COMMITTEE	**AUDIT COMMITTEE**
DATE	**5 MAY 2016**
TITLE	**REPORT OF THE CONTROLS IMPROVEMENT WORKING GROUP**
PURPOSE OF THE REPORT	**TO REPORT ON THE MEETING HELD ON 7 APRIL 2016**
AUTHOR	**JOHN PUGHE ROBERTS, CHAIR OF THE AUDIT COMMITTEE**
ACTION	**TO ACCEPT THE REPORT AND CONSIDER THE RECOMMENDATIONS**

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1. INTRODUCTION

1.1 The executive summaries of 15 reports were presented to the Audit Committee meeting on 11 February 2016, which represented reports that had been released finally between 1 November 2015 and 31 January 2016. 4 of these reports received a ‘C’ opinion.

2. MEETING OF THE WORKING GROUP

2.1 A meeting of the Working Group was held on 7 April 2016 with the Chairman of the Audit Committee and Councillors Angela Russell and Tom Ellis, Luned Fôn Jones, Audit Manager and Mair Williams, Senior Auditor present.

2.2 The reports that the Working Group addressed were:

TITLE	DEPARTMENT	SERVICE	OPINION
Arfon Leisure Centre	Economy and Community	Leisure	C
Plas y Don Care Home	Adults, Health and Wellbeing	Residential and Day	C
Plas Hedd	Adults, Health and Wellbeing	Residential and Day	C
Maintenance of Buildings and Sites	Highways and Municipal	Fleet	C

2.3 Officers attended to discuss the individual reports.

2.4 Arfon Leisure Centre

2.4.1 The main findings of the audit were as follows:

The Duty Manager confirmed that they produced relevant monthly reports for the centre. It was seen that "Point of Sales Transactions - Cancelled" had been produced as well as "Record Refunded" reports. When auditing the three month sample across the 2014/15 financial year, it was seen that the reports for February and July 2015 were available, but the 2014 ones could not be found on the day of the audit.

A sample of four "Applications to Hire Facilities" at the Centre was audited. Upon auditing the applications, it was seen that the invoice number or date had not been noted on the application and consequently, it was difficult to find the correct invoice that matched the "Application to Hire Facilities".

The Centre's debtors details were received from the Revenue Service and it was seen that the total debts were £19,637.10 on 08/06/2015. This total derived from a number of individual debtors (35).

The information and terms of customer direct debits are kept on a file in the Centre. This information is not kept under lock and key, but rather it is kept on a shelf in the back office behind the reception. This means that there is a risk that Personal Information could fall into the wrong hands by not keeping the information securely.

Equipment is marked in the Centre on a regular basis. However, no formal record is kept of what equipment has been marked or of the reference marked on the equipment. Consideration should be given to keeping this information on the Centre's property list so that the equipment could be tracked should anything be stolen.

There are staff induction arrangements in place at the Centre. This information is kept on the individual's personal training plan at the Area Manager's office. Upon auditing a sample of staff induction packs, it was seen that it was mandatory for staff to read and understand the health and safety policy that was included in the induction pack. However, in the sample of two staff induction packs audited it was seen that they had not signed and dated to confirm that they had read the policy.

No formal record of checks on the level of first aid goods was available as evidence for the audit. The Duty Manager noted that they would produce a new form for undertaking first aid stock level checks. Following the audit, the auditor received a copy of the new form that had been produced in September 2015. However, it was seen that it had not been appropriately signed.

The Centre keeps incident reports to record the details of accidents that occur at the Centre, and also completes HS11 forms for serious accidents. The incident reports or HS11 forms are not kept under lock and key. This means that there is a risk that personal information about individuals might reach the wrong hands.

It was seen that harmful substances were kept in the Plant Room at the Centre. However, it was seen that this room was not kept locked during the day, but it was at night. This means that there is a risk for individuals/members of the public to be harmed should they enter the room.

COSHH forms are available in the Plant Room where the swimming pool substances are kept and they are kept on file. The last assessment had been completed in 2013 and it was noted on the COSHH documents at the Centre that the next assessment would not be undertaken until December 2018. This appears to be a long period without an assessment being undertaken.

2.4.2 Guto Williams, Area Manager Caernarfon/Nantlle and David Wood, Business and Quality Manager were welcomed to the meeting to discuss the audit of Arfon Leisure Centre.

2.4.3 The Audit Manager provided a summary of the audit findings. The main areas of weaknesses were outlined which encompassed failure to complete the full details of the 'Request to Hire' forms; the level of debts; the arrangements for storing the vending machines stock and the risk with documentation and the possibility of the theft of personal data.

2.4.4 The Area Manager Caernarfon/Nantlle explained that he was new to the post at the time of the audit and that he agreed with the majority of the recommendations and found the audit report to be of assistance in identifying what needed to be done and establish new arrangements.

2.4.5 The Area Manager explained in respect of the debts, that approximately £10K appertained to the café and was therefore beyond the Centre's control and that since the audit a team of two is responsible for pursuing the centre's debts. A member enquired if there were arrangements in place to ensure that debtors were prevented from using the Centre's facilities. The Area Manager explained that debtors are restricted from the use of the Centre and that the officers are aware of whom they are.

2.4.6 The Area Manager Caernarfon/Nantlle stated that in respect of information not kept under lock and key as stated in the report, that access to the back office is restricted to the reception staff, Manager and Duty Manager only.

2.4.7 The Area Manager Caernarfon/Nantlle stated that arrangements have now been established in respect of the vending machines' stock.

2.4.8 The Audit Manager explained that a follow-up audit will be conducted within the next 6 months and that the audit will be an unannounced visit which would provide a true view of the situation.

2.4.9 A member emphasised the importance that all staff, and in particular duty managers are aware of all arrangements and where the various documentation/forms are kept.

2.4.10 **The Area Manager Caernarfon/Nantlle and the Business and Quality Manager were thanked for attending the meeting and explaining the actions taken since the issue of the report to mitigate the risks identified.**

2.5 Plas y Don, Pwllheli

2.5.1 The main findings of the audit were as follows:

During the audit examples of good practices were seen in some of the Home's arrangements. However, it appears that there are examples of acting contrary to the Council's administrative arrangements, and consequently, contrary to the Financial Procedural Rules.

It is a requirement that the 'Record of a Resident's Money' is signed by two persons for every expenditure of the residents' pocket money. There were two cases where it was seen that only one person had signed the sheet. Receipts to support each expenditure recorded on the cards were not seen in some cases. The running balance was not correct on two out of five of the 'Record of a Resident's Money' forms.

A sample of 'personal items' sheets from the Care Plans of three residents was taken and checked. The forms had not been dated or signed to confirm their contents.

The home's imprest account was checked for 2014/15 and it was seen that applications for reimbursement had been made in November and December 2014 and in January 2015 and it was seen on all three occasions that they were over the predetermined expenditure level.

The home records on a sheet when and who has ordered the medication, checked the prescription and checked the medication received. The record was incomplete for the medication ordered in March and April 2015.

It is required for two members of staff to record that they have received the medication on the MAR (Medication Administration Record) sheet. A sample of 5 individual MAR sheets were checked and it was seen that there were two received signatures for medication on 4 of these sheets.

It was explained as part of managing the home's quality assurance, an independent officer visits the home periodically to check the Home's medication arrangements. At the time of the audit, the home's arrangements were not acceptable, with action points noted as urgent matters. Arrangements to revisit the Home to undertake a further independent review has been planned in order to ensure that arrangements improve.

2.5.2 Meinir Jones, Plas y Don Manager, and Elen Jones, Meirionnydd Area Manager, Adults, Health and Wellbeing Department were welcomed to the meeting.

2.5.3 The Audit Manager explained that the audit was included in the Audit plan following the decision to undertake an audit of residential homes within a cycle of three years. She stated that although the financial arrangements in respect of ordering and the medicines' administrative procedures were problematic, it was emphasised that a 'C' opinion category on these arrangements did not necessarily mean that the quality of care was poor.

2.5.4 The Meirionnydd Area Manager explained that Meinir Jones, Plas y Don Manager was new to the post and that several issues required addressing when she started in the post and that a number of matters were dealt with immediately.

2.5.5 The Plas y Don Manager explained that a number of problems had arisen in the administration of medications and a review was carried out on a monthly basis until arrangements were found to have improved. She explained that the Deputy Manager at Plas Hafan has assisted at Plas y Don for a period of three months. A member enquired how many of the staff was qualified to issue medications. The Plas y Don Manager replied that approximately 12-15 staff (including night staff) are currently qualified.

2.5.6 The Area Manager stated that there is an overspend on the 'Staffing' budget as a result of early retirements. Also, it was stated that there was inadequate provision in the budget for the servicing of beds, wheelchairs, hoists etc. which is required to comply with Health and Safety regulations. It was further explained that the servicing element on some equipment was incorporated in the purchase price. It was also stated that the disposal of clinical waste was expensive.

2.5.7 The Audit Manager emphasised the importance of ensuring that proper arrangements are in place to record the residents' personal items and that a receipt was available to support any expenditure from the residents' personal monies. The Area Manager explained that the Plas y Don Manager had reviewed the care plans and as a result every resident now has a Key Worker who is responsible for maintaining the list of personal items, and taking and storing photos of the items.

2.5.8 A member enquired what action was taken in respect of the recommendation to improve the arrangements for the safekeeping of the keys to the medicines room. The Plas y Don Manager explained that the matter was given immediate attention following the release of the draft report and that access to medications is now restricted.

2.5.9 The Meirionnydd Area Manager stated the she appreciated the collaboration with Internal Audit and stated that the collaboration was very positive.

2.5.10 The Audit Manager explained that the residential homes audit programme has been amended and will be utilised for the 2016/17 audits. She stated that there will be less emphasis on certain areas such as stock books and stock checks which will allow more coverage on matters such as training and the administration of medicines.

2.5.11 The Plas y Don Manager and the Meirionnydd Area Manager were thanked for explaining the current situation, the arrangements already implemented and in the pipeline to improve procedures.

2.6 Plas Hedd, Bangor

2.6.1 The main findings of the audit were as follows:

During the audit examples of good practices were seen in some of the Home's arrangements. However, it appears that there are examples of acting contrary to the Council's administrative arrangements, and consequently, contrary to the Financial Procedural Rules.

The home's expenditure was more than the budget set for the financial year 2014/15 in the following areas: workers; property; transport; and services and supplies due to various reasons such as the sickness and annual leave of contracted staff leading to the appointment of casual staff.

A sample of 15 invoices was selected and no order was attached to 6 of them. An estimated cost had not been noted on the permanent orders in the sample.

A sample of 'personal items' sheets from the Care Plans of 4 residents were taken and checked against the Manager's list of the residents' personal items. They did not match. The forms in the Care Plans had not been dated or signed to confirm their contents.

The records of the home amenities account were incomplete. Some of the orders had been completed on the same day that the invoice had been received. Excluding emergencies, it should be ensured that an order is appropriately prepared and authorised to ensure that a sufficient audit trail exists. The property list was not up-to-date as some items had been moved from the rooms. The Home did not use a system to mark the equipment/furniture purchased either.

It was seen that an incorrect code had been recorded on an application for an imprest reimbursement (TR24). Not all of the petty cash payment slip forms (TR24b) used for expenditure without an official order had been authorised.

Staff annual leave hours had not been calculated correctly in each case, and consequently, many staff members were eligible for more annual leave hours than they were receiving. Two cases were highlighted where annual leave had not been recorded correctly.

The home records on a sheet when and who has ordered the medication, checked the prescription and checked the medication received. The sheet had not been signed in each case. The stock record was checked (weekly) against the 'non blisterpack medication' forms - they did not match. The number of remaining medications had been calculated incorrectly. It was seen that the staff who undertook the stock check was aware of this as they had noted '9 missing' on 26/07/2015.

The home's spare keys are kept in the office, however, every member of staff has access to the office with a keypad, and this weakens the control over these keys.

2.6.2 Carys Owen, Plas Hedd Manager and Gwen Hughes, Arfon Area Manager, from the Adults Health and Wellbeing Department were welcomed to the meeting.

2.6.3 The Audit Manager explained that the audit was included in the Audit plan following the decision to undertake an audit of residential homes within a cycle of three years. She stated that although the financial arrangements in respect of ordering and the medicines' administrative procedures including monitoring the temperature of the fridge were problematic, it was emphasised that a 'C' opinion category on these arrangements did not necessarily mean that the quality of care was poor.

2.6.4 The Area Manager explained that there was no budget for staff training despite the requirement that all members of staff attend 5 training days yearly. In order to address this problem, the Training Unit, Learning and Development have agreed to visit the care homes to conduct training sessions and also the use of e-learning will also be of assistance and will result in a reduction on travelling costs.

2.6.5 The Area Manager stated that the Plas Hedd Manager is very supportive of her staff. It was explained that matters such as long term sickness has an impact on the budget and that the overspend for 2015/16 is approximately £6k.

2.6.6 A Member enquired what action had been taken to protect the residents' personal items. The officers explained that a list has been produced for all the residents and that a tablet is used to take photographs of the items and that the key workers are monitoring the situation.

2.6.7 The officers explained that a pharmacist provide the care home staff with training on medications and that the staff are regularly monitored along with a requirement that they sign to confirm that they have read and understood the Medications Policy. It was also explained that a new fridge has been purchased and that the responsibility for checking the temperature has been allocated to the night staff.

2.6.8 The Area Manager stated that she appreciated the work of Internal Audit and that the audit reports are of assistance in improving the service and that the presence of the Registered Manager at the Working Group ensures ownership on implementing changes.

2.6.9 The Plas Hedd Manager and the Arfon Area Manager were thanked for explaining the current situation and the arrangements underway to improve procedures.

2.7 Maintenance of Highways Buildings and Sites

2.7.1 The main findings of the reports are as follows:

Gwynedd Council holds the Occupational Health and Safety Management System and Environmental Management System accreditations, namely 'BS OHSAS 18001' and 'ISO 14001'.

The Health and Safety Unit visits buildings/sites on a regular basis to undertake inspections to ensure that the buildings/sites comply with the requirements of the accreditations. The Unit follows an audit programme that is relevant to their needs. Arrangements have been established in order to inform the relevant officers of the weaknesses highlighted during the audit and arrangements to ensure that actions are taken to improve the weaknesses. The area where the weakness was identified will be addressed in the next audit to ensure that the action has been successful.

In addition to the unit's arrangement, BSi external auditors visit the Department twice a year and undertake a combined inspection of the 'OHSAS 18001' and 'ISO 14001' standards. A report is prepared after each visit. This is part of an ongoing inspection to ensure compliance with the accreditations.

Site Managers have been appointed for each building/site that is part of the Highways and Municipal Department. A sample of sites to inspect for the audit was selected and the relevant location files were checked. Elements of duplication in the Site Managers' work was identified in relation to the location files, e.g. it was noted that there was a need to complete the 'Statutory Compliance Recurring Survey' form and the 'Health, Safety and Environmental Monthly Inspections Checklist' which include tests relating to fire arrangements. In addition, there is a need to complete documents such as the Fire Log Book.

The monthly inspections carried out in each site were checked:- 'Health, Safety and Environmental Inspections Checklist'. A list has been drawn out to enable Site Managers to identify any problems or weaknesses and make changes so that they are improved. One of the sites had not been completing the monthly inspections as required due to a lack of staff resources for many months. However, at the time of the audit, each site in the sample used the lists.

The 'Statutory Compliance Recurring Survey' forms were not being completed in each site, despite the fact that the Site Manager was aware of them. One Site Manager noted that some of the tests were carried out on a weekly basis but that he did not update the sheet to match this.

There is a possibility that such weaknesses could lead to the loss of the BSi accreditation and could result in serious implications for the Highways and Municipal Department in relation to contracts. These inspections are statutory and therefore any shortfall or failure to comply with the requirements is a breach of the law.

2.7.2 Gwyn Morris Jones, Head of Highways and Municipal and John Edwards. Senior Highways Services Work Manager, Highways and Municipal Department were welcomed to the meeting.

2.7.3 The Audit Manager explained that the audit was included in the 2015-16 audit plan at the request of the Head of Highways and Municipal as the Department's risk assessments had identified that this was an area of high risk due to the massive impact on the service if there was a failure to maintain the accreditations.

2.7.4 The officers provided a background to the BSI – British Standards Institution accreditations. It was explained that attaining the quality assurance on work standards, environmental matters and the health and safety accreditations had taken o lot of time over the years.

2.7.5 It was explained that the external assessments are conducted by the BSI approximately every 6 months and that internal assessments are carried out by the Highways Service. The Senior Manager explained that during one visit by the BSI a "major non-conformance" was found in a review of electrical equipment. The BSI inspector re-visited over a month later and was satisfied to close the "non-conformance".

2.7.6 The officers explained that an internal team led by the Assistant Engineer Environmental Quality Assurance conducts a review on one site on a monthly basis and that a three year programme has been established – it was stated that these reviews do not include fire, asbestos nor legionella, as these are under the remit of the Property Service.

2.7.7 A member enquired how many sites were in the Departments' ownership. The officers explained that there are several sites across the county with a number of smaller sites/depots in the Meirionnydd area and they also stated that there is a site in Ynys Môn due to the contract for the A55 from Llandygai to Holyhead being the responsibility of Gwynedd Council.

2.7.8 The officers explained that they use the statutory checklist when conducting the assessments but that not every element is applicable for every site.

2.7.9 The Members of the Working Group stated they enjoyed the background to attaining the accreditations and the importance of maintaining the standards. It was also stated that not enough credit and recognition is given to the Department and the Council on their success.

2.7.10 The Head of Highways and Municipal and the Senior Highways Services Work Manager were thanked for attending the meeting and for outlining the importance of the accreditations along with the developments since the release of the audit report.