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WIRRAL

Audit and Risk Management Committee

Date:	**Tuesday, 4 November 2008**
Time:	**6.15 pm**
Venue:	Committee Room 1 - Wallasey Town Hall

Contact Officer: Mark Delap
Tel: 0151 691 8500
e-mail: markdelap@wirral.gov.uk
Website: http://www.wirral.gov.uk

SUPPLEMENTARY AGENDA [2]

3. AUDIT COMMISSION SUMMARY REPORT 'ADULT SOCIAL SERVICES - FOLLOW UP OF PIDA DISCLOSURE' (Pages 1 - 28)

- Internal Audit Report
  [Attached]

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WIRRAL COUNCIL

AUDIT AND RISK MANAGEMENT COMMITTEE

4 NOVEMBER 2008

REPORT OF THE DIRECTOR OF FINANCE

ADULT SOCIAL SERVICES - PIDA DISCLOSURE

1. EXECUTIVE SUMMARY

1.1. Following the meeting of this Committee on 30 September 2008 when the Audit Commission presented the above report, I requested Internal Audit to conduct an audit to investigate allegations made against Council staff regarding the proper handling of this matter.

1.2. At the request of Members of this Committee it was also necessary to evaluate the following during the course of the audit:

- Whether the system and procedures utilised to add a named supported living provider to the Adult Social Services Accreditation List were effective and complied with by the Department at all times.

- Whether Whistleblowing procedures in operation within the Adult Social Services Department were effective and had been complied with for this particular case.

2. SUMMARY CONCLUSIONS

2.1. No evidence was identified to support allegations of inappropriate behaviour by any member of staff employed by Wirral Council in connection with this case.

2.2. A number of issues were identified within the system in operation for maintaining an Accreditation List for supported living providers and these are currently being addressed by the Department. However there is evidence to indicate that all of the relevant policies and procedures were complied with when an assessment was undertaken of the named supported living provider prior to them being added to the list.

2.3. Evidence suggests that the Whistleblowing Policy and procedures implemented by the Adult Social Services Department comply with the corporate policy and best practice in general.

2.4 For this particular case however it is unclear whether at the outset this should have been dealt with as a Grievance or a Whistleblowing and there is clearly conflicting evidence available to support both of these options. What is clear is that at the outset management should have established the exact nature of the issues identified and the way in which they were to be investigated and that this should have been agreed by both parties at that time. There is no evidence to suggest that this happened.

3. BACKGROUND

3.1. A number of concerns were brought to the attention of the Audit Commission in October 2007 under the Public Interest Disclosure Act 1998 (PIDA). These concerns related to aspects of the provision of services in the following areas:

- Arrangements for the commissioning and monitoring of contracts for Supported Living and Supported People services.

- Application of the Department of Health Fairer Charging policy.

3.2. The Audit Commission undertook a review of the arrangements for commissioning and monitoring contracts, and for charging service users, to ensure that appropriate arrangements were in place to ensure value for money and compliance with relevant guidance regarding adequate safeguard controls.

3.3. A report was prepared by the Audit Commission identifying a number of recommendations to improve existing arrangements within Adult Social Services which was presented to this Committee on 30 September 2008.

4. INTERNAL AUDIT WORK UNDERTAKEN

4.1. The objectives of the audit were to:

(a) Investigate allegations made by a member of the public at the Audit and Risk Management Committee meeting on 30 September 2008 concerning the activities of employees of the Council involved in the supported living case involving a family member.

(b) Evaluate the efficiency and effectiveness of the system and procedures utilised by the Adult Social Services Department to include a named supported living provider on the Accreditation List.

(c) Evaluate the Whistleblowing policy and procedures in operation within the Adult Social Services Department for effectiveness and compliance in this particular case.

4.2. The audit work undertaken involved interviewing the following individuals concerned with this case and reviewing and evaluating all of the relevant documentation and working papers available for this particular case:

- The person responsible for making the allegations regarding the activities of Council employees,
- The person responsible for the Whistleblowing,
- The relevant Heads of Service,
- Individual managers and officers responsible for systems, policies and procedures in operation within Adult Social Services.

4.3 Due to the deadline identified for the production of this report it has not been possible to interview every officer of the Council involved with this particular case, nor examine every piece of a substantial amount of paperwork. However meetings have taken place with a significant number of relevant officers including all of the 'key' individuals identified and all of the crucial documents have been examined and evaluated.

5. FINDINGS AND CONCLUSIONS

5.1. Allegations of Impropriety

5.1.1. The allegations made by the member of the public concerning the activities of members of staff employed by Wirral Council were investigated and no evidence identified to substantiate any issues of impropriety involving any employee of the Council either past or present. In fact many of the issues presented to the auditors, and referred to at the previous meeting of this Committee relate to the activities of the named supported living provider and its employees. Some of these issues have become known to officers of the Council during their involvement with this case and some questions have been asked regarding the activities of this provider. Not all of these questions appear to have been acted upon by the Department, however, there is no evidence to suggest that any officers of the Council deliberately acted against the best interests of the client or in fact at any time 'colluded' with the named supported living provider in an improper manner.

5.1.2. The issues relating to the activities of the named supported living provider have been reported to the Police by the client and they have conducted a separate investigation and determined not to proceed with a case for reasons not disclosed to the auditors.

5.2. **Accreditation List**

5.2.1. The systems and procedures in place within the Adult Social Services Department for the compilation and maintenance of an Accreditation List for providers of supported living were actually reviewed in detail by the Internal Audit Section in March 2008 and a report prepared for the Head of Service (Appendix 1.a). This report identified that the whilst the system in operation complied with good practice the overall opinion on the effectiveness and efficiency of the control environment was that it was 'less than satisfactory' primarily on account of their being seven high priority weaknesses identified in the system of control. Those recommendations required to address weaknesses were identified in the report for management and an appropriate timescale for implementation agreed. five of these recommendations are summarised in the PIDA report prepared by the Audit Commission and presented to this Committee on 30 September 2008.

5.2.2. Follow-up work conducted during this review to assess progress made by the Department towards implementing these recommendations indicates that of the seven recommendations required to improve systems of control three have been fully implemented and four remain outstanding despite the deadline having passed, although it was observed that progress has been made in some areas (Appendix 1.b). I am advised by management that the revised target date for completion of these is 28 November 2008.

5.2.3. The Accreditation List became operational in December 2006 when a number of supported living providers were assessed by the Adult Social Services Department utilising a detailed scoring matrix that included an evaluation of various criteria and culminated in an overall assessment score. The named supported living provider was one of thirty six providers that attained the required score at this time and was subsequently added to the list. Adult Social Services currently has sixteen individuals placed with this provider representing 6% of the total placements across all of the supported living providers.

5.2.4. It is acknowledged by the Adult Social Services Department that prior to the compilation of the Accreditation Listing in 2006, systems in operation to manage the utilisation of supported living providers were not as robust as they are now and that any control issues previously in evidence have now been addressed. The introduction of an Accreditation List has significantly improved control over this system and removed many of the weaknesses that were in evidence. However, a number of issues do still remain and will only be fully addressed when all of the outstanding recommendations from the Internal Audit and Audit Commission reports are fully implemented.

5.3. **Whistleblowing Policy**

5.3.1. Evidence indicates that the Adult Social Services Department has fully implemented the Whistleblowing Policy which complies with current best practice. A procedure has been developed within the Department to communicate the details to all managers and members of staff via regular team briefings, notices, emails and utilisation of the intranet.

5.3.2. For this particular case however, there is some confusion regarding whether the case was indeed a Whistleblowing or not. The Department has indicated that when issues were first raised by the individual that they were of a 'Grievance' nature and were dealt with under the Council policy and procedure for this, and documentation provided by the department supports this. The Department believed that because the case was a grievance and was being dealt with as such, implementing Whistleblowing procedure was not appropriate. It is their opinion that the case only became a Whistleblowing when it was reported to the Audit Commission and investigated under the Public Interest Disclosure Act 1998. However, evidence has been provided to the auditors by the individual which includes correspondence from the Council referring to the individual's Whistleblowing case that appears to dispute this. The individual is clearly of the opinion that during the course of the investigation of the grievance he requested that the case be identified and investigated as a Whistleblowing, but management disputes this and has provided evidence to support this. It has not been possible to reach a definitive conclusion on this due to the protracted nature of this case, the conflicting evidence provided and the timescale involved. What is clear however is that management should have established at the outset the exact nature of the issues reported and the way in which they were to be investigated and that this should have been agreed by both parties.

5.3.3. What is beyond dispute is that the individual responsible for the actual 'Whistleblowing' is a former employee of the Adult Social Services Department who had been actively involved with the case in question. This individual had expressed concerns to management on a number of occasions regarding systems in operation within the Department and the handling of this case. Evidence obtained indicates that these concerns were investigated by managers although not to the satisfaction of the individual as a formal grievance was raised in September 2006. The grievance process was operational for a prolonged period of time without resolution and consequently progressed to the stage of the Council procedure which involved a report being presented to the Appeals Sub Committee for hearing by Members in May 2007. At the second hearing in July 2007 and without any conclusion being reached the individual withdrew the grievance.

5.3.4. An agreement was subsequently reached with the Council to end the individuals employment on 4 April 2008, on account of their being irrecoverable differences. A 'compromise agreement' that included a confidentiality clause was prepared and agreed by the Individual, the Adult Social Services Department, Legal and Member Services and Human Resources. The Head of Human Resources stated that this type of agreement, whilst not being commonplace, has been utilised by the Council on a number of occasions in certain circumstances where irrecoverable differences are in evidence. On this occasion both parties signed the document agreeing to the terms and conditions included within the agreement. The individuals post was subsequently deleted by the Department following a restructure earlier this year.

5.3.5. Sufficient evidence was obtained during the audit to suggest that in general the Council Whistleblowing Policy and procedures have been implemented effectively by the Adult Social Services Department and that any case brought to the attention of those designated officers identified in the Whistleblowing policy would be investigated in accordance with this. However, it should be noted that since the policy was implemented the Department has not had a single Whistleblowing case to investigate and so it is not possible to evaluate actual compliance with the policy and procedure by officers of the Department.

5.4. During the audit a request was received to review issues relating to the charging policy. However due to the timescale involved it has not been possible to complete this element of the work. A subsequent audit will be undertaken of this and reported to a future meeting of this Committee.

6. RECOMMENDATIONS

6.1. An Action Plan has been prepared that identifies the following recommendations required to address the control issues identified and to improve systems in operation. This will be included in a report to be prepared for management of the Adult Social Services Department following this Committee meeting (Appendix 2):

(a) Immediately review the procedures in operation within the Department for evaluating the performance of supported living providers on an ongoing basis, to ensure that provision is made for the inclusion of the views and opinions of officers of the Council undertaking work in these areas regarding the effectiveness of individual providers.

(b) Immediately implement all of the outstanding recommendations identified in the Audit Commission and Internal Audit reports dated March, August and October 2008 respectively.

(c) Immediately review the procedures in operation within the Department for evaluating reported issues of this nature and determining the most appropriate actions to be taken to investigate them, and assess the adequacy and effectiveness of these arrangements.

7. FINANCIAL AND STAFFING IMPLICATIONS

7.1. There are none arising from this report.

8. LOCAL MEMBER SUPPORT IMPLICATIONS

8.1. There are no local Member support implications.

9. LOCAL AGENDA 21 STATEMENT

9.1. There are no local agenda 21 implications.

10. PLANNING IMPLICATIONS

10.1. There are no planning implications.

11. EQUAL OPPORTUNITIES IMPLICATIONS

11.1. There are no equal opportunities implications.

12. COMMUNITY SAFETY IMPLICATIONS

12.1. There are no community safety implications.

13. HUMAN RIGHTS IMPLICATIONS

13.1. There are no human rights implications.

14. BACKGROUND PAPERS

14.1. Audit Commission – Adult Social Services Follow Up of PIDA Disclosure - August 2008

14.2. Internal Audit Report and Follow Up on Accreditation List for Independent Living Providers (Appendix 1a & 1b).

14.3. Internal Audit Action Plan (Appendix 2).

15. RECOMMENDATION

15.1. That the report be noted.

IAN COLEMAN
DIRECTOR OF FINANCE

FNCE/261/08

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Metropolitan
Borough of Wirral

Appendix 1.a.

Internal Audit Report

Accredited List

Prepared by : **Amanda J Smith**

Authorised by : **Lester Roughley**

Date of Issue : **13 March 2008**

1. INTRODUCTION

An audit has recently been completed to review the effectiveness of the control within the system of the Accredited List process.

An overview of the system is outlined in section 2 and the methodology for the audit is outlined in section 3. The overall opinion is reported in section 4 and the key findings and recommendations in section 5.

An Action Plan has been attached for you to complete and return as your response to the recommendations.

The recommendations have been prioritised in relation to the assessed risk. If a recommendation is not to be implemented it will be assumed that the associated risk has been accepted. However, please note that it is now a requirement to report any non- accepted medium and high priority recommendations to the Audit & Risk Management Committee.

A customer survey questionnaire has also been attached for your completion. This is to help us monitor the effectiveness of our audits.

2. OVERVIEW

- A decision was taken by the Head of Service for Learning, Mental and Physical Disability, to undertake a tendering exercise for companies who wished to provide support services for the under 65 age group who had learning, mental and physical disabilities.

- An advert was placed in an appropriate Trade Journal and local papers with a deadline of noon 3 February 2006.

- Prior to the opening of the tenders a decision was taken to treat as an Accreditation exercise rather than a tendering procedure. This decision was approved by the Head of Service for Learning, Mental and Physical Disability.

- Applications were opened within the Adult Social Services Department. A list of late tenders was retained.

- Current service providers who had not submitted an application were contacted to confirm their interest and to determine if they wished to submit an application.

- A Desktop Evaluation was undertaken to decide a shortlist for interview. All Desktop Evaluations were to be validated by Mr G Flanagan, Joint Commissioning Manager.

- An application received which was incomplete or had missing documentation, the company was contacted for further information.

- Two professional and two service user references were required along with the last two years audited accounts, business plan, constitution, documentation regarding ownership of buildings, list of members of the management committee, policies, complaints book and details of registration with CSCI.

- Potential providers, shortlisted during the Desktop Evaluation, were invited for an interview. The interview panel consisted of two members of staff, one of which was Mr G Flanagan.

- The Desktop Evaluation criteria were based on a similar exercise conducted by DASS i.e. domiciliary care. The questions were approved by the Head of Service and the same questions were asked to each potential provider.

- A number of potential providers were asked to attend a 2nd interview in order for specialist staff to be included on the panel.

- Each question was scored from 0-2. The threshold for inclusion on the list was a score of 70%. All interview score sheets were confirmed by Mr G Flanagan.

- All successful and non-successful applicants were notified in writing of the panel's decision and feedback provided where requested.

- A General Service Agreement, approved by Legal and Member Services, detailing the terms and condition for service provision, was issued to all successful providers. A signed copy to be returned to DASS.

- The monitoring of the service provision is reactive and only takes place when DASS receive a complaint.

- The Accredited List is available to relevant staff and the Panel when procuring services.

- A provider will be removed from the Accredited List if they fail to adhere to the terms and conditions detailed in the General Service Agreement.

- The Accredited List is subject to continuous review.

3. METHODOLOGY

The audit was conducted through:

- Discussions with key staff.
- Observations.
- Identification of key risks and controls within the scope of the audit.
- Testing of some identified key controls.
- Review of documentation.
- Formulation of an opinion.

4. AUDIT OPINION

The audit work identified that there are areas of good practice, where the controls established are considered sufficient to help achieve corporate and departmental objectives.

However, a number of individual weaknesses were identified that should be addressed in order to improve the overall risk management.

The audit opinion of the control environment is categorised as being either good, satisfactory, less than satisfactory or poor. From the testing undertaken it is the opinion that the control environment is currently less than satisfactory.

5. FINDINGS & RECOMMENDATIONS

5.1 **Procedures Manual**

There is no written guidance covering the Accreditation process.

Risk

Unless staff are aware of the procedures they are unable to comply with them

Recommendation

R1	Written procedures should be compiled for the Accreditation process. They should be comprehensive and ensure fair competition and a consistent approach is maintained. They should be authorised by the Departmental Management Team and be readily available to all relevant staff.

5.2 **Consistency**

The panel who conducted the Desktop Evaluations and interviews were not consistent throughout the accreditation process.

Risk

There may be allegations of impropriety against the Authority.

There was no consistency in the appraisal process.

Recommendation

R2	To ensure a fair and consistent approach to the Desktop Evaluation and Interview process, the same panel should be involved in both.

5.3 **Desktop Evaluation**

A second member of the panel was not involved in the validation of all Desktop Evaluations.

Risk

Discrepancies/errors may go undetected.

Recommendation

R3	All Desktop Evaluations should be validated by a second member of the panel. This should be evidenced with a signature and date.

5.4 **Interview**

Not all interview sheets were scored and signed.

Risk

There may be allegations of collusion and favouritism.

Recommendation

R4	Each interview sheet should be scored, signed and dated by the individual undertaking the interview. This should be completed at the conclusion of the interview.

5.5 **General Service Agreement**

Not all of the Accredited Providers have returned a signed copy of the General Service Agreement.

Risk

There was no formal evidence of the terms and price agreed for the services provided.

Recommendation

R5	The Service Provider should return a signed General Service Agreement prior to the inclusion on the Accredited List.

5.6 **Monitoring**

DASS have not introduced pro active monitoring of Service Providers to ensure service provision is in accordance with the service requested. Action is reactive when a problem arises.

Risk

Service Users may receive inadequate care.

Recommendation

R6	A formal system for monitoring and the standard of care being provided, by the Service Provider, should be introduced.

5.7 **Selection of Service Providers**

The Panel's decision on which Service Provider to procure services from is not always retained with the personal file.

Risk

It could not otherwise be confirmed that Service Providers were being selected in rotation and that preference has not been shown to any provider.

Recommendation

R7	A record of the Panel's decision on which Service Provider to procure services should be retained to ensure an effective audit trail exists.

ACTION PLAN

Report Heading: **System Review:** Accredited List **File Ref:** 25.18

	Recommendations	Priority	Officer Responsible	Agreed Y/N	Planned Action Date	Client Comments	Date Verified (For Audit use only)
R.1	Written procedures should be compiled for the Accreditation process. They should be comprehensive and ensure fair competition and a consistent approach is maintained. They should be authorised by the Departmental Management Team and be readily available to all relevant staff.	High					
R.2	To ensure a fair and consistent approach to the Desktop Evaluation and Interview process, the same panel should be involved in both.	High					
R.3	All Desktop evaluations should be validated by a second member of the panel. This should be evidenced with a signature and date.	High					
R.4	Each interview sheet should be scored,	High					

ACTION PLAN

Report Heading: **System Review:** Accredited List **File Ref:** 25.18

	Recommendations	Priority	Officer Responsible	Agreed Y/N	Planned Action Date	Client Comments	Date Verified (For Audit use only)
	signed and dated by the individual undertaking the interview. This should be completed at the conclusion of the interview.						
R.5	The Service Provider should return a signed General Service Agreement prior to the inclusion on the Accredited List.	High					
R.6	A formal system for contract monitoring and the standard of care being provided, by the Service Provider, should be introduced.	High					
R.7	A record of the Panel's decision on which Service Provider to procure services should be retained to ensure an effective audit trail exists	High					

Client Responsible: ..... Signature: ..... Date: .....

Please complete, sign and return this Action Plan to Lester Roughley by 30 June 2008.

Internal Audit,
Department of Finance, PO Box No2,
Treasury Buildings, Birkenhead. CH41 6BU

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Appendix 1.b.

Internal Audit Report

Accredited List
Follow up Audit

Adult Social Services

29th October 2008

Report issued to		
FAO	John Webb	Director of Adult Social Services
cc:	Gerry Flanagan	Joint Commissioning Manager

Report produced by	Report authorised by
Marie Wright	Lester Roughley
Assistant Auditor	Group Auditor
666 3241	666 3272
mariewright@wirral.gov.uk	lesterroughley@wirral.gov.uk

Internal Audit
Finance Department
Treasury Building
Cleveland Street
Birkenhead
Wirral
CH41 6BU

System	Accredited list		
Department	Social Services	Date	29th October 2008
File reference	25.18	Auditor	Marie Wright

Contents

System	Accredited list		
Department	Social Services	Date	28th October 2008
File reference	25.18	Auditor	Marie Wright

1. Introduction

1.1 A follow up audit has been undertaken of the system of Accredited List for Learning, Mental & Physical Disabilities within Adult Social Services. The purpose of the review was to ascertain whether the recommendations made in the report of 13th March 2008 have been implemented.

1.2 This report details the findings and recommendations emanating from this work. The content of the report reflects and summarises the points discussed at the end of audit meeting held with Gerry Flanagan, Joint Commissioning Manager, on 29th October 2008.

1.3 Please consider the report and complete the shaded sections, in consultation with other managers as appropriate, and return a copy to Marie Wright, by **28th November 2008**, being aware of the following:

- If a recommendation is not to be implemented, it will be assumed that the associated potential implications have been accepted. However, any medium and high priority recommendations not accepted will be reported at the next meeting of the Audit and Risk Management Committee, which you may be asked to attend to explain your reasons for non-acceptance.

- Please ensure that your Departmental Management Team is notified of the 3 findings identified as “high priority” within the Report, so that consideration can be given to their inclusion in the Corporate or relevant Departmental Risk Register.

1.4 Internal Audit is keen to provide a quality service to all its clients. This report includes a Customer Satisfaction Survey which provides an opportunity to give feedback on the service you have received. Please ensure that Gerry Flanagan, Joint Commissioning Manager completes and returns the Survey, providing any additional comments, so as to assist our continuous improvement. A manager from within Internal Audit may contact him to discuss the responses.

1.5 Please thank Gerry Flanagan and Roger Chester for their help and co-operation during the audit. Do not hesitate to contact Marie Wright if you should wish to discuss any aspect of this report further.

System	Accredited list		
Department	Social Services	Date	28th October 2008
File reference	25.18	Auditor	Marie Wright

2. Objectives of the Audit

2.1 To ensure that the 7 recommendations made in the report dated 13th March 2008 have been implemented.

2.2 To ensure that identified controls are working effectively and are adequate to mitigate the risks identified in the system.

3. Scope of the Audit

3.1 The recommendations discussed related to:

- The procedures and monitoring involved in the Accreditation process
- The authorization of service user's placements

4. Audit Opinion

The audit opinion is that the overall control environment in the system reviewed is now less than satisfactory, (assuming the system still operates as it did during the audit of 13th March 2008) as 3 out of the 7 recommendations have not been implemented.

System	Accredited list		
Department	Social Services	Date	28th October 2008
File reference	25.18	Auditor	Marie Wright

5. Findings

5.1 The following recommendations have been implemented:

Recommendation 2

To ensure a fair and consistent approach to the Desktop Evaluation and Interview process, the same panel should be involved in both.

Recommendation 3

All Desktop Evaluations should be validated by a second member of the panel. This should be evidenced with a signature and date.

Recommendation 7

A record of the Panel's decision on which Service Provider to procure services should be retained to ensure an effective audit trail exists

5.1.2. No interviews have taken place since the audit in March 2008 therefore the following recommendation has not yet been fully implemented:

Recommendation 4

Each interview sheet should be scored, signed and dated by the individual undertaking the interview. This should be completed at the conclusion of the interview**.**

5.2 However, recommendations **1, 5 and 6** have not been fully implemented. These are detailed on the following 3 pages.

System	Accredited list		
Department	Social Services	Date	28th October 2008
File reference	25.18	Auditor	Marie Wright

5.3.1. Risk and Its Potential Implications

Unless staff are aware of the procedures they are unable to comply with them.

5.3.2 Finding

There is no written guidance covering the Accreditation process

5.3.3 Recommendation

Written procedures should be compiled for the Accreditation process. They should be comprehensive and ensure fair competition and a consistent approach is maintained. They should be authorised by the Departmental Management Team and be readily available to all relevant staff.

5.3.4 Priority level

High

To be completed by client:			
Recommendation agreed?			Yes/No
Target date for implementation 28th November 2008			
Client Comments			
Manager name		Signature	
Date			

Verification of Implementation

To be completed by auditor at follow up audit:			
Follow Up Audit Date		Auditor	
Progress	Implemented/ Partially/ Not Implemented		
Comments			
Follow Up Report Date			

System	Accredited list		
Department	Social Services	Date	28th October 2008
File reference	25.18	Auditor	Marie Wright

5.4.1. Risk and Its Potential Implications

There was no formal evidence of the terms and price agreed for the services provided.

5.4.2. Finding

Not all of the Accredited Providers have returned a signed copy of the General Service Agreement

5.4.3. Recommendation

The Service Provider should return a signed General Service Agreement prior to the inclusion on the Accredited List.

5.4.4 Priority level

High

To be completed by client:			
Recommendation agreed?			Yes/No
Target date for implementation 28th November 2008			
Client Comments			
Manager name		Signature	
Date			

Verification of Implementation

To be completed by auditor at follow up audit:			
Follow Up Audit Date		Auditor	
Progress	Implemented/ Partially/ Not Implemented		
Comments			
Follow Up Report Date			

System	Accredited list		
Department	Social Services	Date	28th October 2008
File reference	25.18	Auditor	Marie Wright

5.5.1 Risk and Its Potential Implications.

Service Users may receive inadequate care.

5.5.2 Finding

DASS have not introduced pro active monitoring of Service Providers to ensure service provision is in accordance with the service requested. Action is reactive when a problem arises.

5.5.3 Recommendation

A formal system for contract monitoring and the standard of care being provided, by the Service Provider, should be introduced.

5.5.4 Priority level

High

To be completed by client:			
Recommendation agreed?			Yes/No
Target date for implementation 28th November 2008			
Client Comments			
Manager name		Signature	
Date			

Verification of Implementation

To be completed by auditor at follow up audit:			
Follow Up Audit Date		Auditor	
Progress	Implemented/ Partially/ Not Implemented		
Comments			
Follow Up Report Date			

System	Accredited list		
Department	Social Services	Date	28th October 2008
File reference	25.18	Auditor	Marie Wright

6. Recommendation Summary

Ref	Risk	Recommendation	Priority Level	Agreed? (To be completed by client)
5.3	Unless staff are aware of the procedures they are unable to comply with them.	Written procedures should be compiled for the Accreditation process. They should be comprehensive and ensure fair competition and a consistent approach is maintained. They should be authorised by the Departmental Management Team and be readily available to all relevant staff.	High	
5.4	There was no formal evidence of the terms and price agreed for the services provided.	The Service Provider should return a signed General Service Agreement prior to the inclusion on the Accredited List	High	
5.5	Service Users may receive inadequate care.	A formal system for contract monitoring and the standard of care being provided, by the Service Provider, should be introduced.	High	

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For Audit Use Only	
File Reference	25.18
Auditor	Marie Wright
Date of Report	29/10/08
Date Received	

7. Customer Satisfaction Survey

Audit of: **Accredited List**
Date of Audit: **29th October 2008**

I am responsible for providing you with a quality Internal Audit Service and I want to ensure that your audit continues to be effective. A number of performance indicators have been adopted and one of the most important of these is your view of the service you receive.

Please spare the time to complete and return this form. This is an opportunity for you to provide your views on the level of service you received during your recent audit. Your answers will help me to develop and maintain the highest level of service possible.

THANK YOU FOR YOUR HELP.

David A Garry C.P.F.A
Chief Internal Auditor

QUESTIONNAIRE			
WERE YOU SATISFIED WITH:	**Yes**	**No**	**Comments (please continue overleaf if you wish)**
1. TIMING:			
• **Advance notice of the audit?**			
• **Duration of the audit?**			
2. COMMUNICATION:			
• **Courtesy of the auditor(s)?**			
• **Level of auditor(s) knowledge?**			
• **Consultation on the findings?**			
• **Method of report delivery?**			
3. AUDIT REPORTS:			
• **Format of the report?**			
• **Speed of production of the report?**			
• **Relevance of the recommendations?**			
• **Value of the recommendations?**			
• **Audit opinion?**			
4. QUALITY OF SERVICE:			
• **Usefulness of the audit?**			
• **Professionalism of the audit?**			
• **Professionalism of the auditor?**			

If you would like to comment further on the conduct, outcome or how you feel I could improve the Internal Audit Service please do so overleaf, or telephone me on 666 3387.
Completed by: Signed: Date:

INTERNAL AUDIT ACTION PLAN

Report Heading:	**ADULT SOCIAL SERVICES – PIDA DISCLOSURE REVIEW**	**File Ref: 25.18**

Ref	Recommendations	Priority	Officer Responsible	Agreed	Planned Action Date	Client Comments	Date Verified (For Audit use only)
1.	Immediately review the procedures in operation within the department for evaluating the performance of independent living providers on an ongoing basis, to ensure that provision is made for the inclusion of the views and opinions of officers of the Council undertaking work in these areas regarding the effectiveness of individual providers.	High	J Webb				
2.	Immediately implement all of the outstanding recommendations identified in the Audit Commission and Internal Audit reports dated March, August and October 2008 respectively.	High	J Webb				
3.	Immediately review the procedures in operation within the department for evaluating reported issues of this nature and determining the most appropriate actions to be taken to investigate them, and assess the adequacy and effectiveness of these arrangements.	High	J Webb				

Client Responsible:..... Signature: ..... Date:.....

Please complete, sign and return this Action Plan to Lester Roughley,

Internal Audit,
Department of Finance, PO Box No2,
Treasury Buildings, Birkenhead. CH41 6BU

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