Report to Audit Committee

Agenda Item: A.5

Meeting Date:	8 July 2021
Portfolio:	Finance, Governance and Resources
Key Decision:	Not applicable
Within Policy and Budget Framework	YES
Public / Private	Public

Title:	Internal Audit Report – Homeless Accommodation (Part 2)
Report of:	CORPORATE DIRECTOR FINANCE & RESOURCES
Report Number:	RD21/21

Purpose / Summary:

This report supplements the report considered on Internal Audit Progress 2020/21 and considers the review of Homeless Accommodation.

Recommendations:

The Committee is requested to

(i) receive the final audit report outlined in paragraph 1.1;

Tracking

Audit Committee:	**8 July 2021**
Scrutiny Panel:	**Not applicable**
Council:	**Not applicable**

1. BACKGROUND INFORMATION

1.1 An initial review of Homeless Accommodation was undertaken in March 2020. However, due to the emerging global pandemic certain elements of audit testing could not be undertaken. A second audit to complete testing was undertaken by Internal Audit in line with the agreed Internal Audit plan for 2020/21. The audit (**Appendix A**) provides reasonable assurances and includes 4 medium-graded recommendations.

2. RISKS

2.1 Findings from the individual audits will be used to update risk scores within the audit universe. All audit recommendations will be retained on the register of outstanding recommendations until Internal Audit is satisfied the risk exposure is being managed.

3. CONSULTATION

3.1 Not applicable

4. CONCLUSION AND REASONS FOR RECOMMENDATIONS

The Committee is asked to

i) receive the final audit report as outlined in paragraph 1.1;

5. CONTRIBUTION TO THE CARLISLE PLAN PRIORITIES

5.1 To support the Council in maintaining an effective framework regarding governance, risk management and internal control which underpins the delivery the Council's corporate priorities and helps to ensure efficient use of Council resources.

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Appendixes	**Internal Audit Report – Homeless Accommodation (Part 2) – Appendix A**		

Note: in compliance with section 100d of the Local Government (Access to Information) Act 1985 the report has been prepared in part from the following papers:

- **None**

CORPORATE IMPLICATIONS/RISKS:

Legal – In accordance with the terms of reference of the Audit Committee, Members must consider summaries of specific internal audit reports. This report fulfils that requirement.

Finance – Contained within the report

Equality – None

Information Governance – None

CARLISLE CITY COUNCIL

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Audit of Homeless Accommodation (Part 2)

Draft Report Issued: 27th April 2021
Director Draft Issued: 7th May 2021
Final Report Issued: 19th May 2021

Audit Report Distribution

Client Lead:	Homeless Accommodation Manager Homeless Prevention and Accommodation Manager
Chief Officer:	Corporate Director of Governance and Regulatory Services Chief Executive
Others:	Homeless Accommodation Assistant Manager Information Governance Manager
Audit Committee:	The Audit Committee, which is due to be held on 8th July will receive a copy of this report.

Note: Audit reports should not be circulated wider than the above distribution without the consent of the Designated Head of Internal Audit.

1.0 Background

1.1. This report summarises the findings from the audit of Homeless Accommodation (Part2). This was an internal audit review included in the 2020/21 risk-based audit plan agreed by the Audit Committee on 30th July 2020.

1.2. Carlisle City Council directly owns and manages 50 units of direct access community based supported emergency accommodation for single homeless and families to whom we owe a statutory responsibility to accommodate in line with the Housing Act 1996 (Part VII Homelessness) amended by the Homelessness Act 2002, and the Homelessness Reduction Act 2017.

1.3. The accommodation schemes are staffed 24 hours a day and provide responsive out of hours homelessness services to anyone who is or at risk of homelessness within the District. Emergency placements are available for priority homeless cases to ensure that the service always offers responsive flexible safe provision for vulnerable people; and actively seeks to assist people to secure alternative permanent accommodation options appropriate to their individual needs.

1.4. Management make an informed decision if and where the Council can house an applicant through consideration of room availability, previous stay history and the applicant's personal circumstances.

1.5. This review is a continuation of the previous audit in May 2020 when some of the testing could not be finalised due to the pandemic outbreak.

1.6. Following the global pandemic outbreak, Management have faced significant challenges to ensure continuation of service and have adapted their working practices to accommodate social distancing arrangements, for the safety of both staff and residents.

2.0 Audit Approach

Audit Objectives and Methodology

2.1 Compliance with the mandatory Public Sector Internal Audit Standards requires that internal audit activity evaluates the exposures to risks relating to the organisation's governance, operations and information systems.

2.2 A risk-based audit approach has been applied which aligns to the five key audit control objectives (see section 4). Detailed findings and recommendations are reported within section 5 of this report.

Audit Scope and Limitations.

2.3 The Client Lead for this review was the Homeless Accommodation Manager and the Homeless Prevention and Accommodation Manager, and the agreed scope was to provide independent assurance over management's arrangements for ensuring effective governance, risk management and internal controls of the following risks:

- Failure to achieve business objectives due to insufficient governance.
- Loss or breach of information / fines and sanctions / reputational damage due to failure to securely process, retain, share and dispose of records and information.
- Failure to effectively manage risks resulting in inadequate safeguarding arrangements and staff and service users being put at risk.
- Failure to meet statutory obligations resulting from the introduction of the Homelessness Reduction Act 2017.

2.4 There were no instances whereby the audit work undertaken was impaired by the availability of information.

3.0 Assurance Opinion

3.1 Each audit review is given an assurance opinion intended to assist Members and Officers in their assessment of the overall governance, risk management and internal control frameworks in place. There are 4 levels of assurance opinion which may be applied (See **Appendix B** for definitions).

3.2 From the areas examined and tested as part of this audit review, we consider the current controls operating within Homeless Accommodation (Part 2) provide **reasonable assurance**.
Note: as audit work is restricted by the areas identified in the Audit Scope and is primarily sample based, full coverage of the system and complete assurance cannot be given to an audit area.

4.0 Summary of Recommendations, Audit Findings and Report Distribution

4.1 There are two levels of audit recommendation; the definition for each level is explained in **Appendix C**. Audit recommendations arising from this audit review are summarised below:

Control Objective	High	Medium
1. **Management** - achievement of the organisation's strategic objectives achieved (see section 5.1)	-	1
2. **Regulatory** - compliance with laws, regulations, policies, procedures and contracts (see section 5.2)	-	3
3. **Information -** reliability and integrity of financial and operational information (see section 5.3)	-	-
4. **Security** - safeguarding of assets (see section 5.4)	-	-
5. **Value** – effectiveness and efficiency of operations and programmes (see section 5.5)	-	-
Total Number of Recommendations	**-**	**4**

4.2 Management response to the recommendations, including agreed actions, responsible manager and date of implementation are summarised in Appendix A.

4.3 **Findings Summary (good practice / areas for improvement):**

The Homelessness Prevention and Accommodation Service has continued to provide a vital front-line service under challenging circumstances throughout the pandemic. Management have adapted their policies, procedures, and processes to minimise the risk of COVID infection to all, whilst taking care of vulnerable residents in need.

The service staffing structure is up to date, and job descriptions accurately reflect staff roles.

Personal information is retained and disposed of in line with the Corporate Records Management Policy, and fair processing notices are displayed throughout the schemes.

Clear, up to date on-line staff rotas are in place, with two bank staff covering absence of permanent staff.

Occupancy is managed effectively for both main sites and the dispersed properties.

Staff training records are maintained, demonstrating continuous professional development.

Resident paper records are held in locked cabinets within a staff only access area and a clear desk policy is operating effectively. Access to electronic files is restricted and key documents are password protected.

Residents are assisted with Housing Benefit applications, minimising personal liability for accommodation costs.

For the protection of staff at both schemes when dealing with sometimes volatile and unpredictable residents, CCTV is in operation and working effectively.

Residents are contacted twice daily to verify their safety, and this is recorded.

There is a comprehensive service guidance in place and staff are kept informed on current developments through regular meetings and discussion, although this is not regularly documented through formal supervision.

There are comprehensive arrival and departure processes in place. Relevant guidance and forms would benefit from review to accurately reflect current practice.

Management record all third-party requests for personal information such as CCTV footage to assist police investigations. Completion, authorisation, and retention of all third-party information request forms will further verify management agreement for the information release.

Current practice is for management to hold daily case conversations with staff, rather than formal case reviews. This is not wholly in line with service guidance, although management have indicated they are now flagging up more issues than they were previously.

Comment from the Corporate Director of Governance and Regulatory Services:

Thank you to the Audit Team for the audit and recommendations which have been agreed. I would like to publicly commend the Homelessness Manager and her team for continuing to deliver a vital service during the pressured time of the pandemic. This placed enormous strain on our resources and by that I mean our staff. They have done a fantastic job in addition to undergoing the audit process at the same time.

5.0 Audit Findings & Recommendations

5.1 Management – Achievement of the organisation's strategic objectives

5.1.1 The staffing structure is up to date, and job descriptions accurately reflect staff roles.

5.1.2 There is a comprehensive 'Information, Policies, Procedures & Health & Safety Guidance for Operational Staff' (service guidance) document in place. Staff are aware of the document and it is available in both hard copy and electronic formats.

5.1.3 Management hold a regular weekly team meeting, keeping staff informed of current developments and training opportunities. Staff also indicated that management are always available to discuss matters arising, offering advice and guidance when required. Although there is regular discussion and meetings between Management and staff, action focussed supervision every 6 – 8 weeks is not formally documented in line with service guidance.

Recommendation 1 – Management to formally record supervision meetings with all staff every 6 – 8 weeks in line with service guidance.

5.2 Regulatory – compliance with laws, regulations, policies, procedures and contracts

5.2.1 A retention schedule and disposal log for both paper and electronic documents is in place and regularly maintained, demonstrating service compliance with the Corporate Records Management Policy.

5.2.2 Service guidance details that Fair processing notices should be displayed throughout the accommodation schemes. The notice explains to residents how Carlisle City Council will store and process their personal data. A copy of the notice is displayed in the general area of both schemes, and in residents' rooms.

5.2.3 There is a comprehensive arrival procedure for new residents. Service guidance details that, 'all relevant documentation should be completed in full, including signing and dating as per the arrival check list.' Management informed Audit that there is limited availability of completed check lists because they are used only as a prompt to carry out the checks and are destroyed when the residents leave the scheme. Individual tasks on the arrival check lists are initialled by staff when completed, and other key notes are recorded on the list, although the form is not always wholly completed.

5.2.4 When a resident exits the scheme, a similar departure procedure is followed, using a departure check list. It could not be wholly demonstrated that the departure check list is regularly completed, verifying to management that all requirements detailed in the staff guidance have been completed.

Recommendation 2 – Amendment of service guidance and forms to reflect current practice, and document how completion of future arrival and departure checks will be verified.

5.2.5 Service guidance details that third-party request forms must be completed by any agency that wishes to obtain personal information held, including Police requests for CCTV footage. Management document all third-party requests for information, detailing the requester name, date, reason for the request, and if information was provided. There were some examples where third-party request forms were not wholly completed and authorised by management or staff with delegated authority.

Recommendation 3 – Forms to be completed and retained for all third-party information requests.

5.2.6 Service guidance details that premises health and safety inspections and monitoring, includes a weekly room check ensuring that any potential risk of harm is minimised. Staff are required to complete, sign, date and initial a document to demonstrate that every room has been checked for fire sensors, tidiness, cleanliness, and damage. Management informed Audit that due to the global pandemic and social distancing requirements to protect both staff and clients, this had not taken place at the required frequency, although it is now being reinstated. Daily premises and repairs checks are carried out, although it could not be demonstrated that the results are regularly recorded and retained. To minimise any potential risk of harm and maximise safety to all within the scheme, it is advised that key risks (such as fire sensor checks) are identified and regularly checked, with the outcome recorded and retained.

5.2.7 Service guidance details that case reviews are carried out every six weeks by senior staff to monitor quality and used to inform service development and strategic planning. Full case review audits are required to be carried out by an independent reviewing officer / manager who is independent, to monitor and improve quality every 6-8 weeks. Management informed Audit that due to the global pandemic and the pressure for bed space, rather than doing formal case reviews, management have had daily conversations about cases and finding that staff are flagging up more issues than before. Management have found it challenging to adapt the review form to all cases, due to the different complexities of the cases.

Recommendation 4 – Management to review service guidance requirement to record case reviews.

5.3 Information – reliability and integrity of financial and operational information

5.3.1 A delegation of authority for Homeless Accommodation Services is in place and has been recently updated during the audit (March 2021) and authorised by management. The document delegates authority to named staff and identifies processes they can authorise on behalf of management.

5.3.2 Clear, up to date on-line rotas are provided to staff. Management informed Audit that there are two bank staff. This number is kept intentionally low, adding value to the service through regular shift availability, and providing a variety of experience.

5.3.3 A handover meeting is carried out at the end of a shift with a handover record form completed. Service guidance details that staff document on the handover form the disposal of any medication left by ex-residents. Although discussions take place during staff handovers and the handover record documented, the record is not always wholly completed, verifying that all key information has been passed on. Management informed Audit that completion of the handover record is not a key activity and that priority may be given to other events that may be occurring. To ensure there is a record of all key information passed on, it is advised that the handover record form is completed in full on a consistent basis.

5.3.4 Daily welfare checks are carried out on each resident and recorded, verifying that they are safe, and not absent for more than three continuous days for housing benefit claim purposes.

5.3.5 Efficient management of occupancy for both main sites and the dispersed properties is demonstrated through documented occupancy monitoring spreadsheets.

5.3.6 Staff training records are documented, demonstrating continuous professional development.

5.4 Security – Safeguarding of Assets

5.4.1 Resident paper records are held in locked cabinets within a staff only access area. The keys to the locked cabinets are stored in an unlocked key cabinet within the staff area. To further increase the security access arrangements already in place, management may wish to consider using a pin access wall safe to hold keys. Should a resident or anyone else

gain unauthorised access to the staff area, this would help prevent easy access to the locked cabinets, and/or safe.

5.4.2 Management operate a clear desk policy which was observed as working effectively.

5.4.3 Access to electronic files is restricted and key documents are password protected.

5.5 Value – effectiveness and efficiency of operations and programmes

5.5.1 Homeless Advice Accommodation Officers advise and assist residents on Housing Benefit applications, minimising personal liability for accommodation costs.

5.5.2 Robust rental income monitoring is in place, demonstrating that residents are held accountable for all costs incurred under their licence agreement.

5.5.3 For the protection of staff at both schemes dealing with sometimes volatile and unpredictable residents, CCTV cameras are located throughout the buildings, recording 24 hours a day, and can be viewed remotely at either scheme. A copy of the corporate surveillance policy and procedures is held with other relevant CCTV documentation at both schemes.

Appendix A – Management Action Plan

Summary of Recommendations and agreed actions					
Recommendations	**Priority**	**Risk Exposure**	**Agreed Action**	**Responsible Manager**	**Implementation Date**
Recommendation 1 – Management to formally record supervision meetings with all staff every 6 – 8 weeks in line with service guidance.	M	Lack of documentary evidence to demonstrate that staff are fully supported in their role.	Structured, scheduled 1:1 sessions to be diarised and documented using formal template.	HAM / AHAM	Immediately
Recommendation 2 – Amendment of service guidance and forms to reflect current practice, and document how completion of future arrival and departure checks will be verified.	M	Key checks documented in service guidance are not carried out and management may be unaware.	Review service guidance and forms; ensure that file check systems ensure this is verified.	HAM / AHAM	Immediately
Recommendation 3 – Forms to be completed and retained for all third-party information requests.	M	Management cannot fully demonstrate authorised release of personal information to third parties.	Raise with staff in team meetings and add as regular agenda item. Amend current request form to include management decision and sign off. Establish management monitoring system.	HAM / AHAM	To update new recording system from 01 April 21

Summary of Recommendations and agreed actions					
Recommendations	**Priority**	**Risk Exposure**	**Agreed Action**	**Responsible Manager**	**Implementation Date**
Recommendation 4 – Management to review service guidance requirement to record case reviews.	M	Quality of case management and resident welfare is not formally verified by Senior staff.	Simplify recording template and monitoring systems, and review service guidance.	AHAM / HPASM	Immediately

Appendix B - Audit Assurance Opinions

There are four levels of assurance used; these are defined as follows:

	Definition:	Rating Reason
Substantial	There is a sound system of internal control designed to achieve the system objectives and this minimises risk.	The control framework tested are suitable and complete are being consistently applied. Recommendations made relate to minor improvements or tightening of embedded control frameworks.
Reasonable	There is a reasonable system of internal control in place which should ensure system objectives are generally achieved. Some issues have been raised that may result in a degree of unacceptable risk exposure.	Generally good systems of internal control are found to be in place but there are some areas where controls are not effectively applied and/or not sufficiently embedded. Any high graded recommendations would only relate to a limited aspect of the control framework.
Partial	The system of internal control designed to achieve the system objectives is not sufficient. Some areas are satisfactory but there are an unacceptable number of weaknesses that have been identified. The level of non-compliance and / or weaknesses in the system of internal control puts achievement of system objectives at risk.	There is an unsatisfactory level of internal control in place. Controls are not being operated effectively and consistently; this is likely to be evidenced by a significant level of error being identified. High graded recommendations have been made that cover wide ranging aspects of the control environment.
Limited/None	Fundamental weaknesses have been identified in the system of internal control resulting in the control environment being unacceptably weak and this exposes the system objectives to an unacceptable level of risk.	Significant non-existence or non-compliance with basic controls which leaves the system open to error and/or abuse. Control is generally weak/does not exist.

Appendix C

Grading of Audit Recommendations

Audit recommendations are graded in terms of their priority and risk exposure if the issue identified was to remain unaddressed. There are two levels of audit recommendations; high and medium, the definitions of which are explained below.

	Definition:
High	Significant risk exposure identified arising from a fundamental weakness in the system of internal control
Medium	Some risk exposure identified from a weakness in the system of internal control

The implementation of agreed actions to Audit recommendations will be followed up at a later date (usually 6 months after the issue of the report).