS received, processed and completed for each financial year.
- The use of external Best Impact Assessor (BIA) to manage workloads and help clear large volumes of applications received. (Action First).

• The DoLS process is prescribed by legislation and during testing it was found that decisions made on the applications reviewed had been appropriately evidenced and communicated.			
Findings and Implications		**Agreed Action**	**When**
1 (R)	**<u>Control Issue: Unauthorised Deprivation of Liberty and Compliance with Legislation</u>** The House of Lords select committee post-legislative scrutiny of the Mental Capacity Act 2005 concluded in 2014 that DoLS due to their excessive complexity and lack of clarity are not fit for purpose and called for them to be replaced. Due to this change there has been an increase in the number of DoLS applications received annually, this has put an additional strain on the service and its ability to meet statutory deadlines for the assessment for DoLS. Testing found: • Delays in allocating, assessing and authorising applications result in many people being deprived of their liberty with no legal protection in place and no opportunity to challenge whilst waiting for a decision to be made. As at 15th May there were 314 referrals at pending decision. • The length of time taken to process applications are not completed within the statutory timeframe of seven days for an urgent application and twenty one days of receiving a standard application. Urgent authorisations expire before the required DoLS assessments can be undertaken. A report (dashboard) from Paris shows the average working days to closure (ref date > closure date) - not including NFAs as 93 days for the month of May 2024. This relates to all types of DoLS applications and not specific to urgent cases. • The service is unable to allocate the volume of DoLS applications received for further authorisations in a timely manner (renewals). This increases the risk of applicants being deprived of their liberty without the continued protection of the safeguards. As at 13th May 2024 there were 14 DoLS applications that were out of date and awaiting renewal, with 79 other applications due to expire within the next 90 days. However, the service takes a risk based approach to best manage the circumstances. The following graph shows the number of applications received / completed during the last 12 months. This excludes the backlog of cases prior to July 2023 due to the way the data is captured and reported.	The Local Authority have agreed to accept the risk associated with this area of work. The risk will be updated in the Council InPhase Risk Management System and reviewed and monitored regularly. The DoLS team have a robust system in place to review and prioritise cases so that limited resources are appropriately allocated. This process will continue. URN 3696	31.03.25

Findings and Implications		Agreed Action	When
	 Due to the time taken to assess these cases, there is a risk is that the Managing Authority is depriving people of their liberty without authorisation from the Supervisory Body (Local Authority).		
2 (R)	**<u>Control Issue: Internal Spreadsheets and Inaccuracy of Data</u>** All DoLS applications received are manually recorded within the PARIS system by the DoLS team. The DoLS Team also maintain a separate excel spreadsheet which they use to track and monitor DoLS applications. Testing between the spreadsheet and the data within PARIS identified: • The DoLS spreadsheet did not reconcile with data held within Paris system, mainly due to the older unallocated cases. • The dates held within the spreadsheet were different to PARIS but the actual case information was accurate. • Due to the increase in the number of DoLS received annually the spreadsheet has not been kept updated or revisited to check the details are accurate or applications remain valid. The current procedures in place for logging and monitoring cases are not an efficient way of working, resulting in data being used to priorities workloads and or make management's decision which is inaccurate and in complete.	The spreadsheet is an administrative tool only and is not used to make Management decisions. PARIS is used to make Management decisions and PARIS date is accurate. The DoLS Manager will ensure that the DoLS administrators regularly check that the spreadsheet data is accurate in the short term. The DoLS Manager will explore whether the PARIS system can replicate the function of the spreadsheet with the aim of dispensing with it, however this may need to wait until the new client information system is in place. URN 3695	31.03.25
3 (A)	**<u>Control Issue: Management of Backlog</u>** <u>Action First</u>	The DoLS Manager will explore whether the PARIS system can assist in identifying timescales for each stage of the DoLS process so Management reports can be	31.03.25

Findings and Implications	Agreed Action	When
To relieve the pressure on the DoLS Service and reduce the back log, a contract was awarded to Action First to assist in completing DoLS applications in February 2021. This arrangement allows the use of external BIA's to asses applications, lower waiting times and reduce the back log. There are no performance indicators detailed within the contract or timeframes for the delivery of DoLS. Unfortunately, despite this arrangement, waiting times for the processing of DoLS are still not meeting legislation. Due the current reports from PARIS it has not been possible to determine whether the level of backlog is reducing. <u>Grant Funding & Budget Pressures</u> Grant funding from Welsh Government has been secured in the past, to support Mental Capacity Act 2005/Liberty Protection Safeguards (LPS) and to be specifically used for "supporting the ongoing work to address the DoLS backlog. Flintshire County Council will offer increased MCA training and Flintshire County Council will appoint an additional part-time Social Worker to work as a BIA alongside the existing BIAs in the in-house team within the Safeguarding Team". Details of the funding received to date is:- **Year** / **Total grant awarded** 2020/21 / £179,841 2021/22 / £120,867 2022/23 / £78,035 2023/24 / £78,035 2024/25 / £130,283 The budget total for Adult Safeguarding for the period 2023/24 was £860,654. The Senior Manager Safeguarding and Commissioning, has stated that should the funding cease, there will be no further budget constraints to continue the processing of DoLS, the backlog will increase, and the service will be placed under further pressure. <u>Examination of case loads with Action First</u> The number of DoLS applications with Action First was examined and it highlighted a discrepancy between the internal 'action first' spreadsheet maintained by the DoLS team and the number as stated on Paris system. 150 cases detailed on Paris and 145 detailed on the spreadsheet. The reason behind this is down to staff error. This was not identified through any quality control process. The Paris system can hold Action First cases in two areas on the system, one being the dummy action first profile and the second against pending decisions. The two profiles on Paris are not regularly reviewed to ensure once they have been transferred over to Action First they are then allocated under the dummy AF profile. It was found during testing that five cases were detailed under the pending decision stage but they	generated to identify the main sources of delay, however this may need to wait until the new client information system is in place. URN 3709	

	Findings and Implications	Agreed Action	When
	should have been recorded against the Action first dummy profile. There is currently no examination of the data held on Paris to ensure consistency. Paris in unable to record the date that the application was sent to Action First. This field is maintained on the inhouse spreadsheet only. The PARIS system can identify case loads but a standard report detailing each stage of the review process and the length of time taken between stages for each case is not currently available, (which could be used to identify any delays in each of the 6 stages of assessment.) At present it is difficult to identify if a specific stage within the process is delaying the application process. This applies to all cases as well as those allocated to Action first. Due to the outcomes of some recent assessments received under the AF contract the Deputy Manager and the AF administrator meet weekly with a member of staff from Action First to ensure issues are addressed and quality assurance arrangements are in place. The findings from testing are:- • The information for the Action first cases was found to be inaccurate and no reconciliation has been carried out between the internal spreadsheet and the data contained within the Paris system. Management information is not in place to identify this at present. • There are no performance indicators detailed for the provision of DoLS applications completed by Action First within the contract. As the caseloads and waiting times increase it is important that expectations and completion of Dols applications are as intended and expected. As this is not detailed or defined within the contract it is difficult to assess and place assurance that the number of DoLS applications processed per annum is meeting the expected DoLS applications. • There is a lack of management information to enable the service to monitor against each of the stages of the assessment process for the applications carried out by Action First. Without timely reports and accurate management information it will prove difficult to monitor and ensure that arrangements in place with AF are not contributing to the waiting times for the processing of DoLS as they are still not meeting legislation.		
4 (A)	**<u>Control Issue: Risk Management</u>** A review of the InPhase system detailed one strategic risk relating to DoLS, which is:- • RSS06 - "Some individuals are unlawfully detained without a DoLS because there is insufficient capacity to manage the waiting list and a limited number of Section 12 Doctors to authorise the applications". A review of InPhase identified:	The Strategic Risk in InPhase has been reviewed by the senior manager and updated in December 2024 to reflect the information in the audit report and subsequent information. The amended risk rating is Risk Impact 4 and Risk 	31.03.25

	Findings and Implications	Agreed Action	When
	• A yellow risk rating (unlikely likelihood and moderate impact) has been assigned to this risk in September 2023. This current risk score has achieved the target risk score of 4, however we are not achieving the statutory deadlines. • The 2022/23 performance data stats issued to Welsh Government suggests the number of DoLS are continuing to increase, with a large number of applications still outstanding. As at 4th September 2024 a total of 121 applications were being worked on (caseload) and 237 awaiting allocation. Total of 358 applications to process. With 72 applications due to expire in the next 90 days. • The number of outstanding applications and failure to meet statutory completion dates does not correspond with the current risk score. • The mitigating actions identified have been closed off on the 2nd July 2024, although the monthly performance has still continued with the August 24 comment stating the risk has been reviewed and the risk score and information remain the same. • It is unclear how the progress of the action can be accomplished and achieved as the data is suggesting DoLS applications are not completed within time frames laid out in legislation leaving applicants deprived of their liberty with no legal protection in place and no opportunity to challenge whilst waiting for a decision to be made. The risk reported and monitored against does not currently reflect the that the Council is not achieving DoLS assessments with the statutory timescales.	The risk will be reviewed quarterly in line with other Strategic Risks identified by the portfolio. URN 3711	
5 (A)	**<u>Control Issue: Insufficient Management Information</u>** The PARIS system records each of the six stages within the DoLS process individually within Paris. A summary dashboard is available within PARIS which is a high level overview of the cases received as at the date the report is run. On examination of the dashboard it was found: • Using the dashboard manual calculation is required to identify the total number of DoLS cases. • The dashboard report does identify the number of applications received but not 'live / allocated' to date to provide an overall number of DoLS applications, including those 'backlog' cases. • The report does not state as which stage of priority each application is at. • Whilst the report identifies the date of the oldest case it doesn't identify an age analysis of all cases. The oldest case outstanding was received on the 08.01.2022. • The reports are intended to be run on the last day of each month, and the "pending" figure will only ever be correct on the day that it is run because it is a count of Case Status = "Pending Allocation". Once the allocation has been made, the status changes to "Allocated", and there is no way of looking back on a	A report detailing each application and the length of time taken between stages could provide Management with a useful management tool to identify arears where delays are being experienced. This could identify issues with various stages of the process and address these to ensure the process is working as intended. URN 3708	31.03.25

	Findings and Implications	Agreed Action	When
	report. There is a functionality in Paris of waiting lists which keeps a history of date on / date off, but DoLS don't currently use it. Without detailed management information there is a risk management cannot easily identify the number of cases loads at any one time and pinpoint any delays at the various stages throughout the DoLS process and which may also impact of decisions made. This level of information would be crucial to manage performance both internally and with the external provider, address and improve future workflow and efficiency of the DoLS process.		
6 (A)	**Control Issue: Quality Assurance Process** Staff are not provided with written processes or procedures relating to the assessment of DoLS applications and instead use the guidance within the legislation. Management confirmed procedures are being drafted for the service. During the audit it was found that a number of Form 1 enquiries had been missed. This is due to them having been screened and put on PARIS, and recorded in the enquiry box that a notification has been sent. However, these notifications have not been received so the Form 1 has not been double checked and actioned. The Adult Safeguarding Manager would usually initiate the review of these cases. At present there are no procedures in place detailing the process or how the outcomes are to be used or aide future cases. In the absence of a robust quality assurance process and documented procedures and workflow processes are not followed, there is a greater risk of misinterpretation of legislation, inconsistency in its applications and these go unnoticed.	An Operational Policy is currently being finalised and this will shared and discussed within the team. The Policy will form part of any induction process for new staff. URN 3694	31.03.25
7 (A)	**Control Issue: Monitoring and Reporting by Priority Applications** Each DoLS is risk assessed using the Welsh prioritisation tool. The outcome of the risk is placed onto the individual note of the DoLS application within Paris. There is a separate field within Paris called prioritisation which is used to copy the outcome of the risk assessment. During testing it was found that once the DoLS application progresses through the various stages of application, the prioritisation field is updated to reflect the current stage and the risk score first applied is then overwritten. There is currently no way to easily identify or report upon the priority rating (High / Medium or Low priority) other than read the notes section within the individual Paris record. Without this information there is a risk that management are unable to target resources to the higher risk applications.	To consult with PARIS team to determine whether a further column can be added for the purposes of identifying the current stage of the process whilst maintaining the original priority rating field. URN 3703	31.03.25

Housing & Communities – Tenancy Enforcement / Support –– 23-2023/24

Background

This review is being carried out as part of the Internal Audit Annual Plan for 2023/24 which has been agreed with Chief Officers and approved by the Council's Governance & Audit Committee.

The Council are responsible for ensuring they have processes and remedies in place to tackle Anti-Social Behaviour and other prohibited conduct with Council contract holders as part of their responsibilities as a landlord to tackle anti-social behaviour and to provide guidance as to what constitutes prohibited Conduct [ASB], as defined under Renting Homes Wales [2016].

When first signing up to rent a property the contract holder is given an occupation contract which clearly explains their responsibilities with regard to prohibited conduct.

The Anti-social Behaviour, Crime and Policing Act (2014) defines ASB as:

• Conduct that has caused, or is likely to cause harassment, alarm or distress to any person.

• Conduct capable of causing nuisance or annoyance to a person in relation to that person's occupation of residential premises.

• Conduct capable of causing housing-related nuisance or annoyance to any person.

This definition has been extended to include behaviour by residents, groups of residents, members of their household or their visitors, which would generally be considered to cause annoyance, nuisance or disturbance to other people in the area.

Conduct of the contract holder prohibited by section 55 of the Act states, The behaviour which potentially breaches these terms is wide ranging and can include excessive noise, verbal abuse and physical assault. Prohibited conduct may also include domestic abuse (including physical, sexual, psychological, emotional and or financial abuse). If a breach is found to have been made, the landlord (FCC) may on that ground make a possession to claim back the property. If the Council makes a possession claim on this basis.

However, possession cases are the absolute last resort due to the direction of policy being no evictions into homelessness (Ending Homes in Wales – WG plan 2021-2026).

The audit focused on the Council's approach in relation to tenancy eviction and the adequacy and effectiveness of the established processes whilst adhering to renting Homes Wales 2016 Legislation. The Audit did not review evictions for rent arrears as this is managed and dealt with by a separate Manager and Portfolio and falls under a different policy.

The Enforcement team consists of a Senior Housing Officer who manages the team, 2 Enforcement Officers (1 term time only) and 1 Neighbourhood Housing Assistant, there are 2 Enforcement Officer vacancies.

The Council currently have 7,352 properties and there are 86 live enforcement cases. 14 of these cases are with the Enforcement team. There are also cases that are with the Police that we are awaiting an outcome on before further action can be taken, these are closed and re-opened when necessary. The remaining 72 live cases are managed by the Housing Officers with the aim of resolving issues and preventing evictions. The Tenancy service follow the Housing Management Policy 2023 and an Anti-Social Behaviour Policy 2023 when managing potential evictions.

The service currently uses an unsupported and out of date IT system, known as React to record all enforcement cases (excluding debt recovery) dealt with by the team, as a consequence it was not possible to provide assurance in key areas of the tenancy enforcement process such as management of current caseload, workflow, cases escalated to

Panel and management information provided by the system. Due to these limitations an amber red assurance has been provided as we have taken into account managements awareness of the systems limitations and that they are currently in the process of testing and implementing an up to date supported system which will address the current limitations going forward.

Areas Managed Well

- Policies are in place and tenancy evictions are operated in in line with statutory obligations.
- New methods of resolving enforcement issues are considered and introduced where applicable.
- Complex cases requiring Legal advice are presented to a case panel and decisions made with relevant officers who asses all the facts.
- The eviction process is used as the final stage before all other remedies have been exhausted.

	Findings and Implications	Agreed Action	When
1 (R)	**Control Issue: Lack of Management Information to Inform Decision** React and Housing Solution The React system holds the details of all Enforcement Team cases sent from the Housing Officers, for review, and where, relevant action by the Enforcement Team. The Housing Officers try to resolve all complaints/issues and once all avenues have been explored, the case is then referred to the Enforcement Team, all work completed by the Housing Officers should also be included onto the React system. It was not possible to determine whether there are cases which have reached the threshold of requiring enforcement action and should have been referred by the Housing Officers to the Enforcement Team as it was not possible to obtain a full list of tenancy enforcement cases during the review due to the limitations of the system. The review identified: • Housing Officers use the Open Housing system and the tenancy Enforcement Section use the React system. • There is no interface between the two systems at present. Without an interface between the two systems or standard reporting available to reconcile the systems it was not possible to provide assurance that Management have overall control over the tenancy cases. The Manager of the Enforcement Team can view cases which have been allocated to staff in his team using manual processes, by accessing each case individually to understand the current position as reporting is not available. Management Information and Reporting Management information is essential to understand how effective a service is in complying with policies and procedures. When reviewing the React system it was noted:	The service is currently implementing a new system which will address all of the concerns raised. The new system will contain all cases irrespective of stage i.e. low level ASB or garden concerns, right through to enforcement action. There will be management reporting to provide ongoing oversight around all cases and progression of these. Actions will require dates for progression and reports will be produced to flag out of date actions, providing a workflow process with key indicators. The system will be used by NHOs and Enforcement staff URN 3730	01/09/2025

	Findings and Implications	Agreed Action	When
	• There is no functionality to report on enforcement cases and provide management oversight and strategic reporting. • The current React system does not have any workflow built in. Most of the steps within the tenancy enforcement process are performed manually. • Tenancy enforcement do not report statistics or other meaningful data to any internal Council Committee at present. To enable testing the enforcement team provided data of individual contract holders and the enforcement details held in the react system for individual enforcement cases. The lack of integration with the Open Housing system, available management information and the lack of reporting functionality does not enable :- • All cases which meet thresholds are referred to the Enforcement Team. • Sufficient oversight of workload, staff cases, details of individual cases, and instances of delays occurring in stages of enforcement. • Absence of monitoring and reporting performance of the enforcement team.		
2 (A)	**Control Issue: Cases may be dealt with using different time periods.** Whilst the Anti Social Behaviour Policy and Occupation Contract set out the steps of the enforcement process and the sanctions that may be applied in cases of tenancy enforcement, there are no timescales for process and escalation for each various stage. During testing it was found that some enforcement cases had taken years to progress, and the sanctions applied had taken a large amount of office time before the case was moved to the next stage. For example:- Contract Holder "A" receives a final warning within 2 months of the case being dealt with by Tenancy Enforcement and Contract Holder "B" receives a final warning within 2 years of the case being dealt with. Without timescales, stages are subjective and are determined by the Housing or Tenancy officer, depending on the situation and may result in inconsistencies of application across the service, and could be deemed unfair if challenged.	Within the regulations there are key stages to enforcement action. The process can be protracted due to current policy of no evictions into homelessness which means there is more focus and attention on support and interventions during the enforcement period. As a solution to tracking cases and ensuring progress this will be resolved on implementation of the new system as detailed above. URN 3738	01/09/2025
3 (A)	**Control Issue: Documented Procedures and Quality Assurance.** Procedures provide staff with the guidance to complete tasks whilst ensuring staff apply process consistently. Whilst the service has draft procedures, they have not been finalised.	Procedures are in the process of being reviewed as part of the implementation of the new system. Performance and case discussions will be included in a newly developed 1-1 template	01/09/2025

	Findings and Implications	Agreed Action	When
	During testing the correct processes had been applied but with the lack of functionality within the react system at present, assurance cannot be given to the quality assurance of enforcement cases and if Management have sufficient oversight to ensure this is in place. Without finalised written procedures and a robust quality assurance process there is the risk. errors, omissions, or inconsistency in process may occur.	which will be rolled out for use alongside the system implementation. This will also serve as a QA process where approaches are discussed and lessons learned. URN 3739	
4 (A)	**Control Issue: Effectiveness of the Panel & Process delays in progression of cases** Enforcement cases are referred by the enforcement team to panel once all other avenues have been explored and applied. Panel will discuss any potential eviction or enforcement cases which require legal advice and guidance. A panel spreadsheet referred to as the tracker records all panel decisions including previous closed panel decisions. The Panel currently meet every three weeks. On review of the panel process and supporting documentation, it was noted: • There is no Terms of Reference set out for the Panel or indicative timescale / escalation process to ensure cases are progressed in a reasonable time. • There are no current documented processes or formal agreement in place between the services who attend panel. • There are often delays in obtaining Legal advice and delays in the issuing of legal letters to Contract Holders as panel decisions were found to be carried forward to the following meeting due unavailability of appropriate legal representation at Panel meetings to provide advice and allow the correct decisions and action to take place. • It was difficult from the records held to establish if all the legal letters to be issued by Legal had been sent. • As part of the panel process advice and guidance from Legal Services is required. Without a clear Terms of Reference and documented procedures setting out the panels roles and responsibility there is a risk enforcement cases may be unnecessarily delayed / progressed to a satisfactory resolution.	TOR to be drafted and agreed Service level agreements to be drafted and agreed with Legal. URN 3716	31/03/25
5 (A)	**Control Issue: Critical information relating to specific cases are not held on/ in a Single system.** During detailed testing it was found that key documents including letters and other important details such as overdue Gas and electrical testing and garden complaints are not always kept in a single system.	This issue has been taken into account and will be resolved by the implementation of the new system. URN 3718	01/09/2025

	Findings and Implications	Agreed Action	When
	Details were found to be kept in different locations making it difficult to obtain the full chronological order to evidence if the entire enforcement process is followed. i.e issued letters relating to overdue gas & electrical inspections were found to be recorded on spreadsheets and not within the react/open housing system. The React system does not currently record overdue gas and electrical inspections as it is not deemed an enforcement issue. During testing it was found that one overdue electrical testing was included onto the panel tracker as no entry will be provided by the Contract Holder and therefore this become an enforcement issue but not all cases are.		
6 (A)	**Control Issue: The enforcement service has no associated risks contained within the Council's Risk Register.** The Council's risk register InPhase was examined and it was found that there is no risk relating to tenancy enforcement. The current IT system in place (React) is not fit for purpose and is no longer supported due to its age. This poses a large risk to the service. The updated system is in the final stages of being implemented, but no specific date has been identified. The Service Manager stated that Housing operational risks are not placed into the Councils InPhase risk register at this time and they maintain a separate operational risk register themselves. On examination, a risk has been identified relating to the React system, but no risk relating to failure of tenancy enforcement in accordance with legislation. Currently the service is failing to comply with the Council's Risk management Framework, where all project, operational or strategic risks should be held and managed within the Council's Risk Management System.	All Risks are to be entered into InPhase. URN 3717	31/03/2025

Red Reports Issued

Appendix E

Chief Executive – Management of Community and Recreation Assets – 05-2023/24

Background

The Council has a range of assets, following the transfer of the Open Spaces team to Aura Leisure & Libraries in 2017, which are now managed either by Valuation & Estates (V&E) or Streetscene and Transportation (S&T) Services. These are referred to as Community and Recreation for the purposes of this review and include playing/sport fields, bowling greens and associated buildings including changing rooms, pavilions. These are not to be confused with the Community and Recreation under Aura's management and control. The Council has access to Tech Forge (TF) to record its assets.

The review focussed on the effectiveness of the controls in place to manage these assets. Dependent on any existing agreement (lease, licence, management agreement, other agreement) for the asset, we evaluated the controls in place to ensure compliance with any maintenance, statutory and landlord checks; in particular any inspection regime to mitigate against relevant health & safety risks, and oversight of income processes. The review assessed whether the split of responsibilities amongst the V&E and S&T teams is effective. Value for money was not part of the scope of this audit. However, we did test to see that fees being charged were being received.

Areas Managed Well

- The booking process for football playing fields is well managed.
- Where there is a known payment for an asset managed by V&E this is recorded in TF and reconciled monthly with Finance.

Progress Since Issuing the Report

On the 12th December the Corporate Manager, Capital Programme & Assets presented the audit report to Corporate Resources Overview and Scrutiny Committee, summarising the findings and confirming the actions the service has already implemented to mitigate risks but also advises action that will be undertaken to address the remaining identified risks within specific timeframes. Since the audit a task and finish group has been established. An action plan to address the risks raised in the audit has been developed and will be overseen by the task and finish group until completion. The groups focus will be: -

- Statutory Health and Safety compliance
- Contract management.
- Ensuring all relevant Asset information is recorded on Technology Forge (TF)
- Resolving cross portfolio working Audit recommendation/s

The following actions are now in place -

- An inspection regime of remote unoccupied buildings in now in place and managed through the Valuation and Estates team and is recorded on Technology Forge (TF).
- There is now a statutory maintenance regime in place and recorded on Technology Forge (TF) the Councils asset management database.

A further update with be provided by the Corporate Manager, Capital Programme & Assets at the Governance and Audit Committee in January.

Findings and Implications	Agreed Action	When

Findings and Implications		Agreed Action	When

1 (R)	**Statutory Health and Safety (H&S) Checks**
	
	Expected
	
	• Assets belonging to the Council are subject to statutory health and safety (H&S) checks. There is a process in place to ensure all H&S checks are completed with the results recorded centrally enabling any issues raised to be actioned.
	
	• Risks associated with the failure to complete statutory checks are recorded on the register, scored and mitigation statements completed.
	
	• In the case of the Council transferring the liability via a lease / management agreement the club contracted with is clear of their responsibility to ensure the statutory checks are completed and provide evidence to the Council of compliance.
	
	Findings
	
	• The Corporate risk register (InPhase) lists risk RCPA06 'Limited / no resource available to fulfil statutory landlord requirements / testing schedule. Risk of liability and risk to life'.
	
	• This was last assessed (October 2023) having a score of 20, making it a major risk to the Council.
	
	• There are two mitigations included with this risk which are future aspirational intentions rather than actual operating controls to mitigate the risk: -
	
	  • New building inspector role being explored.
	
	  • Working with other services/Portfolios to explore options to work collaboratively to fulfil... (the sentence ends there on the InPhase system).
	
	• V&E have contracted with housing (HCA) to deliver legionella checks. Testing identified, of the 62 known Community and Recreation with a building only 14 (22%) are being tested by HCA.
	
	• TF does not record evidence these checks were being carried out.
	
	• There are other statutory landlord checks, for example periodic gas safety, building electrical safety and structure checks; HCA report they have not been asked to complete any of these checks.
	
	• In response to the pandemic the physical inspection of the buildings by V&E stopped and a letter and response process was used. This has continued post pandemic. Council Community and Recreation are not being inspected for damage or deterioration.
		• A multi-disciplinary task and finish group has been established, with its first meetings 17th July 2024.
		
		• An action plan to address the risks raised in the audit has been developed and will be overseen until completion.
		
		The task and finish group will focus on: -
		
		• Statutory H&S compliance
		
		• Contract management.
		
		• Ensuring all relevant Asset information is recorded on Technology Forge (TF)
		
		• Resolving cross portfolio working recommendation
		
		Matters that have already progressed are, as follows:
		
		• An inspection regime of remote unoccupied buildings in now in place and managed through the Valuation and Estates team and will be recorded Technology Forge (TF). (Complete)
		
		• There is now a statutory maintenance regime in place and will be recorded on Technology Forge (TF) the Councils assets Management database. (Complete)
		
		Items to be included on the action plan:
		
		• Streetscene to review & develop a public open space inspection process. (31/12/24)
		
		• Streetscene to review Pitch hire process with the contact centre. (31/12/24)
			31/12/2024

	Findings and Implications	Agreed Action	When
	• The lease and management agreements have clauses for who is responsible for building upkeep internally and externally. However, no evidence provided to show there was a process to record the responses from clubs as to the soundness of the building and if they had complied with their lease / management agreements (if there is one in place). • There is no evidence to show how the Council responds to any reports of failure on the part of the club to maintain the building to a reasonable standard. • TF has a section for the recording of works done and when they are meant to be checked/renewed, this is not being used. <u>Risks Identified</u> • Failure to accurately assess, record, score and mitigate risks can result in objectives not being achieved. • The Council is unable to evidence that all the statutory H&S checks on Community and Recreation buildings remaining under Council control have taken place.	• A review of where individual assets sit will also be undertaken from an efficiency perspective. (31/12/24) The audit report and action plan will be presented to the Corporate Resources Overview & Scrutiny Committee (CROSC) at the earliest convenience. (Complete) **URN 3580**	
2 (R)	**Management Agreements / Leases / Contractual Agreements** <u>Expected Controls</u> • Standard management agreements / leases / contracts are in place. • These are reviewed periodically to ensure the people who signed on behalf of the club are still part of the organisation. Any changes to the clubs' management are noted on TF with emergency contact numbers of key holders kept current. • There is a timetable in place to renegotiate contracts as they come to an end. Where no club can be found to take over a building, a review of the asset is completed and if it no longer meets the needs of the community disposal of the asset is assessed. • The Council retains a copy of the keys for all assets in a secure place, which can be accessed by a limited but relevant range of officers in the case of need. • There is a schedule of asset inspections to ensure lease and agreement holders are maintaining the property and it remains in a good condition. <u>Findings</u> • Many of the agreements / leases have come to an end but there is no action plan in place to address. The history notes on TF show in several cases attempts to renegotiate a new lease /	**The Action plan will include the following:** • Keyholder information will be reviewed, updated, and logged on TF. • Lease and licence agreements will be reviewed by Valuation and Estates team for buildings and land as appropriate. • Formal agreement review dates will be added to TF as a trigger to review/renew in a timely manner. • As part of this process, we will formally clarify the responsibility and liability for H&S for those assets which are subject to a lease / management agreement including Council's expectation of how to evidence these checks have been completed. • A process will be put in place around control and non-compliance. (i.e. agreement to use, duties under any agreement and or payment of bills).	31/03/2025

Findings and Implications	Agreed Action	When
agreement, however the notes end with no progress made on an agreement: some three to five years later. • V&E state they do not know who the key holder is for every building, nor does Council retain a copy of the key to every Community and Recreation asset building. • Management advises due to low level of income, even if a club has stopped paying the Council, and continue to use the building, there is no real push to chase the payments or renew the lease / agreement. This can have implications on responsibilities for building maintenance and other contractual obligations. • Due to lack of resource, V&E switched from physical inspections to sending letters to the club trustees asking them to confirm they had complied with the agreement to maintain the interior of the property and the décor was in good order. TF does not record any responses to evidence the letters has been replied to. • No evidence was provided to show the process for dealing with a club who does not respond to the letter. No evidence was provided to show the process for dealing with any issues reported by clubs. • There is no process in place for ending access to a council asset if a club fails to pay the agreed fees. <u>Risks Identified</u> • The Council does not have key access to all assets under its control. Nor do we have a list of all key holders. This would be a cost to the Council in the event of needing to access the building. • The lack of up-to-date management agreements / leases means lack of clarity around responsibility and liability for H&S. Failure to renew or update agreements risks legal questions over insurance and damage to fixture and fittings. • There is a risk the clubs who continue to use the asset once a contract has lapsed will fail to carry out the maintenance required by the agreement. This could lead to the asset falling into a state of disrepair, which will require costly remedial actions by the Council. The Council does not know the true condition of its Community and Recreation . Buildings could be falling into a state of disrepair and will become more costly to bring up to a reasonable standard. The Council could also be overstating the value of an asset due to unknown/unactioned disrepair.	**URN 3574**	

	Findings and Implications	Agreed Action	When
3 (R)	**Tech Forge System and Asset Data** Expected Controls • All Community and Recreation should be recorded on the TF system and contact / details are accurate. • Unique Reference Numbers should be used to ensure assets are not duplicated. • The asset management system is used to record maintenance, statutory and landlord checks. • All officers with asset management responsibility have access to TF and can update with work done. Findings • We are unable to provide assurance that all Community and Recreation are recorded in TF. The list of provided by S&T could not be reconciled with the list generated from TF by V&E. (circa 67 bowling greens, cricket pavilions, tennis clubs and playing fields with changing facilities) • There is a failure to use a URNs; relying rather on street or club names which were found to be different on each list and risk duplication/inconsistency. (Detailed testing results can be provided) • A previous review of TF highlighted the requirement for a single URN which could be used across systems and services. • Officers in S&T with asset management responsibility do not have access to TF, instead they manage all their Community and Recreation on multiple spreadsheets. Risks Identified • The TF system is not being used to its full potential. The silo nature of the current arrangement is a barrier to good communications and effective multi-service partnership. • Without consistency of names, locations and recording, there is a risk assets have been missed and are not included in TF. It could result in failure of effective management of assets. There is a risk works are not completed or statutory checks cannot be evidenced in case of external audit by HSE. This could result in legal censure and the possibility financial penalty.	• An action plan to address the risks raised in the audit has been developed and will be overseen by the task and finish group until completion. • Members of the task & finish group will reconcile asset management information, to ensure its accuracy. Thereafter a process will be put in place to capture any asset changes in the future. (31/12/24) • The Action Plan will include measures to integrate TF between to two portfolios and to utilise the system to ensure efficiencies of work stream (where practicable) (31/12/24) The audit report and action plan will be presented to the Corporate Resources Overview & Scrutiny Committee at the earliest convenience. (12/12/24) **URN 3575**	31/12/2024
4 (A)	**Roles and Responsibility** Expected Controls	• An action plan to address the risks raised in the audit has been developed and will be overseen by the task and finish group until completion.	31/12/2024

Findings and Implications		Agreed Action	When
	• There is a clearly defined statement of areas of responsibility for the Community and Recreation remaining under Council control. • The name(s) of the officer(s) responsible for an asset is recorded on TF and known to the other portfolios. • There is a clear and easy to understand process for the booking and use of the facilities. <u>Findings</u> • It is unclear how responsibility is shared between various teams and portfolios. An asset can be managed by V&E and S&T or both. An oversight on the process of management is not established. • There is confusion over who is responsible for play equipment. When asked one team member in V&E said HCA and another in S&T said Aura. TF does not clarify this issue. • There is a section in TF for a responsible officer(s) name to be added. In the case of assets managed by S&T, the named officers all left the Council more than 5 years ago. In the case of assets under V&E management, the named officer is mainly the Asset Manager, but also one or other of her team. There is no clear explanation of what the role of the named asset manager is. • S&T carry out the maintenance and booking process of the playing fields, however their process does not include access to the changing rooms which are under the responsibility of V&E; this is ineffective use of resource and complicated for the user. <u>Risks Identified</u> • There is a risk, unless all those managing a shared asset are aware of their own roles and responsibilities and those of the other services involved, necessary jobs may be missed or duplicated. There is risk the confusion over the booking of the changing facilities may stop a team booking a pitch and raising complaints over the condition of the asset.	• Roles and responsibilities between portfolios for all LA retained Community and Recreation will be defined. TF will be updated accordingly with this information. (31/12/24) • The Task and Finish group will review the process of booking with the view to creating a one stop solution for hirers. (where practicable) (31/12/24) **URN 3584**	
5 (A)	**Income Management** Value for money was not part of the scope of this audit. However, we did test to see that fees being charged were being received. <u>Expected Controls</u> • Assets which attract a charge or rental have payments recorded in TF and are reconciled monthly.	**URN 3712** An action plan to address the risks raised in the audit has been developed and will be overseen by the task and finish group until completion As these are community-based organisations manged in the main by volunteers it will be extremely difficult to charge full cost recovery, as	31/03/2025

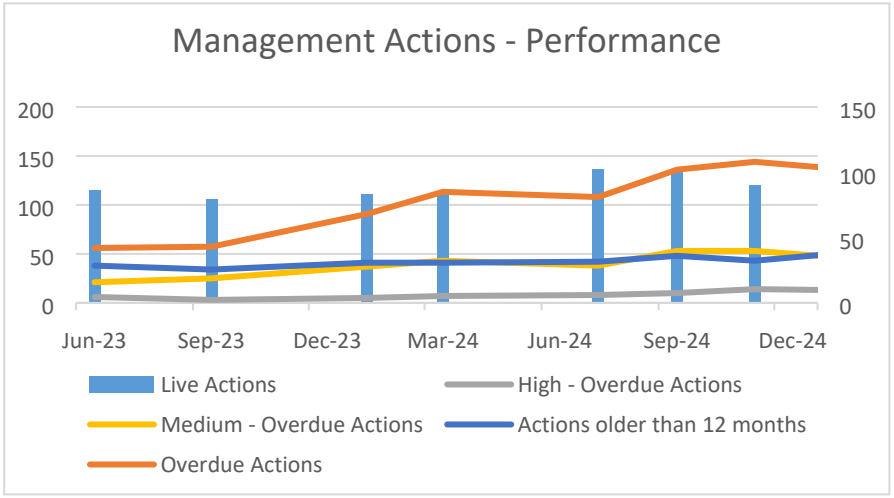
Findings and Implications		Agreed Action	When
	• Missed payments are noted and chased through the Council's normal income recovery process. • Continued missed payments results in the loss of use of facilities. <u>Findings</u> • Not all assets in TF have charges / fees recorded. • Where the asset is managed by S&T a separate system for charging is in place. • A test on bowling club buildings found those with a lease/management agreement (even if in several cases that contract had lapsed) had payments logged in TF. This was checked monthly with finance. • If a club does not pay their fee, no action was taken to pursue nor was access to the asset restricted. • A similar test was carried out on football pitches. S&T have a booking process with recording of invoices paid/not paid. • These payments are being coded to multiple detail codes on the ledger, (5611, 9271, 9273) making it difficult to reconcile payments. <u>Risks Identified</u> • The sums being charged are very small and there is a risk that more resource is being used to invoice/receipt and reconcile fees than is being earned. • It should be noted these assets are public spaces and it is difficult to restrict access, however this is inconsistent with having a booking and charging system. • Whilst a booking process will aid the community to ensure all have a share of the use of the asset, the cost to the Council for invoicing and managing payments could be seen as uneconomic. • Unpaid fees / unused assets can provide management information. It can be an indication of an asset which has fallen out of use and may be a candidate for disposal. • Using multiple codes for recording income makes effective reconciliation difficult.	some organisations are very small. Whilst on the face of it a fee review would be the way forward, this may lead to organisation/groups leaving facilities, losing the facility to the community and the possibility of some facilities being handled back to the Council, leading to additional cost pressures. • The Action Plan will include a review of the income codes and reconciliation process / approach to fees and charges to ensure consistency (where practicable) (31/3/25)	

Action Tracking – Portfolio Performance Statistics

Appendix F

Portfol	Live Actions	Analysis of Live Actions			Total Actions Overdue	Analysis of Overdue Actions			Overall % of Overdue Actions	Actions with a Revised Due Date	Actions between 6 & 12 Months	Actions 13+ Months
		H	M	L		H	M	L				
CE	10	4	3	3	5	2	1	2	50%	3	3	1
P&R (HR)	23	5	10	8	19	0	9	6	83%	14	8	11
P&R (Fin)	6	0	4	2	5	0	3	2	83%	4	1	4
E&Y	0	0	0	0	0	0	0	0	0%	0	0	0
Gov	7	0	2	5	7	0	2	5	100%	5	0	5
H&C	22	3	13	5	11	2	4	5	55%	14	1	14
PE&E	10	1	8	1	4	0	4	0	40%	3	3	0
SS	5	5	4	1	8	5	3	0	80%	2	3	0
S&T	10	2	6	2	8	1	5	2	80%	6	2	5
Ext	5	0	2	3	5	0	2	3	100%	1	3	2
Schools	30	2	14	14	30	2	14	14	100%	1	8	7
Total	**132**	**22**	**66**	**44**	**102**	**12**	**47**	**39**	**77%**	**53**	**32**	**49**

Graph opposite shows the number of management actions raised and performance in implementing these



High Priority Actions Overdue

Appendix G

Portfolio	Audit	Ref:	Action	Original Action Due Date	Revised Due Date	Date of Last Update Provided by Service	Reason for Revised Due Date and Current Status
CEX	Management of Community and Recreation Assets 23/24	3575	• An action plan to address the risks raised in the audit has been developed and will be overseen by the task and finish group until completion. • Members of the task & finish group will reconcile asset management information, to ensure its accuracy. Thereafter a process will be put in place to capture any asset changes in the future. (LM 31/12/24) • The Action Plan will include measures to integrate TF between to two portfolios and to utilise the system to ensure efficiencies of work stream (where practicable) (LM/BW 31/12/24) • The audit report and action plan will be presented to the Corporate Resources Overview & Scrutiny Committee at the earliest convenience. (DH 12/12/24)	31-Dec-24	-	-	Reported separately in Appendix E
CEX	Management of Community and Recreation Assets 23/24	3580	• A multi-disciplinary task and finish group has been established, with its first meetings 17th July 2024. Damian Hughes will chair the group. • An action plan to address the risks raised in the audit has been developed and will be overseen until completion. • The task and finish group will focus on: - – Statutory H&S compliance – Contract management. – Ensuring all relevant Asset information is recorded on Technology Forge (TF) – Resolving cross portfolio working recommendation • Matters that have already progressed are, as follows: – An inspection regime of remote unoccupied buildings in now in place and managed through the Valuation and Estates team and will be recorded Technology Forge (TF). (Lisa McLellan – complete) – There is now a statutory maintenance regime in place and will be recorded on Technology Forge	31-Dec-24	-	-	Reported separately in Appendix E

Portfolio	Audit	Ref:	Action	Original Action Due Date	Revised Due Date	Date of Last Update Provided by Service	Reason for Revised Due Date and Current Status
			(TF) the Councils assets Management database. (Rod Taylor – complete) • Items to be included on the action plan: – Streetscene to review & develop a public open space inspection process. (BW 31/12/24) – Streetscene to review Pitch hire process with the contact centre. (BW 31/12/24) – A review of where individual assets sit will also be undertaken from an efficiency perspective. (LM 31/12/24) – The audit report and action plan will be presented to the Corporate Resources Overview & Scrutiny Committee (CROSC) at the earliest convenience. (DH 12/12/24)				
HR	23/24 - DBS	3610	• Overspend has been highlighted as an issue for several years due to unachieved efficiency. • Options to charge were considered unpalatable and a barrier to recruitment, however we will produce a paper to COT outlining the need for a realist budget / operating model.	31-Mar-24	31-Oct-24	17-Sep-24	COT paper drafted, was scheduled for 02/09/24 but deferred to next meeting. Hopefully will achieve desired outcome at that stage.
HR	23/24 - DBS	3611	• Trent does have the facility to record and identify when a new position (Job) is set up. Systems refer to the HR form and if the position has a mandatory requirement a field is ticked to reflect this and is inherited future occupants. (No further action is required). • Review data sets immediately and investigate and address high risk gaps. • Review any associated processes which have led to the gaps. • Contact other LA's for ideas of good practice.	30-Jun-24	31-Oct-24	15/07/2024	Data sets have been reviewed for all schools, Social Services data is being reviewed and other portfolios will follow. Processes have been reviewed and changes implemented as required. The recording of DBS Update Service recheck results was identified as a significant reason for gaps in recording of data and this has been addressed. Good practice from another LA has been implemented whereby Reporting Managers are notified of rechecks required within the next 3 months and receive monthly reminders - instances of rechecks not being undertaken are escalated.
HR	23/24 - DBS	3613	• Review data sets immediately and investigate and address high risk gaps. • Review any associated processes which have led to the gaps, including use of the update service. • Contact other LA's for good practice ideas.			15/07/2024	Data sets have been reviewed for all schools, Social Services data is being reviewed and other portfolios will follow. Processes have been reviewed and changes implemented as required. The recording of DBS Update Service recheck results was identified as a significant reason for gaps in recording of data and this has been addressed. Good practice from another LA has

Portfolio	Audit	Ref:	Action	Original Action Due Date	Revised Due Date	Date of Last Update Provided by Service	Reason for Revised Due Date and Current Status
							been implemented whereby Reporting Managers are notified of rechecks required within the next 3 months and receive monthly reminders - if it's identified that a recheck has not be undertaken this is escalated.
HR	23/24 - DBS	3614	• Consider including in the risk register. • HR will review value of report to be provided to other Portfolios based on risk. • Reports to be generated consistently and provided to Management. Ensure Portfolios action the reports as necessary. • Define escalation process as part of the workflow.				URN3610 - COT paper seeks additional dedicated resource and the return of DBS checks to HR. If agreed, will map out roles, new processes and reporting etc.
H&C	Homelessness & Temporary Accommodation 21/22	3255	• The response will be delivered in the medium term. All actions are assigned to the Service manager to be delegated across team. • Medium term (June 2022) • Introduce management information to: • Monitor performance timescales at the various stages in Void Management Process. Information to be timely reviewed to identify and address process impediments/ opportunities for improvement. • Provide oversight of all offers for permanent accommodations, those that were declined and the reason for decline. • Oversee length of stays in interim accommodation which is being developed in In-Phase. • Oversee rent collection activities. • Monitor SLA agreement KPIs.	30-Jun-22	31-Mar-24	30-Jan-24	Further to the update provided to Governance and Audit Committee in November 2023, further progress is outlined below: Improve and enhance excel spreadsheet to capture all information in relation to temporary accommodation. • Spreadsheets updated for data capture and available for Audit Team review end January 2024 • Additional tabs on spreadsheets for collection of data relating to Performance Information for length of stay and available for Audit Team review end January 2024 Move away from Spreadsheets for accommodation casework and adopt Back Office • Migration over to the Back Office system for management of all forms of homeless accommodation to be completed end March 2024 • To complete training for all staff working on Back Office functionality for Temporary Accommodation staff once system implemented end of March 2024. • Performance Management dashboard scoped out and once functionality of Back

Portfolio	Audit	Ref:	Action	Original Action Due Date	Revised Due Date	Date of Last Update Provided by Service	Reason for Revised Due Date and Current Status
							Office complete dashboard data will be live end March 2024. Review reasons for refusal of permanent accommodation and develop process to manage "unreasonable refusals". • Suitability Checklist now in place along with Direct Lets Nomination Form and shared with Audit Team 17/01/2024 for review. • Clear process for Homeless Direct Lets now in place with dedicated officer leading the matching process and shared with Audit Team 17/01/2024 for review. • Nominations report and suitability assessment requiring management sign off in place and process documented and shared with Audit Team 17/01/2024 for review. Develop Policy for Income Management relating to the Temporary Accommodation Portfolio to include: o Rent Collection o Service Charge Collection o Arrears management o Income Maximisation and Support o Arrears Write Off • Homeless Accommodation Policy complete with sections on Income Management activity to enable one Policy for all aspects of Homeless Accommodation Management and shared with Audit Team 17/01/2024 for review.
H&C	Homelessness & Temporary Accommodation 21/22- Processes are not adequate to deal with	3237	The response will be delivered in 3 stages – immediate, medium and longer term. All actions are assigned to the Service manager to be delegated across team. Short term (March 2022) • SLAs to be introduced between all areas which have a direct impact in service delivery. Including Responsive	31-Mar-24	30-Jun-23	15-May-24	Email received from MC with evidence of all information available for this action (word document below). A review of the documents provided has highlighted some risks identified through the review would still pertain. An email was sent to MC advising actions will remain open as some of the risks identified still pertained and

Portfolio	Audit	Ref:	Action	Original Action Due Date	Revised Due Date	Date of Last Update Provided by Service	Reason for Revised Due Date and Current Status
	increase in demand.		repairs through FCC, Void Property Turnaround, Cleaning Contracts, Fire Safety Regime • A process to be defined to deal with refused offers of permanent accommodation. • A process to be defined to review lease agreements prior to their renewal/expiration date. • A process for take on of new properties into the Temporary Accommodation portfolio. Medium term (June 2022) • Rental Charge Policy to be define to oversee rent income, arrears and write off. • Review the performance information needed for management oversight when the Policy is in place. Longer term (March 2023) • The full end to end temporary accommodation process to be mapped to assign roles and responsibilities, identify process delays and inefficiencies as well as document controls.				offering the possibility for management to close the actions given the resource challenges and the time the action has been open since the original implementation date.
SS	22/23 Deferred Charges and Management of Residential Care Liabilities	3551	• Monthly FACT Specific Legal Surgeries have now been established with Blake Morgan Solicitors. The advice is being provided by a lawyer specialising in social care finance practice and is specific to the needs of FACT. • Each Deferred Payment Agreement will be reviewed and through the Legal surgeries and where the effectiveness of the legal charge is in question, an alternative charge will be sought. This has begun and it has proven helpful for the service. • Any identified areas of risk of non-payment will be reported upon monthly and escalated as required. • Training will be provided to all Financial Assessment Officers involved in the work to ensure correct agreements and charges are in place going forward. • Review current policy and ensure alignment to required practices. Review of matrix will assist with lessons learned whilst identifying the required revisions to the current policy.	30-Nov-24	-	02-Jan-25	Management have advised that each Deferred Payment Agreement is reviewed as part of the Legal surgeries held and where the effectiveness of the legal charge is in question, an alternative charge is sought/agreed. Management information to evidence this would be required to assist with closing the actions. Evidence of areas of risk of non-payment reporting and escalation would also be required to close the action. A meeting has been scheduled with the Service Manager on 10 January to discuss. Action will remain open.
SS	22/23 Deferred Charges and	3552	• Monthly FACT Specific Legal Surgeries have now been established with Blake Morgan Solicitors. The advice is	31-May-24	-	02-Jan-25	Management have advised that each Deferred Payment Agreement is reviewed as part of the

Portfolio	Audit	Ref:	Action	Original Action Due Date	Revised Due Date	Date of Last Update Provided by Service	Reason for Revised Due Date and Current Status
	Management of Residential Care Liabilities		being provided by a lawyer specialising in social care finance practice and is specific to the needs of FACT. • Each Deferred Payment Agreement will be reviewed and through the Legal surgeries and where the effectiveness of the legal charge is in question, an alternative charge will be sought. This has begun and it has proven helpful for the service. • Any identified areas of risk of non-payment will be reported upon monthly and escalated as required. • Training will be provided to all Financial Assessment Officers involved in the work to ensure correct agreements and charges are in place going forward. • Review current policy and ensure alignment to required practices. Review of matrix will assist with lessons learned whilst identifying the required revisions to the current policy.				Legal surgeries held and where the effectiveness of the legal charge is in question, an alternative charge is sought/agreed. Management information to evidence this would be required to assist with closing the actions. Evidence of areas of risk of non-payment reporting and escalation would also be required to close the action. A meeting has been scheduled with the Service Manager on 10 January to discuss. Action will remain open.
SS	22/23 Deferred Charges and Management of Residential Care Liabilities	3554	• The matrix of information to address Risk 1 will also provide information to address Risk 2. • The matrix of information will identify the levels of outstanding debt and liability and RAG rate the risks attached to the recovery of those long-term debts which will be implemented in January 2024. • The matrix will distinguish between non-recoverable and recoverable costs as part of this process. • It will also record the action plan to reduce that risk rating. • We will also address the wider risk by completing a policy review to evaluate the current operating model and approach including transfer of liability/ debt recovery and all associated implications. Revised policy to be presented to Cabinet for review and approval by November 2024.	30-Nov-24	-	02-Jan-25	At the time of the audit, management advised they were unable to extract information from the ledger to evidence a real time and accurate level of outstanding debt/liability which it is seeking to recover at both corporate and service user level. With all the newly introduced reports as advised in the update, we would require management information/ evidence to demonstrate real time level of outstanding debt which is seeking to recover both at a corporate or user level. A meeting has been scheduled with service manager on the 10th of January to discuss further. The action will remain open.
SS	22/23 Deferred Charges and Management of Residential Care Liabilities	3555	• Internal Audit will provide a copy of this report to Debt Recovery. • Invite Debt Recovery to the Legal Surgeries in order that the recovery charge and process could be understood and recovery action agreed. • As part of this process any debts which may require write off will be identified and reported appropriately to finance colleagues and the Chief Officer.	30-Nov-24	-	02-Jan-25	As agreed within the report ,the appropriate debt recovery process was to be included as part of the policy review. The revised policy provided for action 3556 shows the last set of changes to the corporate debt policy were in reference to the housing rent and the write off authorisation levels. No other changes have been highlighted. To close the action, evidence/ management information

Portfolio	Audit	Ref:	Action	Original Action Due Date	Revised Due Date	Date of Last Update Provided by Service	Reason for Revised Due Date and Current Status
			• Define the appropriate debt recovery process as part of the policy review				which highlights all debts which require write off have been identified, reported appropriately to finance and Chief Officer and written off accordingly. A meeting has been scheduled with the Service Manager on 10 January to discuss further. The action will remain open.
SS	22/23 Deferred Charges and Management of Residential Care Liabilities	3556	• The monthly Legal Surgeries, the matrix management of information and the initial monthly reporting of Deferred Payments to senior management, will provide early sight of risk areas and monitoring of performance of risk management of existing debts – as detailed above, • We will also address the wider risk by completing a policy review to evaluate the current operating model and approach, including decision making at week 13 day 1 and its implications. Revised policy to be presented to Cabinet for review and approval by November 2024.	30-Nov-24	-	02-Jan-25	A review of evidence provided has been completed. Management have advised they are currently reviewing all deferred charge cases. Management have also advised the charging policy has been approved by SSMT for approval and publication and this is sufficient for publication. Need to assess whether the policy ultimately needs to be approved by Cabinet and if so, when this is to take place. Also the copy of the policy provided does not seem to be complete. For example P. 16 stipulates a leaflet is to be added once this has been completed and this will be added to appendix 3 which is still blank. Meeting has been scheduled on 10/1 with the Service Manager to discuss further. Unable to close at the moment.
S&T	22/23 Statutory Obligation for School Transport	3538	• It is agreed that costs for statutory / non-statutory transport should be specifically identified, analysed and reported. An exercise will be undertaken with Audit assistance to identify spend across 2022/23 on statutory and non-statutory transport. A process will be put in place to produce this information on a full termly basis. However, Welsh Government is currently reviewing the Learner Travel Measure, which is likely to impact the eligibility criteria for statutory / non-statutory spend, and data to support analysis is held across the ONE system, Finance and the Integrated Transport Unit and the exercise may be resource heavy, hence the December 2023 implementation date.	01-Dec-23	31-Jul-24	21-May-24	Internal Audit have successfully combined the three datasets (One system, Transport spreadsheet and Finance) we are in process of quality assurance work for this dataset on which all analysis will be based. reporting to management being drafted. to include Claire Homard. EXTEND DUE DATE TO 01/07/24 TO ENABLE THIS TO TAKE PLACE. Agreement to extend due date following request for audit support to analyse data available.
Schools	Ysgol Pen Coch - Financial Governance	3649	• A Scheme of Delegation will be produced by school, based on Flintshire Council Guidance, and approved by	31-Jul-24	-	-	No update provided

Portfolio	Audit	Ref:	Action	Original Action Due Date	Revised Due Date	Date of Last Update Provided by Service	Reason for Revised Due Date and Current Status
			the full Governing Body. This will be completed at the next full governors meeting. • The School will obtain, review and adopt the financial procedures recommended by Flintshire Council. This will be added to the cycle of policy review and updated in line with any new guidance issued by the local authority.				
Schools	Ysgol Pen Coch - Information Governance	3650	• The school will produce a Data Protection Policy (working with E2E) and this will be approved by the full Governing Body. • The school will ensure that Data Protection Privacy Notices (working with E2E) are in place. • Data Protection training (to be provided by E2E) for all staff is planned to be undertaken in the summer term. • The school will ensure that passwords are changed on a defined basis.	31-Jul-24	-	-	No update provided

Appendix H

High Priority Action(s) with a Revised Due Date Six Months Beyond Original Due Date and Not Overdue

Portfolio	Audit	Ref:	Action	Original Action Due Date	Revised Due Date	Date of Last Update Provided by Service	Reason for Revised Due Date and Current Status
CEX	22/23 Strategic Funding (Formally Core Funding for Voluntary & Community Sector): Lack of Oversight of the Strategic Funding Payment Process	3543	• There are checks and controls in place, but these are dependent on human action/input. The Strategic Office are responsible for updating the VSD in terms of organisation details and setting up payments but are reliant on the Sponsoring Officers providing information, carrying out and uploading monitoring forms, approving payments, and conducting payment checks. Sponsoring Officers are responsible for checking and approving payments for release (based on their oversight of satisfactory contract performance/monitoring). Authorising Officers provide a second level of control by checking and giving final approval for payment on the VSD. • Management oversight of budget and payments is conducted through budget meetings with Finance colleague.	30-Apr-24	09-Jan-25	07-Jan-25	Preliminary work around the 4 elements originally identified for review in this audit highlighted the need for the scope of any review to be broadened, to the extent of how Strategic Funding operates. This needs to include its terms and conditions, what the funding can be used for i.e. set criteria, how the funding is applied for and allocated etcetera. The above was informed by various meetings with Sponsoring Officers, Service Areas and discussions with appropriate finance colleagues and legal services. For example a meeting was held with SS representatives on the 17/06/2024 with regards to an issue around one of the avenues of funding that is being provided. Another example was the transfer of funding to SS for 3 specific funding streams. A copy of the confidential part 2 Cabinet Report 23/07/2024 provides further details and is attached as supporting evidence. The Role and Responsibilities document has been amended for this interim period and is attached as evidence. The review has therefore not yet been fully undertaken. However, the confidential Part 2 report was taken to Cabinet 23rd July 2024 made a recommendation that a further review is conducted as outline in 1.15 to address the issues outlined above and those highlighted by this internal audit. This will require appropriate consultation and impact assessment. Cabinet has approved this, and work has already been undertaken in association with the Sponsoring Officers. An in-person meeting was held with Sponsoring Officers on 25/10/2024. To allow further time for this review to be completed and adequate notification of any change to those organisations already in receipt of funding the option of extending the current grant contracts for two years was approved. This means that review must be completed and implemented and notified to stakeholders before 31st March 2027.We are currently in development of a plan for this bigger review and suggest that this now supersedes this action and propose that it should be closed. Decisions of cabinet 23/07/2024 can be found by copy and pasting the link below into your web-browser: https://committeemeetings.flintshire.gov.uk/documents/g5823/Decisions%2023rd-Jul-2024%2010.00%20Cabinet.pdf?T=2&LLL=0

Investigation Update

Appendix I

Ref	Date Referred	Investigation Details
1. New Referrals		
1.1	21/10/24	Misuse of public funds referral – Depravation of Capital
1.2	09/12/24	Petty Cash Loss (£550 Childrens Homes)
2. Reported to Previous Committees and still being Investigated		
2.1		No ongoing investigations
3. Investigation Completed		
3.1	Completed 19/12/24 - Misuse of public funds referral – Depravation of Capital – risk material - referred to SS and Legal for action	

Internal Audit Performance Indicators

Appendix J

Performance Measure	2023/24	Qtr1	Qtr2	Qtr 3	Qtr 4	Target	RAG Rating	
Audits completed within planned time	78%	50%	100%	50%	-	80%	R	↓
Average number of days from end of fieldwork to debrief meeting *	19	32	17	50	-	20	R	↓
Average number of days from debrief meeting to the issue of draft report	4	1	1	4	-	5	G	↔
Days for departments to return draft reports *	9	11	3	17	-	7	R	↓
Average number of days from response to issue of final report	1	1	1	2	-	2	G	↓
Total days from end of fieldwork to issue of final report *	28	49	21	74	-	34	R	↓
Productive audit days	78%	64%	55%	58%	-	75%	R	↓
Client questionnaires responses as satisfied	100%	100%	100%	100%	-	95%	G	↔
Return of Client Satisfaction Questionnaires to date	57%	25%	29%	36%	-	80%	R	↑

Key					
R	Target Not Achieved	A	With in 20% of Target	G	Target Achieved
↑	Improving Trend	↔	No Change	↓	Worsening Trend

* The average number of days from end of fieldwork to debrief meetings, issue final reports has been impacted by officers availability to meet and provide management actions to audit findings.

Internal Audit Operational Plan 2023/24 and 2024/25

Appendix K

Audit – 2023/24	Priority	Status of Work	Supporting Narrative
Corporate			
Management of Leisure Assets	**H**	Complete	
Housing & Assets			
Tenancy Enforcement / Support	**H**	Complete	
Performance & Management Information (Voids)	**H**	Draft Issued	
Social Services			
Deprivation of Liberty Safeguards (DoLS)	**H**	Complete	
External			
SLA - Aura - 10 days per annum	Annual	No Longer Relevant	No Longer relevant due to the move to Gwella
SLA - NEWydd - 10 days per annum	Annual	Complete	

Internal Audit Operational Plan 2024/25

Audit – 2024/25	Priority	Status of Work	Supporting Narrative
Corporate			
Capital Programme and Strategy / Grant funding of Projects	H	Not started	
Future ADMS	H	NLR	No longer relevant
3rd Sector Core Funding - Follow Up	Follow Up	In Progress	Deferred until 2025/26
Capital Receipts			Will undertake if resource is available as per IA Strategy
Education & Youth			
Education Other Than Schools (EOTS)	H	In Progress	
Thematic Review – Safeguarding within Schools (DBS Checks)	H	In Progress	
Not in Education, Employment or Training (NEET)	H	Not started	

Audit – 2024/25	Priority	Status of Work	Supporting Narrative
Control Risk Self-Assessment	Annual	Fieldwork Complete	
Youth Service Consultation around the Strategic Plan			Will undertake if resource is available as per IA Strategy
Governance			
Protection against Ransomware attack	H	Not started	Deferred until 2025/26 due to service request
Procurement – Preparedness of the new Procurement Act	H	In Progress	
Cyber Security	H	Not started	Deferred until 2025/26 due to service request
Corporate Complaints / Handling - Follow Up	Follow Up	In Progress	
Insight & Data Analysis - Unincorporated Association Liability Risk	New	In Progress	
Insight & Data Analysis – Up front payments for fees and charges	New	In Progress	
Housing and Communities			
Landlord H&S Compliance - Asbestos	H	In Progress	
Welsh Housing Quality Standard 2023 - Phase One	H	In Progress	
Supporting People (grant)	Annual	Complete	
Homelessness Temporary Accommodation – Follow Up	Follow Up	Defer	Defer until 2025/26
Housing Support Gateway			Will undertake if resource is available as per IA Strategy
People and Resources			
MTFS – Achievability of Efficiency Savings	H	Draft Issued	
Budget Management	H	Not started	
Taxation	H	In Progress	
Write Offs		In Progress	
Petty Cash		In Progress	
Matrix - off matrix agency Cost reporting	H	Draft Issued	
Payroll, including Approach to Holiday Pay	H	Fieldwork Complete	
DBS Checks - Follow up	Follow Up	Not started	
Planning, Economy and Environment			
Environmental Health	H	In Progress	
Building Control – Fees & Charges	H	In Progress	
Minerals and Waste – Fees & Charges	H	In Progress	
Pest Control – Fees & Charges	H	Draft Issued	

Audit – 2024/25	Priority	Status of Work	Supporting Narrative
Social Services			
Commissioning and Contracts	H	NLR	No longer required – as per review of plan by CO
Investigation – Petty Cash	New	In Progress	
In House Childrens Home - Ty Nyth	H	In Progress	
Deferred Charges Residential Care Cost Liability – Follow Up	Follow Up	Deferred	Deferred until 2025/26
Social Work Agency / Agency Costs			Will undertake if resource is available as per IA Strategy
Streetscene and Transportation			
HRC – Fees and Charges	H	Not started	
Procurement & Contract Management/Monitoring	H	In Progress	
Governance, Delegation & Risk Management	H	In Progress	
Parc Adfer	Biennial	Complete	
External			
Clwyd Pension Fund - Pensions Administration and Contributions	Biennial	In Progress	
Aura Leisure and Libraries	Annual	NLR	No Longer relevant for this financial year due to the move to Gwella
NEWydd Catering and Cleaning	Annual	Complete	
All Wales Chief Auditors Accounts	New	Complete	

Glossary	
Risk Based Audits	Work based on strategic and operational risks identified by the organisation in the Improvement Plan and Service Plans. Risks are linked to the organisation's objectives and represent the possibility that the objectives will not be achieved.
Annual (System Based) Audits	Work in which every aspect and stage of the audited subject is considered, within the agreed scope of the audit. It includes review of both the design and operation of controls.
Advice & Consultancy	Participation in various projects and developments in order to ensure that controls are in place.
VFM (Value For Money)	Audits examining the efficiency, effectiveness and economy of the area under review.
Follow Up	Audits to follow up actions from previous reviews.
New to Plan	Audits added to the plan at the request of management. All new audits to the plan are highlighted in red.
Audits to be Combined	Audits to be combined once detailed scope established. All combined audits are highlighted in purple within the plan.
Audits to be Deferred	Medium priority audits deferred. These audits are highlighted in green within the plan.