READING BOROUGH COUNCIL
DIRECTOR OF RESOURCES

TO:	**AUDIT & GOVERNANCE COMMITTEE**		
DATE:	**24th January 2018**	**AGENDA ITEM:5**	
TITLE:	**INTERNAL AUDIT QUARTERLY PROGRESS REPORT**		
LEAD COUNCILLOR:	**COUNCILLOR BROCK**	**PORTFOLIO:**	**CORPORATE AND CONSUMER SERVICES**
SERVICE:	**FINANCE**	**WARDS:**	**N/A**
LEAD OFFICER:	**PAUL HARRINGTON**	**TEL:**	**9372695**
JOB TITLE:	**CHIEF AUDITOR**	**E-MAIL:**	**Paul.Harrington@reading.gov.uk**

1. PURPOSE OF THE REPORT

1.1 This report provides the Audit & Governance Committee with an update on key findings emanating from Internal Audit reports issued since the last quarterly progress report in September 2018.

1.2 The report:

- Provides assurance, commensurate with the control environment evidenced by audits conducted in the last quarter.
- Advises on significant issues where controls need to improve to effectively manage risks.
- Tracks progress on the response to audit reports and the implementation of agreed audit recommendations.

1.3 Please note audit reviews specific to children and education (including schools) will be reported directly to the children's company (Brighter Future for Children).

1.4 The following document are appended:

- Appendix 1 – Delayed Transfer of Care Audit Report
- Appendix 2 – Continuing Healthcare Audit Report
- Appendix 3 – Residents Parking Audit Report

2. RECOMMENDED ACTION

2.1 The Audit & Governance Committee re requested to consider the report.

3. ASSURANCE FRAMEWORK

3.1 Where appropriate each report we issue during the year is given an overall assurance opinion. The opinion stated in the audit report provides a brief objective assessment of the current and expected level of control over the subject audited. It is a statement of the audit view based on the terms of reference agreed at the start of the audit; it is not a statement of fact. The opinion should be independent of local circumstances but should draw attention to any such problems to present a rounded picture. The audit assurance opinion framework is as follows:

Substantial	 GREEN	**Substantial assurance** can be taken that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.
Reasonable	 YELLOW	We can give **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** expose until resolved.
Limited	 AMBER	**Limited assurance** can be taken that arrangements to secure governance, risk management and internal control within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.
No assurance	 RED	There is **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.

3.2 Grading of recommendations

3.2.1 In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows:

Priority	Current Risk
High	Poor key control design or widespread non-compliance with key controls. Plus a significant risk to achievement of a system objective or evidence present of material loss, error or misstatement.
Medium	Minor weakness in control design or limited non-compliance with established controls. Plus some risk to achievement of a system objective
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration

3.2.2 The assurance opinion is based upon the initial risk factor allocated to the subject under review and the number and type of recommendations we make.

3.2.3 It is management's responsibility to ensure that effective controls operate within their service areas. However, we undertake follow up work to provide independent assurance that agreed recommendations arising from audit reviews are implemented in a timely manner. We intend to follow up those audits where we have given limited or 'no' assurance.

4. HIGH LEVEL SUMMARY OF AUDIT FINDINGS

4.1	Delayed Transfer of Care	2	4	1	

4.1.1 Delayed Transfers of Care (DToC) refers to patients who are ready to leave hospital or similar care provider, but are still occupying a bed. This covers patients in all NHS settings irrespective of who is responsible for the delay. Delays can occur when patients are being discharged home or to a supported care facility, such as a residential or nursing home, or are awaiting transfer to a community hospital or hospice.

4.1.2 The scope of this audit was to review the governance arrangements and relationships with NHS providers, ensuring they were clear, understood and formally documented.

4.1.3 We found officers to be actively engaged and highly motivated to ensure that performance with respect to Delayed Transfer of Care continued to improve. Officers interviewed during our audit communicated openly and demonstrated a detailed knowledge of issues and challenges.

4.1.4 Discussions with the Trusts that account for the majority of delays attributed to RBC reflected the challenges, as have been reported nationally, of ensuring effective working between different parties and IT systems. In particular officers will have to engage in a continuous process of reviewing live data that, could reasonably, be assumed to contain errors of various forms and that clarification and codification of the processes should benefit in increasing accuracy and resilience.

4.1.5 Officers have undertaken to develop formal policies and procedures with respect to various aspects of DToC and are engaged with improving the performance. However, at the time of the review these documents were either still unapproved or in a state that would benefit from expansion and further detail. Where there are no formally documented and approved processes that are readily available to all staff, there is a risk that standardised process will not be followed, upon staff changes institutional knowledge will be lost and opportunities for challenge and improvement may be lost.

4.1.6 Officers demonstrated that they are aware the spreadsheet based system for the recording of individuals ready to be discharged from hospital was resource intensive and issues with data quality were known. As a result officers have undertaken to utilise Mosaic[1] as a replacement system with the benefit of standardising data entry and allowing for advanced reporting.

4.1.7 Although, at the time of the audit, only limited assurance could be provided, the direction of travel is one of improvement, which is further confirmed through the recent CQC inspection.

[1] Social Care Case Management System

4.2	Continuing Healthcare	2	5	1	

4.2.1 Continuing Healthcare (CHC) is the name given to a package of care that is arranged and solely funded by the NHS for individuals who are not in hospital and have been assessed as having a 'primary health need'. It is known and established that historically Reading CCG has had amongst the lowest number of people who have been assessed as eligible to receive Continuing Healthcare funding. Hence there is a risk the Council is not identifying potential CHC cases and so may be contributing for the costs of care for people, when other parties should be financially responsible instead, or as well.

4.2.2 The purpose of the audit was to ensure that as far as possible all reasonable attempts have been made to identify CHC cases, for Clinical Commissioning Group (CCG) funding to be secured. Furthermore if an application had been made, but rejected by the NHS, then the Council has sought to consider and, where appropriate, to challenge or dispute these instances.

4.2.3 There are national criteria governing entitlement for CHC support funding and it was found that these are generally known, clear and understood. However, although there are some Berkshire wide procedures, there is an absence of up to date documented procedures regarding local systems employed in RBC. As a consequence it was noted that there is a lack of consistency both in terms of the approach to and standards of record keeping that was evident during testing. In particular this weakness applied to actions being recorded and updated on Mosaic and so there is an incomplete trail of documentation being copied or saved on to Mosaic.

4.2.4 The directorate has identified that training on CHC should be mandatory for its staff. This is very much supported as it was established during the audit that there is a variety of practice and understanding in place across the service to determine how entitlement to CHC should be assessed and recorded. A survey of a number of staff highlighted that some staff are not confident about how cases should be flagged, assessed, submitted for review and documented. The same applies to staff awareness and confidence about the appeal process in the event of a CHC application being refused by the CCG.

4.2.5 Possibly as a consequence of a lack of local training and systems documentation, it was established that there is a variety of standards in the quality of CHC checklists being undertaken, before these are submitted to the CCG. It was also found that although there is a system used to try to keep a record of (the status of) each CHC application, its effectiveness is limited as some staff are bypassing this and dealing with the CCG direct. This is exacerbated further as there is currently no simple way to interrogate Mosaic to find out details about pending, successful or refused CHC cases or other relevant management information.

4.2.6 In addition to the CHC training programme offered by the CCG and as part of the recent initiative by the Directorate to address some of the known issues around CHC, the directorate has commissioned specific CHC training for staff from (and recently delivered by) an external provider.

4.2.7 The bulk of the review was undertaken earlier in the 2018/19 financial year, since when it is understood that considerable work has been done, jointly with the CCG, to improve knowledge, systems and control. Despite this there were a number of findings and recommendations arising from the audit to further improve controls around the administration and management of CHC.

4.3	Revenue Budget Setting (Hyperion)	0	3	2	

4.3.1 The Planning and Budgetary Control System (PBCS), formerly called Hyperion, is an Excel and web based planning, budgeting and forecasting tool used by the Council to build its budget. An incremental budget can be produced, based on the previous year's figures, which contains information for a number of years, thereby facilitating the production of multiple year budgets. Once the budget has been formally approved and input into the system, it is uploaded into Oracle Fusion, the Council's finance system. Subsequently agreed changes, such as budget savings, are also uploaded into the system.

4.3.2 The aim of the audit was to verify the integrity of internal controls, specifically around data input.

4.3.3 There are policies, procedures and a timetable in place for the budget process and a post budget review was also conducted to identify issues and amendments required going forward. However, documentation does need to be reviewed and updated to reflect current practice and realistic timeframes.

4.3.4 Access to Hyperion was amended during the 2018/19 budget process to restrict the number of people who were able to upload, input and amend data. Also a clear segregation of duties has been put in place between producing the budgets (Budget Managers assisted by Finance Business Partners), approving them (Policy Committee and Council), uploading them (Financial Systems Accountant) and reconciling them (Finance Business Partners at directorate level and Financial Analysis and Planning Lead at organisational level).

4.4	Journal Testing Q2	0	0	0	

4.4.1 Throughout the 2018/19 financial year we will be performing quarterly tests on journals transactions. We have now validated a sample of journals from Quarter 1 and 2 of financial Year 2018-19 and have found these to have been properly evidenced and supported by working papers. We will undertake further testing of Q3 journals in January/February 2019.

4.5	Residents Parking	3	5	0	

4.5.1 This audit primarily focused on the (software) application structure for managing and supporting the management and administration of penalty charges for on-street parking. This entailed reviewing access controls, separation of duties, management of privilege (access levels) and service user account activities and the control of physical permits.

4.5.2 The PermitSmarti application, provided by Imperial Civil Enforcement Solutions Limited is used to provide the administrative and back office solution, whilst a separate software solution (3Sixty) is used for the management of penalty charge notices.

4.5.3 During the audit, it was not possible to establish any overarching governance documents, setting out the management and administrative arrangements for maintaining the applications. Neither could we identify that any consistent or formal process is applied to the monitoring of user activity on either applications reviewed. There is also no system documentation that details the operation and function of the two applications.

4.5.4 There are no system reports showing the roles performed by users accessing the applications, along with their permissions and access rights, thus increasing the risk that inappropriate activity could go unnoticed. As a consequence management have limited assurance that controls are functioning effectively. In addition there are no records of the training undertaken by RBC staff or contractors or evidence to show there has been some form of verification and review, in which user accounts and permissions are validated.

4.5.5 In reviewing the applications against the requirements of the RBC "ICT Standards Expected of Third Parties Policy," it was found that the applications do not meet the password complexity requirements. Where the applications in use by Parking Services do not have in place password requirements that meet RBC standards they may be subject to challenge as to whether they have taken appropriate action to secure the application and the data held.

4.5.6 Parking services are committed to address the audit concerns identified, and have given assurances that procedures will be implemented and controls tightened.

4.6	Declarations of Interest, Employee Gifts & Hospitality	0	4	2	

4.6.1 The purpose of the audit was to ensure that the Council has a clear and consistent process for advising new and existing staff of their responsibility to declare interests and register gifts or hospitality. This was achieved by selecting a sample of employees and managers from each directorate to assess their understanding of process to be followed.

4.6.2 The Council's written policies and procedures for managing and recording Gifts, Hospitality and Declarations of Interest are detailed in three key documents (the Employee Handbook, the Constitution and the Code of Conduct) and although these were up-to-date, we found a number of inconsistencies around the practical reporting and recording arrangements.

4.6.3 With each directorate working independently, each process for the recording of Gifts, Hospitality and Declarations of Interests varies. Although there are registers in place, there is sometimes a lack of supporting documentation to back up the information required on each register.

4.6.4 The directorate registers are apparently reviewed within each directorate; however there is no evidence to substantiate this and no central report on activity is currently required.

4.6.5 Staff in each directorate highlighted conflicting understanding(s), in particular about whether gifts of different values should be accepted or reported, where to access information and whose responsibility it is to promote and enforce policies.

4.6.6 For certain corporate applications users are required to make specific declarations where there could be some potential conflicts of interest arising. For example, staff who have access to Academy, the system used for Revenue and Benefits are required to complete a Declaration of Interest prior to gaining access to the system.

4.6.7 In the case of all new staff a declarations of interest form is sent to them prior to commencing employment as part of the new employment pack. However, there is no corporate procedure for making new declarations of interests arising for existing staff (or staff in potentially targeted services) and similarly there are no regular reminders to staff members to declare any interests.

4.6.8 The Head of HR and Organisational Development has advised that there may be potential for i-Trent to be used to record Gifts, Hospitality and Declarations of Interest. Although this is still at an early stage, there could be significant advantages for the Council if this is progressed, as this is likely to be more efficient, by streamlining the registration, recording and reporting. In turn thus would demonstrate good governance and commitment to the Nolan Principles, as following varied practices restricts the Council to confidently demonstrate each directorate has acted responsibly.

4.7	Bus Subsidy Grant 2017/18	0	0	1	

4.7.1 This audit focused on providing assurance that the conditions of the grant determination had been complied with. Expenditure was reviewed against the relevant conditions set down for the grant and was certified to the Department for Transport as having been spent appropriately.

4.7.2 The council was paid £74,192 by the Department for Transport under the grant to be used only for the purposes of supporting bus services (including community transport services run under a section 19 permit), or for the provision of infrastructure supporting such services in that authority's, or a neighbouring authority's area. We can confirm the grant for 2017/18 was spent in accordance with the determination notice for the purposes of supporting the bus services and infrastructure within the authority.

4.8	Transport Capital Grant funding 2017/18	0	0	1	

4.8.1 This audit focused on providing assurance that the conditions of the grant determination had been complied with. Expenditure was reviewed against the relevant conditions set down for the grant and was certified to the Department for Transport as having been spent appropriately.

4.8.2 The Local Transport Capital Block Funding (integrated Transport and Highways Maintenance) Specific Grant was settled in 2015/16 to be paid over a 5 year period. In 2017/18 as part of this arrangement, the council received £3,790,000, of which £2.210m related to highway maintenance.

4.8.3 Having carried out appropriate investigations and checks, in our opinion, in all significant respects, the conditions attached to Local Transport Capital Block Funding (Integrated Transport, Highway Maintenance, Pothole Action Fund, National Productivity Investment Fund and Flood Resilience fund) have been complied with.

4.9 Commercial lease (Nursey)

4.9.1 The Chief Executive requested Internal Audit undertake a lesson learned review at a detailed level on how a Nursery was allowed to occupy a Council building without paying rent or agreeing a lease, since 2011. In addition we were asked to ascertain the likelihood of there being similar properties across the Council's estate where rent is not being collected.

4.9.2 Clearly there was a significant drift and delay and inter-service confusion over the lease which was compounded by conflicting priorities. Officers appear to have been reluctant to start eviction proceedings, because the Nursery provided an important service in an area of need and the Council wanted and needed to support their work at the same time as ensuring a fair rental income to the Council.

4.9.3 Decisions were taken at an operational level, without strategic oversight and coordination. Hence there were competing service pressures, which subsequently prevented a successful resolution e.g. meeting Early Years' needs, versus the need to secure a proper financial return to the Council that were not adequately resolved. This was probably compounded during the period where there was a lack of consistent senior managerial (at Head of Service level) oversight in Education.

4.9.4 There was an assumption that the Nursery couldn't pay a commercial rent, because they hadn't submitted a business case or audited accounts. However, the Nursery had a sufficient surplus cash balance since 2014.

4.9.5 From the documentation and evidence made available, we concluded that all officers involved in this matter had to accept a degree of culpability, in that there was a collective corporate failure to manage this situation over the years. There are obvious lessons to be learnt, such as giving consideration to central oversight of property management, rather than individual services with potentially conflicting priorities, being responsible for their own property portfolio. Having one central team charged with oversight of property management would lead to speedier decisions with less conflict and deliberation. In addition property visits by the Valuation team, Health & Safety and Facilities Management (condition surveys) need to be better coordinated to ensure each property is inspected more regularly, otherwise similar situations may arise and go unnoticed.

4.9.6 The fixed asset register is still administered using an Excel spreadsheet and limited by this and is not reconciled to other property databases. We therefore do not have confidence in the completeness of records and the ability to identify gaps in the information held. There also appears to be a lack of capacity within the Valuation Team, with the service appearing stretched and under resourced.

4.9.7 In order to address some of the issues identified the CIPFA Asset manager software for accounting for fixed assets has been procured and is in the process of being implemented. We've been informed that once this core functionality has been established additional asset management models of the same software will be assessed with a view to providing integrated capacity to proactively manage the council's property asset register.

4.9.8 In addition the proposed new management restructure creates a Deputy Director post, which will include an integrated Corporate Assets Team. The detailed structure and responsibilities will be reviewed when the post is recruited to.

5 AUDIT REVIEWS 2018/2019

5.1 The table below details those audit reviews in progress and the reviews planned for the next quarter. Any amendments to the plan to reflect new and emerging issues or changes in timing have been highlighted.

	Timing							Res			
Audit Title	**Q1**	**Q2**	**Q3**	**Q4**	**Start Date**	**Draft Report**	**Final Report**	**P1**	**P2**	**P3**	**Assurance**
Continuing Health Care (CHS)	●				Apr-18	Aug-18	Nov-18	2	5	1	Limited
Delayed Transfer of Care	●				Apr-18	Jul-18	Sep-18	2	4	1	Limited
Entitlement & Assessment	●				Jan-19						
Revenue Budget Setting (Hyperion)	●				Jun-18	Oct-18	Nov-18	0	3	1	Substantial
Additional Payments	●				Apr-18	Jul-18	Sep-18	1	3	1	Limited
PCIDSS	●				Jun-18	Aug-18	Sep-18	0	3	0	Reasonable
Data Storage	●				Jun-18	Dec 18					
Network Infrastructure Security	●				Apr-18	Sep-18	Sep-18	0	3	2	Reasonable
Residents Parking	●				Jun-18	Oct-18	Dec-18	3	5	1	Limited
Use of CCTV - Urban Traffic Control	Deferred until 2019/2020										
Homes for Reading	●				Jun 18	Sep-18	Jan-19	0	6	3	Reasonable
Right to Buy (follow up)	●				Apr-18	Jun-18	Aug-18	0	1	3	Reasonable
Norcot Nursery School	●				Jun-18	Jul-18	Jul-18	0	3	5	Reasonable
New Bridge Nursery School	●				Jun-18	Jul-18	Sep-18	0	1	1	Reasonable
Commercial Leases (Nursery)*	●				May-18	Jul-18	Sep-18	2	1	1	N/A
General Ledger Q1 Journal testing		●			Aug 18	Aug 18	Aug 18	0	0	0	Substantial
Bank and Cash Reconciliations (follow up)		●			Dec-18						
Budgetary Control & Savings		●			Dec-18						
Section 106 Agreements		●			Jan-19						
South Reading Leisure Centre		●			Jul-18	Sep 18	Sep-18	0	1	0	Substantial
LTP Capital Settlement (Grant Certification)		●			Sep-18	Oct-18	Nov-18	0	0	1	Substantial
Bus Subsidy Grant		●			Sep-18	Oct-18	Nov-18	0	0	1	Substantial

	Timing							Res			
Audit Title	**Q1**	**Q2**	**Q3**	**Q4**	**Start Date**	**Draft Report**	**Final Report**	**P1**	**P2**	**P3**	**Assurance**
General Ledger Q2 Journal testing		●			Oct-18	Jul-18	Jul-18	0	0	0	Substantial
Employee Gifts & Hospitality & Declarations of Interest			●		Sep-18	Nov-18	Jan-19	0	4	2	Reasonable
Creditors (Accounts Payable)			●		Dec 18	Jan 19					
Troubled Families Grant Sign Off			●		Sep-18	Sep-18	Sep-18	0	0	0	Substantial
Direct Payments (f/up)			●		Jan-19						
Commissioning (Adults)	Deferred until 2019/2020										
Business Rates			●		Nov-18						
Sundry Debtors			●		Oct-18	Dec-18					
Payroll			●								
Commercialisation			●		Oct-18	Jan-19					
Redlands Primary School**			●		Nov-18	Nov-18	Dec-18	0	0	2	Substantial
The Hill Primary School**			●		Sep-18	Oct-18	Nov-18	0	3	5	Reasonable
Whitley Park Primary School**			●		Jun-18	Jul-18	Jul-18	0	3	3	Reasonable
Stronger Together Partnership*			●		Sep-18	Oct-18	Oct-18	0	0	0	N/A
Births Deaths & Marriages (spoil certificates & counterfoils)*			●		Oct-18	Oct-18	Oct-18	0	0	0	Substantial
General Ledger Q3 Journal testing				●	Jan-19						
Public Health Grant (f/up)				●							
Blessed Hugh Farringdon Catholic Secondary School**				●	Oct-18	Oct-18	Nov-18	0	0	3	Substantial
Christ the King Catholic Primary School**				●	Jan-19						
St Michael's Primary School**				●	Feb-19						
Foster Care (follow up)**				●							
Administration of looked after children**				●							
Child Exploitation & Missing Children (follow up)**				●							

*This audit was added as was not part of the original planned programme of audits

**Outcome of audit to be reported directly to BfFC

6 INVESTIGATIONS (April 2018 – December 2018)

6.1 Housing Benefit and Council Tax Support Investigations

6.1.1 For the period the Council Tax Support Overpayment is **£13,672.47**. One case generated a Housing Benefit overpayment of **£34,360.95**. The team investigated an allegation of fictitious tenants; this resulted in the return of **£13,503.42** in owned Council Tax payments.

6.2 Single Person Discount

6.2.1 Following a data matching exercise matching **21,918** address records against tracing and occupier lookup databases to determine the strength of residency for all individuals in a household within the borough, investigations officers are working with Council Tax reviewing the very high risk data matches and high risk matches. From the matches investigated to date **£195,247.80** has been identified for CTAX recovery.

6.3 Housing Tenancy Investigations

6.3.1 Since 1st April 2018 Investigation Officers have assisted in the return to stock of **18** Council properties. At present we have **21** ongoing tenancy investigations.

6.3.2 It is difficult to quantify the financial implications of these types of investigations, however the RBC agreed figure of £15,000 is considered to be the average cost for retaining a family in temporary accommodation. Using this figure (18 x £15,000), to date notional savings of **£270,000** have been made as a result of tenancy investigations.

6.4 Right To Buy (RTB)

6.4.1 There are organisations and individuals that offer tenants money to apply to buy the home on their behalf. Money laundering is also a risk for property transactions. Money is paid by a third party who has no obvious link with the transaction. Money launderers often use front buyers to enter into transactions on their behalf. The money for a deposit or even to pay a mortgage may have come from someone other than the customer and could very well be the proceeds of crime.

6.4.2 We are working with Housing Officers to check applications against Council tax and other records and will investigate any applications that look suspicious. Improper applications can result in eviction and criminal prosecution. Since 1 April 2018 one application has been refused as a result of our investigations. This property transaction would have been entitled to the maximum of **£80,900**.

6.5 Internal Investigations

6.5.1 Following authorised surveillance at one of the Council's leisure establishments, a now former member of staff was arrested on the suspicion of theft of cash. The matter was heard at Reading Magistrates Court on the 6th April 2018 and the defendant pleaded guilty to all charges. Full costs were awarded to the Council and the defendant has since paid **£13,198**.

6.6 Social Care Fraud & Investigations

6.6.1 The team were involved in a complex investigation relating to allegations of Direct Payment[2] Fraud in excess of **£62,000**. On the 21st December 2018 the defendant was found guilty on three accounts of fraud by false representation, three accounts of furnishing false information and one account of fraud by abuse of position and concealing criminal property (money laundering). The defendant is due to be sentenced on the 16th January 2019.

6.6.2 This is a very difficult offence to identify and prove; and shows just how much effort went into concealing this particular fraud. This was a very complex offence and great care was taken by the defendant to ensure she wouldn't be found out. It was only when she became increasingly greedy that she started to slip up. In our view, there was very little anyone could have done to detect this earlier, and it was well spotted by the Direct Payment team. The defendant went to great lengths to deceive the Council RBC, and other large organisations.

6.7 New Homes Bonus

6.7.1 The New Homes Bonus (NHB) is a grant paid by central government to local councils to reflect and incentivise housing growth in their areas. It is based on the amount of extra Council Tax revenue raised for new-build homes, conversions and long-term empty homes brought back into use.

6.7.2 Investigations officers, under the direction of the Council's Empty Homes Officer, worked in partnership with CTAX officers to maximise potential income, by reducing empty properties recorded on the CTAX database. A reward of 4-years' worth of Band D council Tax is paid for each reduction in "long term empty" homes registered on Academy[3].

6.7.3 The project team reduced the registered CTB1[4] figure from 502 to 387. The 'net reduction' of 115 long term empty properties earns the Council an NHB payment of **£106,467** for 2020/21, part of the 4-year NHB reward of **£425,870**.

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[2] Direct payments are payments for people who have been assessed as needing help from social services, and who would like to arrange and pay for their own care and support services instead of receiving them directly from the Council.

[3] Revenues and Benefits data management system

[4] Local authorities are required to return the Council Tax Base Return (CTB1) form each year.

6.7.4 The majority of the work was undertaken by the Empty Homes Officer and Council Tax Visiting Officer, with investigators supporting by undertaking fact finding enquiries (credit references etc.) and visits.

6.8 Disabled Persons Parking Badges (Blue Badges)

6.8.1 A Blue Badge is issued to a person with a disability where they have difficulty using public transport; it allows them to park closer to where they need to go. Since the 1st April 2018 (to the 31st December 2018) the team have received 24 referrals with regards to the potential misuse of a Blue Badge. Of these, there have been 2 successful prosecution cases with respect to the misuse of a Blue Badge, and 2 further Blue Badges have been seized and taken out of circulation. There is one outstanding case which is due in court on the 18th January 2019.

7. CONTRIBUTION TO STRATEGIC AIMS

7.1 Audit Services aims to assist in the achievement of the strategic aims of the Council set out in the Corporate Plan by bringing a systematic disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes. In particular audit work is likely to contribute to the priority of remaining financially sustainable to deliver our service priorities.

8. COMMUNITY ENGAGEMENT AND INFORMATION

8.1 *N/A*

9. LEGAL IMPLICATIONS

9.1 Legislation dictates the objectives and purpose of the internal audit service the requirement for an internal audit function is either explicit or implied in the relevant local government legislation.

9.2 Section 151 of the Local Government act 1972 requires every local authority to "make arrangements for the proper administration of its financial affairs" and to ensure that one of the officers has responsibility for the administration of those affairs.

9.3 In England, more specific requirements are detailed in the Accounts and Audit Regulations in that authorities must "maintain an adequate and effective system of internal audit of its accounting records and of its system of internal control in accordance with proper internal audit practices".

10. FINANCIAL IMPLICATIONS

10.1 N/A

11. BACKGROUND PAPERS

11.1 N/A

Internal Audit Final Report

Delayed Transfer of Care

To: Seona Douglas, Director of Adult and Health Care Services

From: Amondeep Basra, Senior Auditor

Date: 1 November 2018

Limited Assurance

Ref: 11/18

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1 Purpose and Scope of Review

1.1 Delayed Transfers of Care (DToC) refers to patients who are ready to leave hospital or similar care provider, but are still occupying a bed. This covers patients in all NHS settings irrespective of who is responsible for the delay. Delays can occur when patients are being discharged home or to a supported care facility, such as a residential or nursing home, or are awaiting transfer to a community hospital or hospice.

1.2 The Community Care (Delayed Discharges etc.) Act 2003 introduced statutory duties on the NHS and councils with the aim of strengthening joint working and encouraging clear and timely communication, and reducing the numbers of people waiting for alternative care arrangements once they were ready to move from the NHS setting. This legislation has now been repealed by the Care Act 2014.

1.3 Where the sole reason for the delay lies with the local authority and the delay relates to an acute patient, the daily amount that may be payable has been set at £130 in respect of local authorities outside of London (previously the lower rate was £100). The legislation was amended such that the mandatory system of reimbursement became a discretionary one. It was felt that the introduction of a financial incentive would lead to improvement in the assessment process and the provision of community care services for people in hospital.

2 Main Conclusions

2.1 The audit has shown that Reading officers are actively engaged with and appear highly motivated to ensure that performance with respect to Delayed Transfer of Care improves. The officers interviewed have communicated openly and demonstrated a detailed knowledge of issues and challenges. In addition since February 2018 the Director of Adult and Health Care Services personally reviews and authorises DToC performance, providing greater oversight.

2.2 Interviews with the two Trusts that account for the overwhelming majority of delays attributed to Reading Borough Council (RBC) were requested, only one meeting was held. The meeting reflected the challenges, as have been reported nationally, of ensuring effective working between different parties and IT systems. In particular the meeting highlighted that RBC will have to engage in a continuous process of reviewing live data that, could reasonably, be assumed to contain errors of various forms and that clarification and codification of the processes should benefit in increasing accuracy and resilience.

2.3 The audit has identified that RBC has adopted a number of different governance and reporting structures. It has been evidenced that senior RBC staff are focused on reducing delays in the transfer(s) of care and have been a part of an approach of working collaboratively within RBC but also with health partners and other local authorities for the purpose of seeking to improve performance. It has been noted that there is a potential risk where forums e.g. project group meetings are disbanded as these may impact upon the quality of reporting.

2.4 There is an informal agreement with partners not to impose financial penalties, but to instead work cooperatively to find practical ways to reduce delays. It was found that a single payment in respect of a fine in had been made to the Royal Berkshire Hospital Foundation Trust in early 2017, however it is understood this was an oversight.

2.5 RBC officers have undertaken to develop formal policies and procedures with respect to various aspects of DToC. These documents however were either still unapproved or in a state that would benefit from expansion and further detail. Given the complexity of the activity undertaken and the variety of parties involved there has been a lack of both awareness and availability of documents setting out the policies and procedures within RBC.

2.6 It has been evidenced that RBC staff are engaged with improving the performance of DToC beyond the requirements of the High Impact Change Model. It was not possible however to assess the adequacy of the model itself nor possible to evidence that RBC staff had analysed data available from NHS England to identify areas for potential improvement.

2.7 RBC has identified that it was aware that the spreadsheet based system that it had in place for the recording of individuals ready to be discharged from hospital was resource intensive and issues with data quality were known. RBC has undertaken to utilise Mosaic as a replacement system with the benefit of standardising data entry and allowing for advanced reporting.

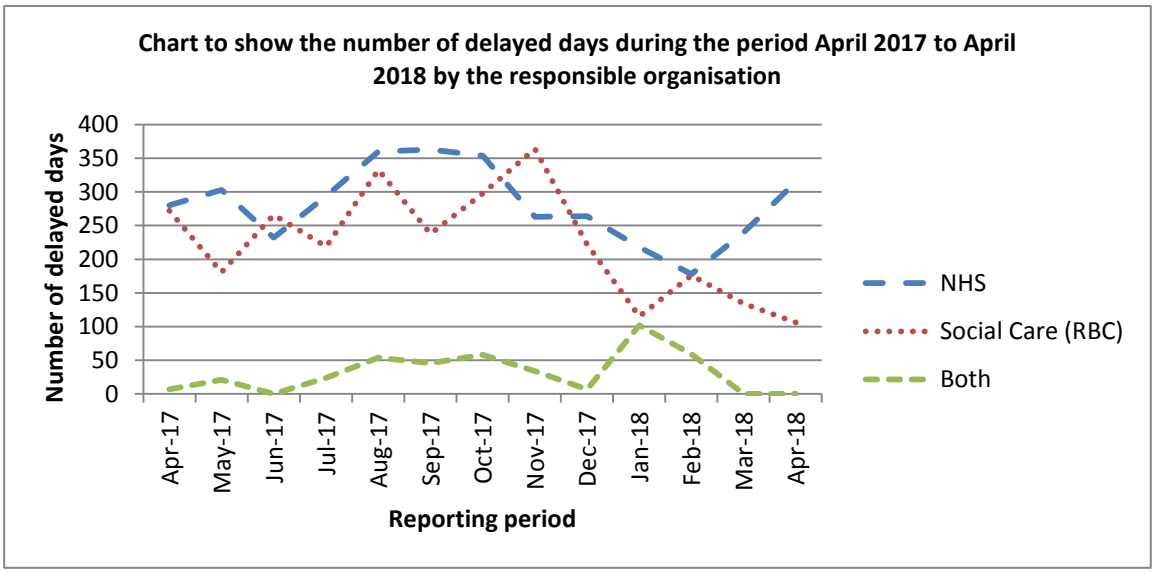
2.8 A total of 6 recommendations have been raised, of which 1 has been considered a high priority. The full detail of these recommendations and the corresponding management action plan are attached to this report as Appendix 1.

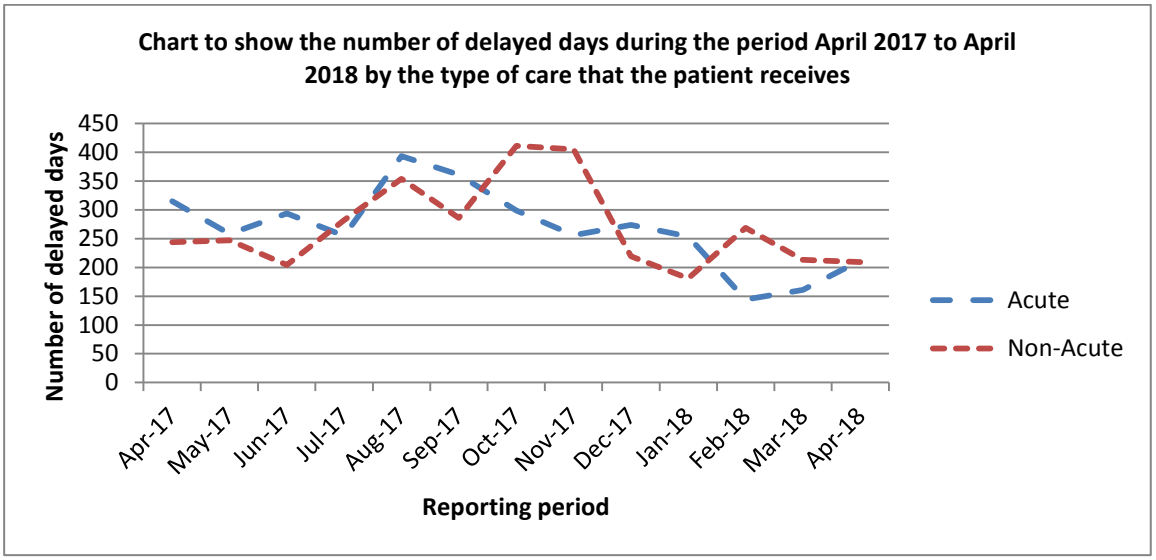
3 Summary of Findings

3.1 Analysis of nationally available data

3.1.1 NHS England makes available via its website data collected through the Monthly Situation Reports. The information is organised such that the agency responsible for any delay in the transfer of care (i.e. NHS, Social Services or both) can be seen.

3.1.2 An analysis for the period April 2017 to April 2018 shows that there has been a general trend towards improving DToC performance figures by the Council. Whilst it is a perception that the majority of DToC delays can be attributed to delays occurring as a result of social care, the graph below shows that for the past 13 months this is not an accurate assessment of the delays attributed to Reading. Where delays have been attributed to "Both" however further investigation as to the cause of the delays should be made.





3.2 Governance

3.2.1 The National Audit Office (NAO)[1] has identified local governance arrangements as an issue that can affect local health and social care from working effectively together. It has stated that nationally it has found issues with *"Unclear accountability within local systems for discharging older patients. One-third of group chairs in our survey said no individual person or organisation was accountable for ensuring delays to patients were minimised."* The NAO report also found that "*planning was not always coordinated in practice."*

3.2.2 A key aspect of activity undertaken by RBC in order to improve DToC performance has been identified as the implementation of the High Impact Change Model. This model has been given prominence by the Government as the Integration and Better Care Fund Planning Requirements for 2017-19[2] set out that one of the required four national conditions is that *"All areas to implement the High Impact Change Model for Managing Transfer of Care to support system-wide improvements in transfers of care."*

3.2.3 The High Impact Change Model was developed in order to focus on a year round approach to supporting timely hospital discharge. The model was itself developed by partners including the Local Government Association (LGA), the Association of Directors of Adult Social Services (ADASS), NHS England, the Department of Health (DH), the Emergency Care Improvement Programme (ECIP), Monitor and the Trust Development Authority.

3.2.4 From discussions with key personnel and review of minutes of the Berkshire West 10 Integration Board, it has been identified that the governance arrangement for the management of the implementation of the High Impact Change Model has gone through multiple iterations, although this has not been separately or critically reviewed as part of this audit.

3.2.5 It has been established that project groups and the Integration Project Board, that had been established to provide a line of reporting and forum for discussion with regards to implementation status and to inform the content of update reports have been disbanded. It is understood that the project group meetings formed the basis of preparing Highlight reports which were to be reported to the Project Integration Board and then subsequently the Reading Integration Board.

3.2.6 The reason for disbanding the groups was that following the Local Government Association (LGA) Peer review the decision was taken that a more effective approach would be for the Berkshire West 10 localities to work jointly as opposed to in isolation and as such, project group meetings were no longer held.

[1] National Audit Office: Discharging older patients from hospital May 2016
[2] Department of Health: Integration and Better Care Fund planning requirements for 2017-19

3.2.7 In addition the Director of Adult and Health Care Services has instigated weekly meetings with the Head of Adults to review DToC performance generally in order to understand and sign off delays personally.

3.2.8 At this time it is understood that the Urgent Care Operational Group has been the vehicle for developing and delivering a plan in relation to the High Impact Change Model and the Highlight Reports prepared within RBC have been reported to Reading transformation boards and Reading Integration Board. Note that Internal Audit have not reviewed or critically assessed this model.

3.2.9 It was advised, by the Integration Programme Manager (RBC), that the appropriate individuals to contact in order to obtain Urgent Care Operation Group (UCOG) meeting minutes were the Urgent Care Support Manager and Urgent Care Lead at the Berkshire West CCG and North & West Reading CCG. A request was made for the meeting minutes but no response was received. It is understood from discussion with the Transformation Project Manager (RBC), that at the most recent meeting of the UCOG that it had been discussed that in future the intended arrangements will be that the Berkshire West 10 Delivery Group will become the governing body for how the High Impact Change Model is being implemented. The LGA conducted a Peer Challenge for Berkshire West in early 2018. The output of the challenge included a self-assessment performed by the Local Authorities involved in which the self-assessed progress against the High Impact Change Model was recorded. For RBC the progress recorded at the time was based upon a workshop conducted in 2017. In discussion with the LGA Programme Manager it appeared that the self-assessment did not necessarily accurately reflect the status of RBC. It has been evidenced that within RBC that the Transformation Project Manager (RBC) and the Integration Project Manager (RBC) undertook to update the RBC understanding of its actual position with respect to the High Impact Change Model, to identify the criteria necessary to record having reached a particular stage of implementation and where possible to verify the evidence necessary to confirm that the assessment was accurate.

3.2.10 The Highlight and Dashboard Reports that have been made available show that within the governance and reporting structures that have been described RBC set out an approach where there is a format for reporting progress against an identified action plan. The reporting structure and format allow for RAG ratings alongside a summary of activity and progress and a narrative description of issues encountered and resources required.

3.2.11 It has been advised, by the Integration Programme Manager (RBC), however that in the absence of project groups and the Integration Project Board as a facilitator for the updating of reports, that the quality and detail of information reported may be impacted. There has additionally been a change in focus away from local authorities attempting to implement changes in isolation to one in which a joint approach is taken. **(R1)**

3.2.12 With respect to the governance and arrangements in place within RBC to record and monitor progress against the High Impact Change Model, it has been noted that whilst there have been a various methods for recording and forums for reporting there have been recorded concerns with respect to the speed of implementation. **(R1)**

3.2.13 The Berkshire West 10 meeting minutes reviewed demonstrate that the parties involved have sought, over an extended period of time, to identify evidenced based reasons for the variations in performance between the local authorities. The meeting minutes for 11th October 2017 record that there had been some difficulty in establishing an evidence based action plan as well as arranging information sharing with respect to best practice. The meeting on 11th April 2018 additionally identified that the parties involved with the group would need to shortly arrive at a position as to the basis that their involvement would take. **(R1)**

3.3 Communication

3.3.1 Communication and co-ordination between health and local government has been recognised as a long standing barrier to achieving DToC objectives at a national level. NHS England has identified that it has re-written its guidance documentation as it had found that differences in interpretation had created operational issues and concerns.

3.3.2 It has been evidenced that the Integration Project Manager (RBC) has undertaken activity to improve the process of approving monthly DToC performance figures by seeking to formalise and document it, within a process flow diagram, in order that the operation can be conducted efficiently and with responsibilities clearly identified.

3.3.3 The Information Analyst (BHFT) identified that working with a wide array of personnel within his organisation as well as external partners often required clarification as to processes. When asked to identify whether the Trust had formally communicated the requirements that it has for local authorities, in order to effectively review data, it was noted that it had not and that this could be beneficial in reducing the duplication of work and assisting in the identification of errors.

3.3.4 In addition to seeking to formalise the process for data review and approval the Operational Manager for Adult Social Care (RBC) and the Senior Social Worker – Intermediate Care team (RBC) have both identified that adopting an approach of having hospital workers present on wards to signpost patients has allowed RBC to become far more proactive as it has removed a barrier that was present in the form of the flow of information and communication. This presence on the ward was additionally identified by the Program Manager (LGA) as a key component as to how improvement could be achieved.

3.3.5 The Care Act 2014 has now made it discretionary for Trusts to fine Local Authorities for a delayed transfer of care for which they are responsible. In RBC's case most patients are usually resident within the borough and hence the agreement reached between RBC and Royal Berkshire Hospital Trust is not to invoke this process, but to focus instead on fostering a cooperative approach to solving practical barriers. The statutory guidance states that fining should not be used by NHS bodies as a first approach to address any local difficulties around delayed transfers.

3.3.6 At the time of testing it was not possible to identify the existence of formal agreements between RBC and Berkshire Healthcare Foundation Trust (BHFT) or Royal Berkshire NHS Foundation Trust (RBH) with respect to the charges being applied against RBC as a result of social care delays.

- It has been identified from discussion with staff at BHFT that the Trust had itself, historically, experienced some issues with respect to the records it held internally and the figures that were reported nationally with respect to DToCs. The issues concerned an internal need to clarify the reason why the data held on RiO, the patient record system, differed from that which was reported nationally.
- Having discussed the matter with the Information Analyst (BHFT) it was not possible to clarify on what basis or data BHFT may base any charges.
- It was not possible to determine the basis upon which the RBH bases its calculations of charges to a Local Authority.

3.3.7 For the reason(s) outlined in para 3.3.5 above it has not been possible to establish any documented record of the payments that have been made as a result of DToC fines. Although Fusion shows that a single payment was made to the RBH for £10,790 as a result of charges for the period December 2016 to January 2017, it was not possible to ascertain whether other invoices have also been paid with respect to the Trust or any other. The Director of Adult and Health Care Services has confirmed that this was an oversight and was raised and paid in error.**(R2)**

3.4 Policies and Procedures

3.4.1 Requests have been made for copies of formal policies and procedures within the RBC with respect to any and all aspects of the operation of DToC. It has been identified by various officers within RBC that in their experience that such documents have not been produced and that the need to determine and formalise current practices is an area that they have sought to improve.

3.4.2 Some work has been undertaken by various officers to formally document processes and provide clarity as a means to improve performance, although knowledge of these documents did not seem to be commonly known. Work that has been undertaken includes but is not limited to:

- At the time of the audit the Integration Project Manager (RBC) was able to share work that had been undertaken with partners in order to document and agree a process with which RBC and partners would agree and approve monthly DToC delays prior to submission to Unify, which is the system that is run by NHS England for the collection of data. At the time of the audit it is understood that this process had not been formally agreed. The formalisation of this process has the potential to reduce the administrative burden on staff of multiple levels of data verification and could improve data quality and ensure the opportunity to scrutinise data prior to submission.
- The Operational Manager for Adult Social Care (RBC) has provided access to a Standard Operating Procedure with respect to Delayed Transfer of Care at Reading Borough Council. This document provides useful background information to the topic of DToC as well as more specific and pertinent information to elements of the processes in place at the Council. The document however has significant potential to be expanded and updated to record current practices. It is notable that of the people within the Council that were interviewed there was no awareness of this document prior to attention being drawn to it. **(R3)**

3.4.3 Issues with respect to the way in which hospitals report figures has been identified nationally and NHS England has sought to update guidance in order to reduce the likelihood of this occurring. Additionally, however, based upon the meetings taken with the Information Analyst (BHFT) it is apparent that the configuration and use of the RiO may result in data being submitted to RBC that is not accurate and will have to be challenged for several different reasons. In order to ensure that knowledge is not lost due to staff changes and that RBC can continue to effectively challenge, a formal document record of the agreed challenge process should be kept. **(R4)**

3.5 Staff training

3.5.1 It has been noted by officers interviewed that they had themselves encountered an absence of structured DToC training as well as a lack formal process and guidance with respect to the RBC DToC systems and operations.

3.5.2 The Operational Manager for Adult Social Care (RBC) has supplied a Standard Operating DToC Procedure document that has been drafted, although none of the people interviewed as a part of this audit were aware of this. The spreadsheet that was in use for the purpose of tracking delayed transfers of care additionally contained some guidance as to how it should be completed. Other than this and the training that the Senior Social Worker – Intermediate Care Team (RBC) undertakes as a part of one to ones, there has been limited evidence of a formal agreed approach to DToC that is communicated to staff through training. **(R5)**

3.6 Performance Benchmarking

3.6.1 Through the review of available evidence and from meeting staff it is clear and understandable that the implementation of the High Impact Change Model has been a significant focus for how RBC intends to improve its DToC performance figures. It is noted however that staff have also acted beyond the requirements of the High Impact Change Model to implement changes that could bring about improvement. However there does not appear to have been any identifiable exercise undertaken to analyse the DToC data available from NHS England or data available locally to identify causes of DToCs. Whilst the staff interviewed all demonstrated a detailed understanding of various causes for DToC's there was none that was able to draw attention to a root cause analysis of the issue. **(R6)**

3.6.2 The Berkshire West 10 meeting minutes dated 11 October 2017 record the need to develop evidenced based action plans. The minutes also reflect the difficulty that has been faced in achieving this goal.

3.7 Reliability of Records

3.7.1 There is a requirement upon Trusts that prior to uploading monthly data with respect to health, social care and joint delays that data should be validated, agreed and signed by the trust and the Local Authority social care service. Information was sought from the BHFT and RBH in respect of the process of verification that they undertake, however it was only possible to hold a discussion with BHFT. Neither Trust was able to provide access to a stated policy or procedure document outlining the steps that they take although the Information Analyst and Head of Information at BHFT freely and openly discussed the approach that they take with all Local Authorities that they work with. The process undertaken by the Trusts has relevance for the nationally reported figures and the potential for financial charges to RBC.

3.7.2 Interviews were held with the Operational Manager for Adult Social Care (RBC), Performance Analyst (RBC) and the Business Systems Analyst (RBC) to discuss the system that RBC has in place for the tracking of individuals who are being discharged from hospital and may be experiencing a delay. At the time of the audit the system in place had been recognised as being insufficient to meet the requirements placed upon it. The Business Systems Analyst (RBC) presented a completed Business Requirements document that detailed an intention on the part of RBC, to move from the current system which was spreadsheet based to one in which the Mosaic Social Care Records System would be used. The process in place during the course of the audit required that Adult Social Care track individuals who are being discharged from hospital and in instances where there may be a delay to the discharge to agree a reason for this with the health partner. This involved the recording of

discharges and delays via a spreadsheet and this created a large administrative burden in order that the data could be used in regular checkpoints with health partners. The administrative responsibility for the completion of the spreadsheet was undertaken by the Assistant Team Mangers (ATM) (RBC) in the Short Term Team. During the course of the review the ATM (RBC) with primary responsibility had recently vacated her post and spreadsheet was being administered by multiple members of staff.

3.7.3 In discussions with officers it was raised that the implementation of the spreadsheet, whilst initiated as an improvement upon the previous approach, is resource intensive and that ensuring a consistent approach to inputting data had been difficult. When reviewing the spreadsheet it was evident that officers had taken different approaches as to the information that would be input. Officers also related that they experienced considerable difficulty in utilising RBC held data, in order to scrutinise the information that was provided by Trusts on a weekly basis prior to uploading to Unify. The additional benefit of migrating to Mosaic could be the requirement and added functionality of being able to run "live" reports which will be used to agree DToC figures with Health colleagues. The "next steps" identified within the Business Requirements document include: prototyping workshop; user acceptance testing; training; go.no go decisions and go live (including communication to staff and go-live support).

3.7.4 From discussions with the Information Analyst (BHFT) it was identified that their internal process regarding the preparation of figures for month end reporting to Unify broadly followed a process of continuous revision and correction of data held on RiO. RiO is the electronic patient record solution used to record and report on DToC figures The process was outlined as follows:

- Each Tuesday the Information Analyst (BHFT) will extract from RiO the records held, as at that date, showing all DToC figures.
- The data that is extracted will be reviewed for possible errors and any identified will be marked as such.
- The data is then sent in spreadsheet format on Tuesday to the wards where the appropriate NHS staff will be asked to check the data and correct any errors that are required on RiO. The ward staff are informed that they have until Wednesday night to perform these checks and make these amendments.
- On Thursday each week the Information Analyst (BHFT) will run the script against RiO again and produce an updated report with the most current data, not all changes will necessarily have been made by NHS staff. This report will then be distributed to the Local Authorities to scrutinise and challenge.

- This process will continue throughout each week in the month in order to capture, cleanse and correct the data at each opportunity with the intention that the report provided in the final week should contain a record of DToC that all parties agree with.

3.7.5 The process outlined allows for multiple opportunities, for RBC, to make corrections to data in order that RBC and the Trust can reach agreement on the position at the end of the month. Awareness of the potential weaknesses of the system in operation is of potential benefit to RBC as it may assist in the design of its own verification processes in order that attributed delays are reduced where possible. Issues that were identified include:

- The RiO system allows for health staff to make entries into the database using invalid combinations of codes.
- The RiO system allows health staff to create records with respect to DToC that do not contain complete information.
- The Information Analyst (BHFT) is not able to make amendments to RiO data and instead changes must be made by ward staff, yet these changes are not always made.
- The RiO system can be amended with respect to the way in which information is recorded. During the course of the audit an amendment to the system resulted in the RBC Performance Analyst making contact with the Trust in order to determine the potential ramifications for DToC figures.
- The script that the Information Analyst (BHFT) uses to extract DToC data from the RiO system draws information from within a specific database table. The Information Analyst (BHFT) believes that it may be possible for Trust staff to create a DToC record within RiO without it appearing on this table.
- It is not always possible to make amendments to RiO data as records may have been created subsequent to the initial error and therefore the error becomes fixed in place.
- As a result of instances occurring where agreed changes cannot be made to RiO data the information that is uploaded to Unify is based upon data that has been extracted from RiO and then subsequently amended. A consequence of this is that the data held on RiO does not in fact reflect the data that is reported in national statistics.

3.7.6 The final point is of particular relevance because the Information Analyst (BHFT) related that the Trust had itself experienced an issue where NHS Senior Management had queried the data that they held as they could not reconcile the information held on RiO to the information that is reported nationally. The compatibility of IT Systems is known to have affected DToC performance at a national level. A number of RBC Officers have expressed the belief that direct access to Health IT Systems may improve performance,

therefore it may be beneficial to further develop an understanding of these systems.

3.7.7 It has not been possible to arrange a meeting with staff at the RBH or to obtain a response to the Internal Control Questionnaire that was submitted. From meeting with the RBC Performance Analyst however attention was drawn to the fact that the current process in place involves the trust providing a weekly snapshot of delays each Thursday. It was stated however that the way in which this data is formatted such that the date on which an individual ceases to be a delay may impact on the ability of RBC to challenge the number of days attributed to it. Additionally the approach to preparing the snapshot data creates the possibility that individuals who have been classed as a DToC delay following the issue of one snapshot report and then ceased to be a delay prior to the issue of the next snapshot report may not be drawn to the attention of RBC. **(R7)**

Appendix A - Report Distribution

Staff Interviewed

- Paula Johnston, Acting Locality Manager (RBC)
- Naomi Cambridge, Performance Analyst (RBC)
- Mechelle Adams, Operational Manager for Adult Social Care (RBC)
- Samm Mills-Hutchinson, Business Support Team Leader (RBC)
- Shaun Rogers, Senior Social Worker Intermediate Care Team (RBC)
- Michael Beakhouse, Integration Programme Manager (RBC)
- Lewis Willing, Integration Project Manager (RBC)
- Ben Fisher, Business Systems Analyst (RBC)
- Jacob Obadara, Information Analyst Berkshire Healthcare NHS Foundation Trust (BHFT)
- Duncan Simpson, Head of Information Berkshire Healthcare NHS Foundation Trust (BHFT)
- Stephanie Clark, Berkshire West 10 Integration Programme Manager (RBC)
- Marcus Coulson, Program Manager at the Local Government Association (LGA)

Additional information sought from

- Jacqueline Tanner, Performance Analyst Royal Berkshire NHS Foundation Trust (RBH)
- NHS Improvement (NHS)
- Unify2 (NHS)

Draft Report Distribution

- Paula Johnston, Acting Locality Manager
- Seona Douglas, Director of Adult & Health Care Services

Final Report Distribution

- Paula Johnston, Acting Locality Manager
- Seona Douglas, Director of Adult & Health Care Services

Auditor Contact Details

- Amondeep Basra, Senior Auditor - (0118) 937 2693
- Paul Harrington. Chief Auditor - (0118) 937 2695

For further details on our assurance opinions please click this link

Audit Management Action Plan
Delayed Transfer of Care

Ref	Risk	Recommendation	Priority	Management Response	Responsible Officer(s)	Target Date
1	Where the format and forums for reporting progress and improvement with respect to DToC performance are not sufficient for the purpose of reporting management information there may be an increased risk that: - Opportunities to enact improvement may not be implemented as quickly as possible. - Management may have insufficient opportunity to review progress and determine an appropriate course of action. Where the Council does not have regularly updated and accurate information recording the current status of implementing high impact changes, and impediments to doing so, management may encounter difficulty strategically allocating resources and improving performance.	The following recommendations are made: - RBC should review the reporting lines, formats and forums to identify and improve performance as well as current impediments to performance identified. - In particular RBC should identify the governance and reporting structures in place that allows for transparency and likelihood of successful implementation. - RBC review the process they have in place to monitor and record progress against targets as well as barriers to doing so in order to determine whether they have access to sufficiently up to date information that has been verified against available evidence.	Priority 2	Agreed – An action plan for Reading Borough Council is in progress in response to the LGA peer review. Where any decisions are taken as a part of this process with respect to reporting or governance the decision will be formally recorded and available to evidence. Progress locally against the High Impact Change model is being monitored through the Reading Integration Board. The dashboard to monitor progress against targets continues to be monitored at the Reading Integration Board. Reading has it's own governance and reporting structures to monitor delayed transfers of care and progress against targets. The Berkshire West 10 is the governance and reporting structure for the implementation of the High Impact Change model across the	Michael Beakhouse, Integration Programme Manager	14/12/2018

Ref	Risk	Recommendation	Priority	Management Response	Responsible Officer(s)	Target Date
2	Where RBC does not have formally documented and approved processes that are readily available to all staff there is an increased risk that: - Standardised processes will not be followed. - Upon staff changes institutional knowledge will be lost. - Opportunities for challenge and improvement may be lost.	It is recommended that the Council develop and approve comprehensive formal policies and procedures concerning the operation of all aspects of DToC with respect to the activities undertaken by the Council and in conjunction with partner organisations. Additionally: - Documentation should be stored in a location where it will be available to all staff involved with DToC operations and data verification work. - Policies and procedures should be regularly reviewed and updated. - Documentation should identify key roles and responsibilities of staff and establish accountability. - The processes in place where the Council is required to work with third parties should be recorded.	Priority 1	Agreed. A Standard Operating Procedure will be developed to inform staff members of the tasks involved in the activities related to DToC. This will be kept in a shared folder in the S drive accessible to all staff managing hospital discharges. It is challenging to keep policies and procedures up to date as the processes with partner agencies are frequently changing and is being developed both locally and across the West of Berkshire. This Standard Operating Model will be in place by 1/11/2018 and will be reviewed and updated every two months, monitored by the Team Manager.	Paula Johnston, Acting Head of Service Older and Physically Disabled People	01/11/2018
3	Where the Council does not have a formally recorded approach to the review and challenge of data received from trusts there is an increased risk that: - the approach taken will not be sufficiently robust as to incorporate all known opportunities / requirements for challenge. - where staff changes occur there will be a loss of institutional knowledge. - the process adopted will be inefficient and create duplication of administrative effort.	The Council is advised to: - Formally document and make available to staff the process that is to be undertaken when challenging data from health partners. - The Council should ensure that the documented process incorporates an understanding of the features of the systems used by health partners and is updated to reflect changes to those systems.	Priority 2	Agreed. The Standard Operating Procedure will include what constitutes a DToC, what data to check, and how to challenge the data.	Paula Johnston, Acting Head of Service Older and Physically Disabled People	01/11/2018

Ref	Risk	Recommendation	Priority	Management Response	Responsible Officer(s)	Target Date
4	Where the Council does not have formally documented and approved processes that are readily available to all staff there is an increased risk that: - Standardised processes will not be followed. - Upon staff changes institutional knowledge will be lost. - Opportunities for challenge and improvement may be lost.	The Council should review the Standard Operating Procedure and: - Ensure that the document is expanded in order to provide a robust reference document incorporating processes set in place by the Council. - Is publicised and made known to officers involved with the DToC process either through specific training or else through 1 to 1 supervision(s) - Is regularly updated to reflect changes made in the approach taken by the Council and partners.	Priority 2	Agreed. The Standard Operating Procedure will incorporate all processes related to hospital discharges. It will be kept in the Team Hospital Discharge folder, launched in a Team meeting and be incorporated in the team induction.	Paula Johnston, Acting Head of Service Older and Physically Disabled People	01/11/2018
5	Where RBC has not made use of available data to determine whether there are causes for attributable delays outside of those currently known the opportunity for improvement may be lost.	The Council is advised to consider a periodic analysis of the available data from NHS England or local partners, as it pertains to the causes of delays, in order to determine whether there are any causes of delays that it can act upon to bring about an improvement in performance.	Priority 3	Agreed that analysis of data is required, but of local data rather than the national data, as this is more detailed, enabling specific actions to be identified. Analysis will be retained and made available during the course of any follow up review.	Lewis Willing, Integration Project Manager	31/10/2018 and ongoing

Ref	Risk	Recommendation	Priority	Management Response	Responsible Officer(s)	Target Date
6	Where the idiosyncrasies of systems used by partners to record information that forms the basis of DToC figures are not understood and formally documented by RBC staff: - There is an increased risk that the Council will not identify all opportunities in which it would be appropriate to challenge partners as to the accuracy or appropriateness of the information. - There is an increased risk of RBC being assigned inappropriate DTOC delays. - Where the process and basis of challenge is not formally recorded and updated to record new developments there is an increased risk that there will be duplication of work. - Where the process and basis of challenge is not formally recorded and updated there is an increased risk that there will be an institutional loss of knowledge that impacts efficient functioning in the event of staff changes.	It is recommended that officers meet with health partners in order to: - Agree and document an understanding of the systems used for the recording of DToC figures and any limitations and restrictions of those systems. - Agree and document the internal processes of the partner with respect to making alterations to data at the request of the local authority. - Agree and document the error checking / audit processes of the health partner with respect to the data that they hold. - Agree and document the types of error that the health partner generated data is capable of generating - The information obtained as a result of meetings should be documented, retained and added where changes occur in order that the Council is able to challenge effectively in the event of staff changes. - The Council should where possible negotiate with the Trusts to ensure that the data provided within the month is sufficiently detailed to allow for a complete picture of attributed delays and also to allow for challenge. - The Council should review and agree with health partners the processes it intends to put in place utilising the Mosaic reporting functionality in light of an understanding of the limitations with the health partners reporting capabilities.	Priority 2	Partly agree. We monitor the accuracy of the Social Care DToC data on a weekly basis, checking the figures that we have agreed against those recorded on the RBH and BHFT systems. When we find inaccuracies, we then request changes to this data. The process in place with the RBH is robust, however the process in place with BHFT is currently being refined and will be in place by 1st November 2018. These processes will be included in the Standard Operating Procedure.	Paula Johnston, Acting Head of Service Older and Physically Disabled People	01/11/2018

NB: Your management response is your commitment to treat the risk identified as part of the review. The standard response time to draft recommendations is 15 working days; any failure to meet this target could be reported to the Audit & Governance Committee.

The management response to recommendations will be reported to both CMT & The Audit & Governance Committee as part of our quarterly monitoring arrangements. Audit recommendations and agreed actions will be followed up during the year, where deemed appropriate by the Audit Management Team. All outstanding recommendations will also be reported through CMT as part of the Council's monthly performance monitoring.

Reading Borough Council
Working better with you

Internal Audit Report - Final

Continuing Healthcare (CHC)

To: **Seona Douglas, Director, DACHS**
Paula Johnstone, Acting Head, Older People and Physically Disabled People
Jo Purser, Acting Head of Adult Social Care
Mechelle Adams, Acting Head, Operational Manager, Short Term Team

Limited Assurance

From: **Kevin Parker, Principal Auditor**

Date: **27 November 2018**

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1 Purpose and Scope of Review

1.1 Continuing Healthcare (CHC) is the name given to a package of care that is arranged and solely funded by the NHS for individuals who are not in hospital and have been assessed as having a 'primary health need'. Until mid-October 2017 Wokingham BC had been commissioned to manage and handle potential RBCs CHC cases. The Director of DACHS made the decision in September 2017 to bring CHC back into RBC's administration for efficiency and cost saving reasons. Responsibility for CHC cases within ASC was assigned to the Older Persons team and a resource identified to administer this on a part time basis.

1.2 The purpose of the audit was to ensure that as far as possible all reasonable attempts have been made to identify CHC cases, and where justified, for the relevant Clinical Commissioning Group (CCG) funding to be secured. Furthermore if an application had been made, but rejected by the NHS, then the Council has sought to consider and, where appropriate, to challenge or dispute these instances. The audit also sought to establish whether training is available to all adult social care staff covering statutory duties and legislation with regard to Continuing Health Care together with the values and principles of carrying out a good assessment, key issues, the process, completing the checklist & decision support tool and informing service users.

1.3 The bulk of the review was undertaken earlier in 2018, since when it is understood that considerable work has been done, jointly with the CCG, to improve knowledge, systems and control. This will be reviewed as part of the follow up audit scheduled for early 2019/20.

2 Main Conclusions

2.1 It is known and established that Reading CCG has amongst the lowest number of people who have been assessed as eligible to receive Continuing Healthcare funding. It was not the purpose or objective of this review to specifically ascertain the reasons for this, as these have been reported to Committee and are being investigated further and this is to be welcomed. This is important as potentially the Council may be contributing for the costs of care for people when other parties should be financially responsible instead, or as well. Despite this there are a number of findings and recommendations arising from the audit that are made in this report to further improve controls around the administration and management of CHC.

2.2 There are national criteria governing entitlement for CHC support funding and it was found that these are generally known, clear and understood. However, although there are some Berkshire wide procedures, there is an absence of up to date documented procedures regarding local systems employed in RBC. As a consequence it was noted that there is a lack of consistency both in terms of the approach to and standards of record keeping that was evident during testing. In particular this weakness applied to actions being recorded and updated on Mosaic and so there is an incomplete trail of documentation being copied or saved on to Mosaic.

2.3 The directorate has recently identified that training on CHC should be mandatory for its staff. This is very much supported as it was established during the audit that there is a variety of practice and understanding in place across the service to determine how entitlement to CHC should be assessed and recorded. A survey of a number of staff highlighted that some staff are not confident about how cases should be flagged, assessed, submitted for review and documented. The same applies to staff awareness and confidence about the appeal process in the event of a CHC application being refused by the CCG.

2.4 Possibly as a consequence of a lack of local training and systems documentation, it was established that there is a variety of standards in the quality of CHC checklists being undertaken before these are submitted to the CCG. It was also found that although there is a system used to try to keep a record of (the status of) each CHC application, its effectiveness is limited as some staff are bypassing this and dealing with the CCG direct. This is exacerbated further as there is currently no simple way to interrogate Mosaic to find out details about pending, successful or refused CHC cases or other relevant management information.

2.5 In addition to the CHC training programme offered by the CCG and as part of the recent initiative by the Directorate to address some of the known issues around CHC, the directorate has commissioned specific CHC training for staff from (and recently delivered by) an external provider.

2.6 Our attention was drawn to the fact that there has not always been consistent, and regular management support and engagement over the CHC process, particularly since responsibility for this came back in house. It seems likely that the turnover of senior management in the directorate was unlikely to have helped in this respect.

2.7 A total of 8 recommendations have been raised in respect of this review, of which 2 have been considered a high priority. The full detail of these recommendations and the corresponding management action plan are attached to this report as Appendix 1.

2.8 The quality assurance process has confirmed that this internal audit review was conducted in conformance with the Public Sector Internal Audit Standards, a copy of which can be found on the Internal Audit Team's intranet page on Iris.

3. Summary of Findings

3.1 Criteria governing entitlement to CHC support funding are clear and understood

3.1.1 The processes and principles of Continuing Healthcare are set out in a National Framework issued in 2012 and which is to be superseded by a revised Framework in October 2018. It is intended that these updated guidelines should clarify details and better reflect the changes introduced by the Care Act 2014.

3.1.2 The guidance defines the key information and eligibility thresholds necessary to define whether CHC funding entitlement is met, although there is no agreement between RBC and the CCG(s) that defines local operating standards of practice, such as the response times for making and reporting decisions. **R1**

3.1.3 The NHS Berkshire West Clinical Commissioning Group (CCG) covers the Reading area (as well as the Newbury and Wokingham areas). National data released by NHS England has, for some years, shown that approved applications for CHC funding by Reading CCG have been amongst the lowest in the country. It was not the purpose or objective of this review to specifically ascertain the reasons for this, as it is understood there have been (and remain) ongoing efforts to investigate this specific aspect further. **R2**

3.1.4 The statistics relating to CHC funding continue to demonstrate the apparent disparity of CHC funded cases between the Reading CCG and other CCG areas.

3.1.5 The Council has for some time recognised the apparent poor CHC funding rates and this issue has been regularly reported through to Members, most recently in July 2018. As part of that report a number of improvement targets were detailed for further action.

Number of standard and fast track CHC eligible cases per 50,000 population *****

CCG	Standard		Fast tracked	
South Reading	7	8	2	3
North & West Reading	14	14	4	5
Comparator CCGs	42	39	10	11

*****NHS England CHC statistics May 2018 as reported to ACE Committee 11/07/2018

3.1.6 Audit testing of a sample of ongoing CHC applications and supporting documentation held on Mosaic was undertaken to assess whether these complied with existing national guidelines. It was noted that:

a) There was no clear path or single record (such as on Mosaic) that provided an evidential trail to support all actions surrounding a case
b) In particular it was noted there is currently no way of tracking dates for / of action(s) concerning CHC cases
c) one instance was noted where an application for CHC funding was made directly by a social worker to the CCG that resulted in a comprehensive rejection of the application by the CCG because of a fundamental failure (by the social worker) to properly understand the CHC criteria. **R3**

3.2 Policies and procedures governing the assessment and administration of CHC cases are up to date and agreed by both the CCG and the Council and reflect national guidelines

3.2.1 Although there is a wealth of detail in the National Framework guidelines concerning how to assess or determine CHC cases, no local guidance or written procedures have been recently produced for staff within the Council that prescribe the local standard operating procedures for the assessment and administration of potential CHC cases. There are some procedures but these are Berkshire wide procedures, rather than borough specific.

3.2.2 In particular the type of issue(s) that should be detailed might be around the workflow recording of cases and in particular could track dates that assessments and checklists have been submitted to the CCG, the dates and outcomes of the CCG's decisions and also any subsequent appeal process(es). **R3**

3.3 Relevant staff have been trained to identify potential CHC cases, to undertake necessary assessments and correctly make the necessary referral process

3.3.1 The national guidelines concerning the identification and assessment of potential CHC cases define the principal standards and protocols that are intended to ensure consistency of standards for administration and assessment of cases. The standards are then reinforced by (mandatory) training, delivered by the CCG, for relevant practitioner staff within the Council. The Council's position is that training in CHC is mandatory for all Adult Social Care staff.

3.3.2 To assess that training had been delivered a simple questionnaire was devised by Audit and sent to a sample of care practitioner staff within Adults. Each respondent confirmed that they had attended (or were due to do) this training, although two people advised the training was not particularly helpful.

3.3.3 The Acting Head of Adult Social Care and Operational Team Manager (Adults) advised getting CCG training for RBC staff has been delayed in the past due to resource issues within the CCG and that, although no cases found as part of the audit sample testing where staff had not been trained, there were instances where some other staff had not been trained at the time. **R4**

3.3.4 However, it is evident that the Directorate recognised some of these weaknesses and recently commissioned specific training *'Continuing Healthcare: law and practice'* from an external provider that was delivered in September and November 2018. This is in addition to the training delivered through the CCG.

3.3.5 The Workforce Development Manager has advised that where details of this training are known then these are recorded on iTrent. Although this was not specifically tested as part of this audit review, the Learning & Development Officer has advised that she has the details of staff who attended the specific CHC training referred to above (para 3.3.4).

3.3.6 Interestingly, one of the respondents to the same audit questionnaire commented that "I believe it should be part of the induction process from the beginning to ensure there is an understanding of the process. Training is very rare for CHC and when we did have a session it was not helpful at all. It has encouraged me to complete my own learning in my own time as it is not robust in RBC. It would be very helpful to have more training and even split as it is quite an extensive topic to cover." **R4**

3.3.7 Other points to arise from the completed survey were:

a) Although respondents were aware there exists an appeals process, most were unsure how it operates;
b) About 50% of the respondents indicated they had not made a recent referral;
c) For the few practitioners who have evidently made CHC applications or referrals to the CCG direct, it was not clear whether they would also monitor the subsequent assessment outcome by the CCG. **R4**

3.3.8 It is recognised within the directorate that CHC training is key. The recent report to the ACE Committee on CHC funding highlighted that CHC training is mandatory for all staff in Adult Social Care, as well as being covered as part of the induction process. Moreover it advised that further specific CHC-focused training would be delivered in September 2018.[1]

3.4 New and ongoing assessments routinely identify whether there is any potential entitlement to CHC funding

3.4.1 The process for when screening or assessment for potential CHC eligibility should be undertaken is not clear. According to the Acting Head of Adult Social Care and the Operational Team Manager (Adults), social care practitioner staff should definitely be considered as part of any assessment or re-assessment, but that there are occasions where potential entitlement is discussed, raised or applied for in between re-assessments.

3.4.2 Although assessments are generally recorded on Mosaic, currently there is no way on Mosaic to flag CHC cases (either applications or agreed cases). **R3**

3.5 There is a reliable record keeping system that is used to track the status / progress of each potential CHC case

3.5.1 As per 3.4.2 above there is no process on Mosaic to be able to categorise and therefore easily identify and report on all CHC cases. As a result a local procedure and record keeping system is in operation. The established - but not documented – RBC procedure is that for any potential referral for CHC assessment is supposed to be notified to the CHC Administrator so that progress on the application can be tracked. This is important because national guidance specifies clear deadlines for the submission, assessment and turnaround of applications for CHC funding. Currently these are not tracked and the situation is complicated by the fact that apparently applications are sometimes made directly to the CCG(s) by social care staff, so there is no reliable single record of all CHC related applications, whether successful or otherwise. **R3**

[1] Agenda item 14, Adult Social Care, Children's Services and Education Committee , 11 July 2018

3.5.2 The summary spreadsheet devised and maintained by the CHC Administrator is a simple but effective record of names, case numbers together with a few details about the status of each case. In turn these may / may not be supported by copies of documentation and correspondence on Mosaic. Whilst an improvement on the records handed back by Wokingham BC, this control spreadsheet could be improved to record with more detail its precise status. For example the dates of application submissions and returned assessment outcomes could also be usefully recorded, as the National Framework for CHC makes it clear that there are targets for assessments to be made, decisions to be reported etc. **R5**

3.6 There are clear records detailing the outcomes of CHC assessments

3.6.1 As above the principal tool recording the assessments of CHC cases, Mosaic should be used to record and store copies of documents and correspondence internally but importantly also with the CCG.

3.6.2 Those cases currently on the CHC Administrator's control spreadsheet of cases were tested to ensure that the Checklist (and Decision Support Tool if appropriate) and supporting documentation and correspondence was recorded or copied on Mosaic, together with key information relating to the outcomes of the assessment(s). It was found that generally there was a lack of a complete and clear audit trail to support the status of those cases. In particular:

a) Instances where found where key records (i.e. final copies of checklists) were not attached on Mosaic
b) Notes on Mosaic of actions or conversations (with the CCG) were not detailed enough to demonstrate or support outcomes.

3.6.3 An important finding was that in instances where the CCG had rejected applications (either at the preliminary or later stages) there was no evidence on Mosaic that the CHC decision reasons had been understood and analysed by RBC staff (and attached to Mosaic) and when appropriate for these decision(s) to then be appealed or challenged. Despite an increase in the number of cases being appealed by the Council, this approach needs to be more robust in future and the records around this need to be more detailed and visible. **R6**

3.6.4 As part of the recommended improvements to the system(s) to coordinate the submission and receipt of applications, documentation and communication, the service needs to consider how to improve recordkeeping so that there is a complete audit trail to support each application. Essentially the current system is fragmented and weak which means the Council is limited in its options in the event of a negative assessment by a CCG to an application lodged by the Council. **R3, R6**

3.7 There is effective communication between RBC and CCG staff

3.7.1 Judging from copies of correspondence and notes recorded on Mosaic it is evident that there is regular communication between RBC and CCG staff and mostly this *appears* to be professional and adequately recorded on Mosaic. However examples were noted during audit testing which demonstrated or suggested that there were frequent gaps in records, some of which were significant, meaning that the likelihood of a successful application could be impacted. **R3**

3.7.2 This situation is compounded further by the fact that some of the social care practitioners are evidently communicating directly with CCG staff with the result that any record(s) are less likely to be captured on Mosaic. It needs to be established who should communicate directly with the CCG (staff) and then this is agreed with all staff as standard procedure. **R7**

3.8 Progress of all CHC cases is reviewed by appropriate ASC management

3.8.1 The role of senior ASC management in the workload and treatment of CCH cases is important given the potential cost sharing / savings that could potentially be achieved for RBC. However it was apparent that the lack of consistent and ongoing support from senior management has not contributed to develop a coherent approach to systematically identifying potential CHC cases that clearly meet national CHC eligibility criteria and that can be confidently presented to the CCG. Equally outcomes of the initial or detailed assessments refused by the CCG are not being assessed and challenged by senior ASC management, again possibly in part due to the absence of regular senior manager awareness or support. **R7**

3.9 Non – ASC CHC clients and records

3.9.1 This review only reviewed Adult CHC cases and not any in the Children's directorate, so it is not known how systems work within the directorate, but it might be worthwhile for both services to learn how the other operates to see whether any lessons can be learnt and best practice shared. **R8**

Appendix A - Report Distribution

Staff Interviewed

- Mechelle Adams, Operational Team Manager, Adult Social Care
- Paula Johnston, Acting Head of Service, Older and Physically Disabled People
- Natalie Chamberlain, CHC Support Administrator
- Various social care practitioners within ASC

Draft Report Distribution

- Seona Douglas, Director of Adult and Health Care Services
- Paula Johnston, Acting Head of Service, Older and Physically Disabled People
- Mechelle Adams, Operational Team Manager, Adult Social Care

Final Report Distribution

- Seona Douglas, Director of Adult and Health Care Services
- Paula Johnston, Acting Head of Service, Older and Physically Disabled People
- Jo Purser, Acting Head of Adult Social Care
- Mechelle Adams, Operational Team Manager, Adult Social Care
- Melissa Wise, Head of Transformation - DACHS
- Lorraine Goude, Head of Strategic Commissioning and Personal Budgets

Auditor Contact Details

- Kevin Parker, Principal Auditor - (0118) 937 2694
- Paul Harrington, Chief Auditor - (0118) 937 2695

For further details on our assurance opinions please click this link

Audit Management Action Plan
Continuing Healthcare

Ref	Risk	Recommendation	Priority	Management Response	Responsible Officer(s)	Target Date
1	The lack of an agreed local protocol or specification between the Council (RBC) and the Berkshire West Clinical Commissioning Group (CCG) for the application, assessment and administration of CHC applications means that there is no local framework around which standards can be set and adhered.	It is recommended that the Head of Service works with CCG partners to establish and agree a locally set of documented specifications and standards that detail what the joint arrangements for the procedures and timescales for the application, assessment and recording of CHC cases should be. Once agreed these should be signed off by both parties and all relevant staff advised accordingly.	Priority 2	Agreed, following the implementation of the revised CHC Framework in October 2018, the Acting Head of Adult Social Care will work with the CCG and partners to review the current Berkshire wide joint policy for CHC.	Jo Purser, Acting Head of Adult Social Care	1.1.2019
2	Unless there is senior officer support and resource devoted to analysing the reasons for the disparity of CHC eligible cases with similar local authorities there is remains a risk that the real reasons for the low rates locally may not be fully understood with the result that the financial burdens for care provision of these people may not be fairly met.	Ongoing efforts to further research and understand the disparity rates in local CHC funding should be fully and consistently backed by senior management in order that the reasons can be properly understood, and any changes made. Resources to do this may have to be found from existing budgets but the work should have senior officer support and the outcomes should be shared with other parties if necessary. Any system changes made as a consequence should be regularly monitored to establish their future effect.	Priority 1	Partly agreed. NHS England are responsible for auditing the application of the CHC framework. The Local Authority can refer to NHS England if there are specific concerns around the implementation of the framework locally but not research how the framework is being implemented across other areas. Senior management are focusing on ensuring that applications have robust evidence to support individuals to achieve CHC funding. This is a priority for Reading as if the process and framework is not followed there is a lack of evidence for NHS England. Whilst we accept that the current level of success in this area remains low there are required actions for Reading to implement before highlighting this with NHS England.	Jo Purser, Acting Head of Adult Social Care	1.1.2019

3	Without a recordkeeping system to provide a complete and consolidated audit trail of all activity in respect of a (potential) CHC case there is a risk that a key record or outcome could be missed or overlooked.	It is important that, as the corporate system, Mosaic is used to fully capture and record all activity relating to CHC cases, including copies of correspondence, official reports as well as meeting notes and notes arising from telephone conversations, as well as completed Checklists and Decision Support Tools. Mosaic should be used by all staff to provide important (date) tracking information so that can be used to by the CHC Administrator and management to view activity on individual CHC cases, as well as to be able to apply high level monitoring of CHC cases.	Priority 1	Agreed, Mosaic has the functionality to record the CHC process and related documents, but some minor amendments are required before being this is launched across Adult Social Care.	Jo Purser, Acting Head of adult Social Care Kelly Roberts, Mosaic Support Officer	1.4.19
4	Inadequate training or understanding about how to understand, assess and apply how criteria governing potential CHC cases could result in appropriate or incomplete applications being made to the CCG.	Although there is already recognition that there is a need to bring all CHC training up to date, it is important that in future all staff are adequately trained on CHC procedures, that they are clear they understand these and that a record of this training (and any future updated training) is kept on iTrent. The Head of Service may wish to consider making this training mandatory and to sign this off by formally launching the initiative across the directorate. It is further recommended that any CHC training guides or documentation are kept up to date and located in an appropriate place (e.g. on a shared drive or on IRIS).	Priority 2	Mandatory CHC training delivered to Adult Social Care staff, they are required locally to attend CCG training to submit checklists. All checklists are being scrutinised by Head of Service. An Assistant Team Manager is being recruited to lead operationally and to support workers at MDT's. CHC is included in the inductions of new staff - this will be reviewed by the Assistant Team Manager who will keep all training guides and material up to date and accessible in the S drive. Additional information is being shared with staff regarding key points of reference in the framework and a process flow chart is being developed by the Head of Service.	Jo Purser, Acting Head of Adult Social Care	1.12.2018
5	Currently there is no quick way to determine the status of a CHC case (i.e. dates checklists or Decision Support Tools submitted or returned) which means there is a potential risk that CHC applications are not progress on a timely basis.	It is recommended that the current control spreadsheet record maintained by the CHC Administrator is expanded to also capture dates key documents are submitted to / received from the CCG. This should then be regularly updated and checked to ensure each case is progressed on a timely basis. Where it is found that a case has not progressed then the relevant social work practitioner should follow this up and record this as an action on Mosaic.	Priority 2	Agreed, a dashboard to be devised to hold all information in relation to the staged process to easily identify individuals progress through a CHC application. The dashboard will be updated by the Health Liaison Business Support Officer, and monitored by the Assistant Team Manager who will follow up with the allocated social care practitioner if progress is not timely.	Jo Purser, Acting Head of Adult Social Care Natalie Chamberlain, CHC Support Administrator	1.12.2018

6	In instances where applications for CHC funding have been made to but rejected by the CCG, the reasons for this need to be understood to ensure consistency of understanding between the Council and the CCG and to ensure that all parties are aware of their (financial) commitments.	Where an application for CHC support and funding has been rejected by the CCG the reasons for this need to be properly understood and (any lessons) absorbed for consideration with future cases. Where appropriate decisions should be formally challenged. It is therefore recommended that all rejected cases go through a formal review process by an appropriate senior officer so that any lessons can be learnt (and challenged, where appropriate) and outcomes fed back to social care colleagues.	Priority 2	The Assistant Team Manager will review all rejected cases, who will advise the worker how to challenge if appropriate. If issues arise this will be escalated to the Head of Service. Quarterly information will be collated and shared with DMT about the number of checklists completed, MDT's, successful and unsuccessful applications and disputes. Learning pointes will be collated and shared with Adult Social Care staff to improve consistency and learning.	Jo Purser, Acting Head of Adult Social Care	1.4.2019
7	Currently there is a lack of clarity over roles and responsibilities in communicating with the CCG (staff) which means the recognised process can be confused.	It should be determined as part of the review of procedures recommended in R1 above, which RBC staff should communicate with CCG staff over the submission, assessment, determination and follow up of CHC cases. This should then be disseminated to relevant staff. Similarly the role and profile of senior management (eg the Head of Adult Care) in relation to CHC cases needs to be visible so that there is a sufficiently high level presence on any joint board or forum to ensure that the Council's position and role is adequately	Priority 2	Agreed. Since 22.10.18, all checklists are ratified by the Head of Service. This will transfer to the Assistant Team Manager when they are in post. The Health Liaison Business Support Officer submits all checklists to the CHC team and is the main channel for communication. The Head of Service has met with staff regarding CHC and the application of the framework offering support if and when required, this will then be lead operationally by the ATM. The Head of Service attends the CHC panel.	Jo Purser, Acting Head of Adult Social Care Assistant Team Manager	1.12.18
8	Although the incidence of CHC related cases within the RBC Children's directorate there is a risk that good practice and procedure in Adults may not be known and shared.	It is recommended that the Adults and Children's services within RBC share best practice in relation to the handling, administration and management of CHC cases.	Priority 3	Agreed. Once Brighter Futures has become established the Head of Service will meet with their Head of Service to ensure that consistency of practice is embedded across Children's and Adult's services.	Jo Purser, Acting Head of Adult Social Care	01/09/2019

NB: Your management response is your commitment to treat the risk identified as part of the review. The standard response time to draft recommendations is 15 working days; any failure to meet this target could be reported to the Audit & Governance Committee.

The management response to recommendations will be reported to both CMT & The Audit & Governance Committee as part of our quarterly monitoring arrangements. Audit recommendations and agreed actions will be followed up during the year, where deemed appropriate by the Audit Management Team. All outstanding recommendations will also be reported through CMT as part of the Council's monthly performance monitoring.

Reading Borough Council
Working better with you

Internal Audit Report - Final

Residents Parking

To: **Cris Butler – Strategic Transport Programme Manager**
Simon Beasley – Network & Parking Manager
Elizabeth Robertson – Civil Enforcement Manager
Alison Bell – Director, DENS

From: **Amondeep Basra, Senior Auditor**

Date: **06/12/18**

Limited Assurance

Ref: **17/18**

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1 Purpose and Scope of Review

1.1 Reading Borough Council introduced Parking Enforcement in 2000, when responsibility for enforcement of parking contraventions passed from Thames Valley Police to the Local Authority. The current legislation that allows for Reading to enforce parking and waiting restrictions is under The Traffic Management Act 2004. This also permitted local authorities to enforce restrictions by other methods which are now known as 'Civil Parking Enforcement'. Parking offences are classified as civil offences rather than criminal offences under Civil Parking Enforcement.

1.2 Reading Borough Council has an integrated Parking Service, which manages both on-street and off-street activities. The Council introduced Civil Parking Enforcement under Part 6 of the Traffic Management Act 2004 from 31st March 2008.

1.3 The current guiding transport policy document is its Local Transport Plan (LTP) 2011- 2026. The Local Transport Plan includes a 15-year strategy document and a rolling 3-year implementation programme. The LTP programme is reviewed annually to ensure the aims and objectives are being delivered.

1.4 Permit Parking Zones came to Reading in the mid 1970's with the intention to enable residents to park in streets that would have otherwise been occupied by shoppers or commuters parking in the town centre. As levels of car ownership and traffic patterns have developed, the zones have spread away from central Reading to other parts of the town affected by parking problems.

1.5 In 2011/2012, the parking permit service and the zoning system was updated with zones becoming larger and a better split between the number of permits

being issued and the number of on-street parking spaces being made available. Changes to the permit scheme are made so it is vital people continue to check the signs and lines where they park.

1.6 There are currently three main types of permits available, resident, visitor and business, however temporary permits and other discretionary permits are also available.

1.7 Reading Borough Council utilises the PermitSmarti application, as provided by Imperial Civil Enforcement Solutions Limited, to provide the administrative and back office solution for the application for residents parking permits.

1.8 Parking enforcement is conducted both on- and off-street by Reading Borough Council Parking Services through Civil Enforcement Officers employed through a contractor.

1.9 Penalty Charge Notices are issued when people contravene the parking code. Penalty Charge Notice tickets can be categorised as higher or lower depending on the seriousness of the contravention. Penalty Charge Notices can be paid either online, by post or by phone.

1.10 Reading Borough Council is currently using the 3Sixty application for the management of penalty charge notices.

2 Main Conclusions

2.1 A total of 9 recommendations have been raised in respect of this review, of which 3 have been considered a high priority. The full detail of these recommendations and the corresponding management action plan are attached to this report as Appendix 1.

2.2 In the course of the audit it has not been possible to establish any formal documentation that sets out the governance, management and administrative arrangements for maintaining the PermitSmarti and 3Sixty applications, further there was no Separation of Duties (SoD) table documented recording roles, responsibilities nor how segregations of duties will be enabled. Additionally it has been identified that there is no record in place of the training undertaken by RBC staff or contractors.

2.3 It has not been possible to evidence that there has been a complete identity management review, in which user accounts and permissions were validated, with respect to either PermitSmarti, 3Sixty or their predecessor applications.

2.4 In reviewing the applications against the requirements of the RBC "ICT Standards Expected of Third Parties Policy," it has been found that the applications do not meet the password complexity requirements. Further the policy also requires that any third party provider is “compliant with the ISO27001/2013 standards," whereas the Imperial Civil Enforcement Solutions Limited has stated that they are not ISO27001 certified but that they do observe the principles.

2.5 In was not possible to establish that there was a consistent and formal process applied to the monitoring of user activity on either applications reviewed, and there was no evidence presented of the performance of user activity audits. It was noted however that in 2017 that the Civil Enforcement Manager had identified anomalous activity on the penalty charge notice application that was in place at the time via a review of user activity that had been performed in July 2017.

2.6 With respect to the limited quantity of Temporary and Tradespersons it has been identified that whilst a record is kept where a package of permits is made available for distribution there is no reconciliation performed of those permits issued to the stock that is held.

3 Summary of Findings

3.1 Governance

3.1.1 The PermitSmarti application which is in use at RBC for the purposes of providing an administrative solution for residents parking permits went live within the Council on the 31st October 2017. The 3Sixty application which is currently in place for the management of penalty charges notices went live on the 5th June 2018.

3.1.2 It has not been possible as a part of this audit to identify any formal documentation that sets out the governance, management and administrative arrangements for maintaining the PermitSmarti and 3Sixty applications. RBC does currently retain a copy of the original contract and supporting documents that were put in place with NSL Limited in 2014, which relate in part to the predecessor applications. It has not however been possible to identify a document that identifies specific roles and responsibilities related to the operation of controls and procedures that support the PermitSmarti and 3Sixty applications. **(R1)**

3.1.3 RBC has in place a number of Council wide information security policies and mandatory training that staff are required to review and undertake. The training includes Information Security Training, General Data Protection Regulations and Information Security and ICT Use of Equipment Policy. Parking Services does not have in place any application specific policies and instead places reliance upon the mandatory training. There is no training log or record maintained to demonstrate that users of the service have reviewed and completed the training. **(R2)**

3.1.4 There is currently no system documentation in place that has been prepared by Parking Services that details the operation and function of the PermitSmarti and 3Sixty applications. The NSL Client Account Manager was asked whether it would be possible to provide access to system documentation and the responses that he obtained from NSL and the sub-contractor Imperial were that there are no generic user guides and that all training is based on the customer requirement from the system configuration. The Civil Enforcement Manager (RBC) has advised that there is no formal programme of training for application users and that any training is provided via the inductions process.

3.1.5 It is noted however that Imperial has provided a "Guide to The Most Frequently Asked Questions by Users of the 3Sixty Application," that concerns the use of the Security Config module that allows for the management of the application.

3.1.6 The Civil Enforcement Manager (RBC) has stated that preliminary work has commenced on documenting some of the processes in place with respect to the systems, but it was not possible to review the work that had been completed to date.

3.2 Access to the system, information and resources / Enforcing Segregation of Duties

3.2.1 There was not found to be an independent list of authorised personnel that were approved to have system access to either application at the time of the audit.

3.2.2 It was not possible to obtain direct from the applications itself a report showing all users on the system and the current permissions and access rights that have been enabled for them. Whilst the 3Sixty Security Config module did allow for a display of all users of the system the Civil Enforcement Manager was unaware of how this information could be exported into a useable and manageable format. **(R3)**

3.2.3 The Civil Enforcement Manager (RBC) has advised and provided access to a document that has been prepared by the Civil Enforcement Supervisors in order to review user accounts. At the time of the audit the review of user accounts was not complete, and the Civil Enforcement Manager advised that the process involved the Supervisors manually typing out the user accounts and determining whether they should be deleted. There was no evidence available to demonstrate that user access reviews had been undertaken on the predecessor applications. **(R3)**

3.2.4 There is no Separation of Duties (SoD) table that exists for either the PermitSmarti or 3Sixty application or equivalent document setting out how functions and processes have been enabled to ensure that there is appropriate segregation of duties. **(R4)**

3.2.5 The Civil Enforcement Manager (RBC) has advised that PermitSmarti has approximately 7 users based on the first floor of the Civic Offices and a number of users based in the reception of the Civic Offices. It has additionally been advised that the 3Sixty application has approximately 30 users, of these 16 are employees of RBC and the remaining are contractors. The Civil Enforcement Manager (RBC) has advised that contractors are not required to undertake RBC mandatory training or to review RBC Information Security policies.

3.2.6 With respect to the PermitSmarti application the response received from Imperial has advised that "staff have appropriate data protection and confidentiality clauses in their contracts," and "all new members of staff are provided with data protection training as part of their induction. Members of staff whose role necessitates a more thorough level of training are provided with is at the start of their employment and then refreshed at regular intervals (usually annually unless changes in legislation require additional training)."

3.2.7 The response received with respect to the 3Sixty application from NSL states that "Training is provided by ICES – NSL staff are trained by then in the operation of the product – the training is based on Job of work and specific to

the functional requirements of RBC." RBC does not retain any records or detailed information with respect to the training undertaken by contractors. **(R5)**

3.2.8 The Reading Borough Council "ICT Standards Expected of Third Parties Policy," version 1.4 last reviewed August 2016 states that "Reading Borough Council will expect any Third Party to have formal Information Security Management Policies and Procedures written to provide ICT Services compliant with ISO27001/2013 and therefore deliver services which are legally compliant and of a consistent high standard and quality."

3.2.9 The response received from Imperial Civil Enforcement Solutions Limited with respect to their Information Management Security Policies stated "We are not ISO27001 certified. We observe ISO 27001 principles and in accordance with the standard the different risks to the business are analysed and either resolved, mitigated or accepted," and "We are Cyber Essentials certified (certification number 2170553)," and "We are also members of the CiSC (Cyber Security Information Sharing Partnership)." **(R6)**

3.2.10 The response received from NSL Limited with respect to their Information Management Security Policies stated that "NSL Data is hosted in the Microsoft Azure Cloud. The Azure Cloud is ISO27001 certified." Additionally they have provided a copy of a certification received from Exova BM TRADA that identifies NS Centrality has having "been audited and found to meet the requirements of standard ISO/IEC 27001:2013 Information Management Systems Requirements. The date of the initial certification is recorded as the 5th September 2017 and is valid until the 4th September 2020.

3.3 Management and monitoring of privilege and service user account activities

3.3.1 There is no formally defined process or procedure with respect to the detail or frequency with which management will review the user activity on either the PermitSmarti or 3Sixty applications. There have been no documents available to evidence that management review of user activity has taken place on either the current or previous applications. It is noted that the Civil Enforcement Manager (RBC) has advised that periodic and informally defined review does take place and this statement is supported by an investigation that was undertaken within the RBC in August 2017 as a result of anomalous activity identified by the Civil Enforcement Manager during the course of a review. **(R7)**

3.3.2 The Civil Enforcement Manger and Supervisors have available to them within the 3Sixty application an audit tab within the Security Config module and the ability to generate management information, regarding user activity, via the use of User Activity Letters. This combination of management information allows for the monitoring of activity on the 3Sixty application. The Civil

Enforcement Manager has advised that the Supervisors will utilise the User Activity Letters to monitor the processing activity of personnel on the application for discussion at one to ones. There is no formal documentation or procedure outlining how this information should be used or how frequently and it was not possible to evidence its use in one to one documents.

3.3.3 The Civil Enforcement Manager has advised that the PermitSmarti application does not have a management reporting function equivalent to 3Sixty or an available audit tab showing all user activity. Whilst all information required for the purposes of supervision and management review is recorded and available within PermitSmarti the system does not allow for a search to be performed on the basis of activity undertaken by a specific user. The Civil Enforcement Manager has additionally advised that to her knowledge a review of user activity has not been undertaken and there has not been a process in place by which the available management information has been used to review a sample of all activity, regardless of user, at identified periods.

3.3.4 The Reading Borough Council "ICT Standards Expected of the Third Parties Policy," version 1.4 reviewed August 2016 states that the RBC expectation of third parties with respect to passwords is that they will "…follow CESG password formats (9 minimum, combinations of alpha and numeric etc). The NSL Client Account Manager has advised that the current settings with respect to the 3Sixty application are; a minimum length of 4 characters, 0 digits required, 0 uppercase letters required, 0 lowercase letters required, and 0 symbols required.

3.3.5 In response to the enquiry as to the password requirements for the PermitSmarti application Imperial Civil Enforcement Solutions responded, via the NSL Contract Manager, that the current requirements are that "Passwords must contain at least 8 character including one lower case and one numeric character." **(R8)**

3.4 Management and monitoring of physical permits held by Reading Borough Council

3.4.1 The RBC Parking Annual Report 2016-17 shows that the permits issued by the Council can be sub-divided into 19 different categories. The current system in place is such that where an online application is made for a permit and approved via PermitSmarti the permit itself will be printed by the contractor and mailed directly to the applicant. RBC does however maintain control of a small volume of physical permit stock that fall into the Temporary and Traders permit category.

3.4.2 The processing of Temporary and Traders permits occurs on the PermitSmarti application as do other permit types and the serial number of each permit issued is recorded in a free entry text box with the application as well as the application itself assigning a system generated reference number of the

permit. The physical stock of permit is held primarily on the 1st floor of the Civic Offices and is distributed to the staff within the reception area of the Civic Offices as and when a request is made of additional stock. The permits are batched in groupings of 199 permits.

3.4.3 The Parking Services team maintain 2 different logs in excel spreadsheet format for the Temporary Permit stock and Tradesperson stock of permits that are distributed. The logs record the serial number range of the batch of permits issued, the person that issued them, the date on which they were issued and the person to whom they were issued. The Civil Enforcement Manager has confirmed that at the current time there is no reconciliation performed or stock check taken of the permits that are held and the records for those that have been issued. **(R9)**

Appendix A - Report Distribution

Staff Interviewed

- Cris Butler, Strategic Transport Programme Manager
- Elizabeth Robertson, Civil Enforcement Manager

Draft Report Distribution

- Cris Butler, Strategic Transport Programme Manager
- Elizabeth Robertson, Civil Enforcement Manager

Final Report Distribution

- Alison Bell, Director, DENS
- Simon Beasley – Network & Parking Manager
- Cris Butler, Strategic Transport Programme Manager
- Elizabeth Robertson, Civil Enforcement Manager

Auditor Contact Details

- Amondeep Basra, Senior Auditor - (0118) 937 2693
- Paul Harrington. Chief Auditor - (0118) 937 2695

For further details on our assurance opinions please click this link

Audit Management Action Plan
< DENS 0035 Residents Parking

Audit Management Action Plan
DENS 0035 Residents Parking

Ref	Risk	Recommendation	Priority	Management Response	Responsible Officer(s)	Target Date
1	a) Where there is no formal documentation that sets out the governance, management and administrative arrangements for maintaining the PermitSmarti and 3Sixty applications there is an increased risk that control activities being duplicated or not fully completed where roles are not properly understood. b) The system may not be properly maintained leading to service/performance issues or system failure.	Parking Services should develop a formal policy document that sets out the governance, management and administrative arrangements for maintaining the PermitSmarti and 3Sixty applications.	Priority 1	Recommendations accepted. Parking Services will develop formal policy documentation that sets out the: - Governance - Management - Administrative Arrangements with respect to the PermitSmarti and 3Sixty applications. The documentation will set out the controls that are in place with respect to the applications and will be subject to periodic review.	Elizabeth Robertson – Civil Enforcement Manager, Emma Benger – Civil Enforcement Supervisor, Halima Khan – Civil Enforcement Supervisor, Pritam Surdhar – Civil Enforcement Supervisor, Gurpreet Vig - Civil Enforcement Supervisor	31/03/2019
2	a) Where there is no formal record in place to record that system users have undertaken required and appropriate training the Council cannot have assurance that it has undertaken appropriate action to ensure that all users are adequately equipped to meet their responsibilities as required and of the expectation upon them.	Parking Services should develop a training log to demonstrate, provide oversight of and assurance as to the training undertaken by the users of the PermitSmarti and 3Sixty application.	Priority 2	Recommendations accepted. Training logs will be updated and maintained in order to demonstrate that the application users have been informed as to the use of the systems and their responsibilities with respect to access.	Elizabeth Robertson – Civil Enforcement Manager, Emma Benger – Civil Enforcement Supervisor, Halima Khan – Civil Enforcement Supervisor, Pritam Surdhar – Civil Enforcement Supervisor, Gurpreet Vig - Civil Enforcement Supervisor	31/03/2019

3	a) Where an identity management review of users accounts on applications are not performed at regular intervals there is an increased risk that the application may be subject to unauthorised or inappropriate access.	Parking Services should perform periodic identity management reviews of the user accounts for the PermitSmarti and 3Sixty applications and will document that these have occurred and the changes that have occurred as a result.	Priority 2	Recommendations accepted. Parking Services in conjunction with NSL services will perform bi-annual identity management reviews of the PermitSmarti and 3Sixt applications. The identity management reviews will review user account access and permissions within the application.	Elizabeth Robertson – Civil Enforcement Manager, John Evans – NSL Client Account Manager	31/03/2019
4	a) Where an applications does not have the separation of duties set out and formally documented there is an increased risk that users will be provided with inappropriate system access or that segregation of duties will not be maintained.	Parking Services should set out a Separation of Duties (SoD) table for the PermitSmarti and 3Sixty applications demonstrating how users have been assigned permissions in a manner that demonstrates appropriate segregation of duties.	Priority 2	Recommendations accepted. A review will be performed of settings within both applications. Additionally a review will be performed of user access within the applications a record maintained within the training log to demonstrate their access levels.	Elizabeth Robertson – Civil Enforcement Manager, Emma Benger – Civil Enforcement Supervisor, Halima Khan – Civil Enforcement Supervisor, Pritam Surdhar – Civil Enforcement Supervisor, Gurpreet Vig - Civil Enforcement Supervisor	31/03/2019
5	a) Where the RBC is not aware or has not reviewed the training undertaken by users that have access to applications that it utilises then it cannot have assurance that those users have met an appropriate standard.	Parking Services should, periodically, liaise with the NSL Contract Manager in order to ensure that non-RBC personnel that have system access have received adequate training and meet the requirements of the RBC "ICT Standards Expected of Third Parties Policy." Evidence of this action will be retained.	Priority 3	Recommendations accepted. The NSL Contract manager will be contacted in order to establish: - The training that is undertaken by non-RBC personnel - That the training provided meets the requirements of the RBC "ICT Standards Expected of Third Parties Policy." Evidence of this activity will be retained.	Elizabeth Robertson – Civil Enforcement Manager, John Evans – NSL Client Account Manager	31/03/2019

6	a) Where a third party provider is not ISO27001 certified but observes the principles they may not have complied with the RBC "ICT Standards Expected of Third Parties Policy."	Parking Services should seek guidance from the RBC Corporate ICT Services as to whether Imperial Civil Enforcement Solutions Limited observing ISO 27001 but not being certified is sufficient for meeting RBC requirements. Parking Services should ensure that it advises RBC Corporate ICT Services of the Cyber Essentials certification and membership of CiSC that Imperial has referenced.	Priority 2	Recommendations accepted. RBC Corporate ICT Services will be contacted in order to discuss and to confirm the approach to observing standards by the current application provider is sufficient to meet the requirement of the RBC "ICT Standards Expected of Third Parties Policy." The conclusions of the discussions will be documented and held on file as confirmation that Parking Services has acted with appropriated care and in compliance with Council standards.	Elizabeth Robertson – Civil Enforcement Manager	31/03/2019
7	a) Where there is no formally documented approach to the review of user activity of applications there is an increased risk that the activity when performed will not identify all potential activity of interest as the activity may be performed inconsistently or inadequately. b) Where records are not retained of the performance of user activity reviews on a periodic basis management cannot have assurance that controls are functioning effectively and anomalous activity will be detected or prevented.	Parking Services should formally define the requirements for the review of user activity, who is to perform the review and with what frequency.	Priority 1	Recommendations accepted. Supervisors have been tasked with reviewing the current arrangements in place for the review of user activity. They will formally document the current processes that are in place. Additionally Supervisors will review the possibility of implementing reviews and discussions in one to one minutes.	Elizabeth Robertson – Civil Enforcement Manager, Emma Benger – Civil Enforcement Supervisor, Halima Khan – Civil Enforcement Supervisor, Pritam Surdhar – Civil Enforcement Supervisor, Gurpreet Vig - Civil Enforcement Supervisor	31/03/2019
8	a) Where the applications in use by Parking Services do not have in place password requirements that meet RBC standards they may be subject to challenge as to whether they have taken appropriate action to secure the application and the data held.	Parking Services should liaise with the NSL Contract Manager to ensure that password access rights are set within the PermitSmarti and 3Sixty applications to meet RBC standards.	Priority 1	Recommendations accepted. The NSL Contract Manager will be contact with respect to ensuring that the PermitSmarti and 3Sixty applications meet the RBC password requirements.	Elizabeth Robertson – Civil Enforcement Manager, John Evans – NSL Client Account Manager	31/01/2019
9	a) Where reconciliations are not periodically performed between the permit stock that is held and that which is issued management there is an increased risk of the misappropriation of stock.	Parking Services should perform periodic reviews of the physical inventory of permits that it holds and document that it has done so.	Priority 2	Recommendations accepted. Periodic review of permit inventory will be performed and documented by the Supervisors Pritam Surdhar and Gurpreet Vig.	Elizabeth Robertson – Civil Enforcement Manager, Pritam Surdhar – Civil Enforcement Supervisor, Gurpreet Vig - Civil Enforcement Supervisor	31/01/2019

NB: Your management response is your commitment to treat the risk identified as part of the review. The standard response time to draft recommendations is 15 working days; any failure to meet this target could be reported to the Audit & Governance Committee.

The management response to recommendations will be reported to both CMT & The Audit & Governance Committee as part of our quarterly monitoring arrangements. Audit recommendations and agreed actions will be followed up during the year, where deemed appropriate by the Audit Management Team. All outstanding recommendations will also be reported through CMT as part of the Council's monthly performance monitoring.

Audit Management Action Plan
DENS 0035 Residents Parking

Ref	Risk	Recommendation	Priority	Management Response	Responsible Officer(s)	Target Date
1	a) Where there is no formal documentation that sets out the governance, management and administrative arrangements for maintaining the PermitSmarti and 3Sixty applications there is an increased risk that control activities being duplicated or not fully completed where roles are not properly understood. b) The system may not be properly maintained leading to service/performance issues or system failure.	Parking Services should develop a formal policy document that sets out the governance, management and administrative arrangements for maintaining the PermitSmarti and 3Sixty applications.	Priority 1	Recommendations accepted. Parking Services will develop formal policy documentation that sets out the: - Governance - Management - Administrative Arrangements with respect to the PermitSmarti and 3Sixty applications. The documentation will set out the controls that are in place with respect to the applications and will be subject to periodic review.	Elizabeth Robertson – Civil Enforcement Manager, Emma Benger – Civil Enforcement Supervisor, Halima Khan – Civil Enforcement Supervisor, Pritam Surdhar – Civil Enforcement Supervisor, Gurpreet Vig - Civil Enforcement Supervisor	31/03/2019
2	a) Where there is no formal record in place to record that system users have undertaken required and appropriate training the Council cannot have assurance that it has undertaken appropriate action to ensure that all users are adequately equipped to meet their responsibilities as required and of the expectation upon them.	Parking Services should develop a training log to demonstrate, provide oversight of and assurance as to the training undertaken by the users of the PermitSmarti and 3Sixty application.	Priority 2	Recommendations accepted. Training logs will be updated and maintained in order to demonstrate that the application users have been informed as to the use of the systems and their responsibilities with respect to access.	Elizabeth Robertson – Civil Enforcement Manager, Emma Benger – Civil Enforcement Supervisor, Halima Khan – Civil Enforcement Supervisor, Pritam Surdhar – Civil Enforcement Supervisor, Gurpreet Vig - Civil Enforcement Supervisor	31/03/2019
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