APPENDIX A

Internal Audit
Quarter 1 Internal Audit Report
2017/18
London Borough of Haringey

Mazars Public Sector Internal Audit Ltd.
September 2017

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Executive Summary

Introduction

This is our first quarter report to the Corporate Committee for the 2017/18 financial year including details of all reports which are now at final stage. The report provides information on those areas which have achieved full or substantial assurance and gives an indication of the direction of travel for key systems work which will provide Members with information on how risks are being managed over time. The format of this report is also designed to highlight the key risks facing individual departments and the Council which have been identified during the course of our internal audits. A more detailed summary of the limited assurance audit findings is included for information. The report draws together the summary information which is provided on a monthly basis to Members of the Corporate Committee. Members of the Committee will also be provided with full copies of our audit reports upon request.

All recommendations are agreed with Council officers, and any disputes are discussed prior to the final report being issued. All recommendations to address any control weaknesses highlighted within this report have been agreed. Officers' actions to address the recommendations, including the responsible officer and the deadline for completion, are fully detailed in the individual final audit reports.

The attached tables reflect the status of the systems at the time of the audit, and recommendations may already have been implemented by Council officers by the time the final report is issued and reported to the Corporate Committee.

As a reminder, our recommendations are prioritised according to the following categories:

Priority 1	-	major issues for the attention of senior management
Priority 2	-	other recommendations for local management action
Priority 3	-	minor matters and/or best practice recommendations

Key Highlights/Summary of Quarter 1 2017/18:

2016/17 Internal audits finalised in the quarter

- Re-Referrals
- Special Guardianships
- Care Reviews
- Childview Application
- Facilities Management
- Supply Chain Resilience (Adult Services)
- Cyber Security

- Residential Care
- Sexual Health & Substance Misuse
- Dynamic Purchasing
- Tetherdown Primary School
- Earlham Primary School – Follow –Up
- St Ignatius Primary School Follow-Up
- Earlsmead Primary School Follow -Up

2017/18 Internal Audit Reports finalised in the quarter:

- Osborne Grove

2017/18 Draft Internal Audit Reports issued this quarter

- Alexandra Primary School
- Bruce Grove Primary School
- Chestnuts Primary School

Audit Progress and Detailed Summaries

The following table sets out the audits finalised in Quarter 1 of 2017/18 financial year and the status of the systems at the time of the audit. It must be noted that the recommendations may already have been implemented by Council officers by the time the final report is issued and reported to the Corporate Committee. Detailed summaries of all audits which do not receive 'Full' or 'Substantial' assurance ratings are also provided for Members' information.

Audit Title	Date of Audit	Date of Final Report	Assurance Level	Direction of Travel	Number of Recommendations (Priority)		
					1	2	3
2016/17							
Re-referrals	Nov 2016	May 2017	Substantial	N/A	0	2	0
Special Guardianships	Nov 2016	May 2017	Limited	N/A	4	6	0
Case Reviews	Jan 2017	May 2017	Substantial	N/A	1	0	1
Childview Application Review	Nov 2016	May 2017	Substantial	⟺	1	3	1
Facilities Management	Oct 2016	May 2017	Substantial	N/A	1	1	0
Supply Chain Resilience (Adults Services)	Feb 2017	Jun 2017	Substantial	N/A	0	3	1
Cyber Security	Feb 2017	Jun 2017	Substantial	N/A	0	0	2
Residential Care	Nov 2016	Jun 2017	Substantial	N/A	0	1	0
Sexual Health & Substance Misuse	Oct 2016	Jun 2017	Substantial	N/A	0	1	1
Dynamic Purchasing	Dec 2016	Jun 2017	Substantial	N/A	0	3	0
Appointeeships	Feb 2017	Jun 2017	No	N/A	8	2	1
2017/18							
Osborne Grove	Apl 2017	Jun 2017	No	N/A	11	9	2

Audit area	Scope	Status/key findings	Assurance
Priority 1 – Outstanding for all			
Special Guardianships	Audit work was undertaken to cover the following areas: • Policies & Procedures • Support Plans • Financial assessments • Other Payments • Performance Monitoring and Reporting	Weaknesses in the system of internal controls are such as to put the client's objectives at risk. The level of non-compliance puts the client's objectives at risk. The key findings are as follows: As a result of our audit work we have raised three Priority 2 and one Priority 3 recommendation which should assist in improving the control environment. • A Protocol for payment of: Adoption, Special Guardianship, and Child Arrangement Orders Allowances has been created. The protocol references the Department for Education's (DfE) special guardianship guidance. We noted that the protocol is still in draft format and is yet to be finalised and approved by senior management. • The DfE means testing calculator is used to determine the financial status of the beneficiaries of Special Guardianship Orders (SGOs). We were informed by the Acting Team Manager that undertaking the means test calculations was a task previously undertaken by the Council's finance team. The finance team withdrew this service; the task was passed to the Fostering & Adoption teams. Adoption identified that there has not been any dedicated training for staff involved in managing SGOs relating to carrying out financial assessments of the individuals subject to SGOs using the DfE means testing calculator. • Testing identified 13 cases where the financial assessment using the DfE calculator was used. This financial assessment could not be evidenced in 12 cases. • A support plan should be in place for each special guardianship package, which details the assessments of the child's circumstances and support needs. Testing of 25 SGOs identified	**Limited**

Audit area	Scope	Status/key findings	Assurance
		21 cases where a support plan could be evidenced and four cases where a support plan was not seen. Also, there were six cases where there was no evidence of sign off of the support plan by the Head of Service and one case where the support plan was not signed off by the special guardian. • A letter is sent to the beneficiary once the support plan has been agreed. Testing of 25 SGOs identified 14 cases where the letter sent to the beneficiary could not be located. • There should be an annual monitoring and review of the support plan as a minimum requirement including the financial plan. Testing of 25 SGOs identified 21 cases where on-going yearly review of the support plan including its financial elements could not be evidenced. • Payments made to the beneficiary should be in line with the agreed plan. Testing identified 16 cases where a fully approved support plan could be evidenced which showed full approval of the amount agreed in respect of SGO. This could not be evidenced in nine cases. We also evidenced payments to the beneficiaries via bank statements in seven cases but not in the other 18 cases. • We have noted a number of issues with the documentation retained and management of cases, although no action plans have been developed to address these. We also identified that a number of cases are managed in finance - funding granted without these being subject to scrutiny by the Adoption team (a total of 247 cases were identified as at audit date from Finance listing provided). • Discussions with the Acting Team Manager - Adoption identified that there is currently no reporting on SGOs to senior management within the Council. • We identified that there is no dedicated personnel in charge of the financial calculations to support SGOs. Discussions with the Acting Team Manager - Adoption identified that there used to be an officer overseeing the financial management of SGO cases but this individual has since left the Council (2013/14) and since then this position has not been filled.	

Audit area	Scope	Status/key findings	Assurance
		As a result of our audit work we have raised four Priority 1 and six Priority 2 recommendations, which should assist in improving the control environment. The Priority 1 recommendations are as follows Staff involved in managing SGOs should be trained in the use of the DfE financial means calculator. Management Response: Negotiation are continuing with the Brokerage Team in Commissioning and Shared Financial Services to identify which service will undertake the process of financial assessments and the process of annual financial reviews. Deadline June 2017 The support plan's financial elements should be subject to regular (at least annual) reviews to confirm on-going eligibility of the beneficiaries Management Response: Following the policy being approved and the process confirmed, the reviews will be undertaken at least annually. Deadline June 2017 Key Performance Indicators (KPIs) and targets in relation to how many SGOs are in place, monitored and reviewed should be put in place. Reports should then be made to senior management against these targets on a regular basis (at least quarterly). Management Response: The Fostering & Adoption Service Manager will produce an annual report with quarterly reporting to the Head of Service. Deadline July 2017 A process flowchart should be developed, which includes all parts of the process for managing SGOs and this should be used to design a revised process which ensures all those involved in the process work together to optimise outputs. Management Response: This is work in progress and is linked to point re: training. A draft flow chart is being developed which is linked to legal timescales. Deadline June 2017. The Priority 2 recommendations are as follows: The Protocol for payment of: Adoption, Special Guardianship, and	

Audit area	Scope	Status/key findings	Assurance
		Child Arrangement Orders Allowances should be finalised and approved by senior management of the Council Management Response: The draft payment policy is currently being developed by the Head of Service and a senior Department lawyer. An implementation plan will also be developed alongside. Deadline June 2017 A support plan should be put in place in all cases, which should be approved by the Head of Service and the special guardian. Management Response: The draft policy proposes that the Asst Director Safeguarding & Support will authorise all SGO and adoption allowances. Deadline June 2017 The letter sent to the special guardian/beneficiary signifying the agreement should be retained in all cases. Management Response: Discussions are taking place with the Council legal department to ensure that there will be an evidence trail of correspondence and support plans on letter & report templates. June 2017 Financial assessments of the special guardian's circumstances should be carried out using the DfE calculator in all cases. Management Response: Negotiation are continuing with the Brokerage Team in Commissioning and Shared Financial Services to identify which service will undertake the process of financial assessments and the process of annual financial reviews. Deadline June 2017 Payments to be made to beneficiaries should be clearly detailed within the support plan and evidence showing payments should be retained in all cases. Management Response: The draft policy will identify the level of allowance payable subject to the means test calculator and based on the DfE minimum fostering rate for London deadline June 2017 Monitoring arrangements for the financial assessment of SGOs should be put in place. Management Response: Negotiations are continuing with the Brokerage Team in Commissioning and Shared Financial Services to identify which service will undertake the process of financial	

Audit area	Scope	Status/key findings	Assurance
		assessments and the process of annual financial reviews. Deadline June 2017	
Ad-Hoc Audits			
Appointeeship	Audit work was undertaken to cover the following areas: • Governance & procedures • Management of Client Finances • Fees • Access Controls • Performance Monitoring & Reporting	Existing controls are inadequate to manage the risks in this area and/or operation of existing controls is ineffective The key findings are as follows: • Haringey Council act as Appointee for 136 residential clients, and 81 community clients. • Staff have been provided with training related to their role, including training on benefits from Child Poverty Action Group (CPAG), a variety of training using FUSE, a learning platform, and a combination of internal training, arranged by the Team Leader of the Income Maximisation and Personal Budget. • Policies and procedures are in the process of being drafted by a Transformation Project Manager. • We found that there is not currently a Job Description in place for all roles relating to Appointeeships. • When an application is made for an Appointeeship, the Council will receive a BF57 form, which confirms the Council have been formally appointed to act for the claimant. BF57 forms are retained in Mosaic. • We established that when Department of Work and Pensions (DWP) payments are made to the Council, these will be assigned to the suspense account, with the National Insurance number used as a reference. Using the National Insurance number, the banking team will allocate this money to the clients account in SAP AR. When payments are due, the funds	**No**

Audit area	Scope	Status/key findings	Assurance
		will be transferred from the client account to their Personal Funds account, in the General Ledger. • Testing was undertaken on 10 community clients. It was found that five clients had Personal Spending plans in place. It was found that authorisation of Personal Spending plans has not been formally documented. • Personal Spending plans are reviewed on at least an annual basis, or if there has been a change in the clients' circumstance. • The Income Maximisation and Personal Budget team have a Purchase Card, for who the Team Leader is the only authorised persons for expenditure. The Purchase Card is used to make payments for clients in an appointeeship, where raising invoices is not suitable. • Monthly statements received for the purchase card are reconciled with the logged use. The Purchase card in replenished on a monthly basis. • Haringey Council do not currently charge fees for the administration of Appointeeships. • We found that client data is held securely by the Finance Team. Spreadsheets including clients' personal information are password protected and can only be accessed by the Financial Assessments Officer and the Head of Service Assessment and Personalisation. • We established from the SAP access levels: - 211 users who are able to move money from one General Ledger account to another. - 205 users who are able to move money from a customer account to a General Ledger account - 63 users who are able to move items and clear them.	

Audit area	Scope	Status/key findings	Assurance
		As a result of our audit work we have raised eight Priority 1,two Priority 2 and one Priority 3 recommendations which should assist in improving the control environment. Our priority 1 recommendations are as follows Policies and procedures should be established for the provision of Appointeeships. These should be formally approved and disseminated to all relevant staff and subject to annual review to ensure they are in line with current practices and legislation. The policy for appointeeship is within IAPP procedures. The policy requires a review and if necessary updated. The team is currently undergoing a review of its functions and when the re-design of the team has been implemented, timelines will be agreed to produce procedures. At present there is a resource issue due to historical savings. It should be noted that all operational process maps have been drafted and updated with the team as part of the recent service review. Deadline March 2018 Job descriptions should be established for all roles relating to Appointeeships Due to historical changes to the team driven by savings, the roles and responsibilities of staff has evolved to meet service demands. A subsequent re-alignment of JD's is required to detail the appointeeship activity and review what the original job descriptions detail. Going forward this will be addressed by the service review. Deadline March 2018 Client funds should be maintained in a separate bank account for each client. The Project Manager for the service review has identified this and put forward a recommendation to the Departmental Management Team to	

Audit area	Scope	Status/key findings	Assurance
		procure new bank account(s) and IT products(s) to manage appointeeship. Subject to approval this will be addressed. Deadline March 2018 All personal spending plans should be authorised by the relevant authorities prior to the provision of payments. Once we move towards the implementation of plans and re-design of the team, this area will be reviewed to ensure that clear plans and the decisions around the plans are in place. This will principally be the responsibility of the delegated officer to review and sign off. At present, expenditure which is not regular, for example, funerals, holidays, clothes, furniture, emergency cash, rent arrears, social activity is agreed by the team manager / head of service. This information is uploaded to Mosaic. The income / expenditure plans in place will be reviewed and considered for authorisation by 31/3/18. Income and expenditure should be reconciled on a monthly basis and at year end. The Project Manager for the service review has identified this and put forward a recommendation to the Departmental Management Team to procure new bank account(s) and IT products(s) to manage appointeeship. Subject to approval this will be addressed. Deadline March 2018 Haringey Council should reconsider its decision to not charge fees. This will be considered as part of the service review. However, this requires a wider legal and member's consideration and possibly a public consultation. Once the upfront analysis is complete and it's agreed to proceed then a consultation strategy and timelines will need to be agreed. Deadline March 2018	

Audit area	Scope	Status/key findings	Assurance
		SAP Access should be reviewed and updated so that access is in line with users' duties and responsibilities. With the implementation of Segregation of Duties across SAP AR we have reduced user access rights to the SAP AR function therefore limiting the number of users that would be able to access Corporate Appointee Accounts from 211 to 14. Thankfully we have not identified any Corporate Appointee account where a fraud has taken place due to User access rights. However; I believe the requirement for preventative measures and better ways of working is essential to safeguard the service. SAP AR access has already gone through a Segregation of Duties review which has been carried out by the SAP systems Team Deadline June 2017 KPIs should be established, and these should be compared against actual performance periodically. The service review proposes the development of KPI's and governance which will allow the team to monitor and report activity associated with the management of appointeeship and to monitor performance. As part of this process IT systems will need to be developed to produce the KPI's. Senior management should receive periodic management reports which should also identify any key issues. The service review proposes the development of KPI's and governance which will allow the team to monitor and report activity associated with the management of appointeeship and to monitor performance. As part of this process IT systems will need to be developed to produce the KPI's. Our priority 2 recommendations are as follows Personal spending plans should be in place for all community clients.	

Audit area	Scope	Status/key findings	Assurance
		In terms of income and expenditure plans, we recognise that this element of work has been ad-hoc and we do have aspirations to have 100% personal spending plans in place. However, due to team resources and current set up, the team does not have the capacity to undertake this significant and substantive piece of work. The importance of this activity has been recognised and recommendations have been put forward for the approval of resources and reconfiguration of the team. At present, income and expenditure plans involve collating the information from Care Management teams and care providers to produce the plans. Personal expenditure which is not regular, the team seeks approval from the manager of the team and Service Managers. Deadline March 2018 Job descriptions should be established for all roles relating to Appointeeships. Due to historical changes to the team driven by savings, the roles and responsibilities of staff has evolved to meet service demands. A subsequent re-alignment of JD's is required to detail the appointeeship activity and review what the original job descriptions detail. Going forward this will be addressed by the service review. Deadline March 2018	
Priority 2 – Outstanding for all (Adult Social Services)			
Osborne Grove	Audit work was undertaken to cover the following areas: • Governance • Staffing • Personal Care Plans • Complaints • Medical Care • Financial management	Existing controls are inadequate to manage the risks in this area and/or operation of existing controls is ineffective The key findings are as follows: • We obtained the CQC master action plan and identified that this included comments, RAG rated tasks and specified an officer responsible for each task. • We confirmed that the Home uses Haringey Council Payroll Service, and identified that reconciliations between expected and actual expenditure for payroll is not conducted.	**No**

Audit area	Scope	Status/key findings	Assurance
	• Ordering & Invoicing • Assets • Security & Safety • Business Continuity	• We examined a sample of five overtime claims made within the March payroll report and found none specified a reason for overtime, and one had not been signed by the claimant. • We were informed that there is no Central Employee Record that records all permanent and agency staff. • Due to the home failing the CQC inspection and the need to quickly recruit nursing staff, new staff are recruited from agencies, for which starter forms are not completed, and for five new agency staff examined, we confirmed the following: o No formal contract for any of the five; o No evidence of checks conducted by the Home for DBS; o No medical certification for the three staff where it was required; and o No references obtained. • There are seven staff carers and three registered nurses confirmed for week day shifts, and staff are supervised by the Nurse Specialist and Deputy Clinical Manager. We identified that for week nights and weekends, there is no supervision of nurses and care assistants. • There are 19 residents within the Home of whom, five had not had a Malnutrition Universal Screening Tool (MUST) completed within the last month. Two residents were identified to have been scheduled for monthly MUST evaluations as specified within their MUST forms, and three residents were observed to require MUST screening on at least a monthly basis via review of their Personal Care Plans (PCP) and risk assessment forms. • We observed that following the monthly shipment of pharmaceuticals, excess medication was kept within the	

Audit area	Scope	Status/key findings	Assurance
		Hairdresser's room instead of the locked cabinet within the Treatment room. • We were informed that there is no contract in place between the Home and 'Care to Homes' (formerly known as Chemistree), the pharmaceutical company providing medication to the Home on a monthly basis. • Budget monitoring reports are produced on a monthly basis, reasons for variations are noted by the Home Manager, and reports uploaded to SAP for review by the Council Finance department. • We selected 10 payments under £5,000. Six of the 10 payments were identified to be payments made by procurement card. We confirmed via review of documentation that all six were approved by the Home Manager and reconciled to bank statement prior to submission to the Council for formal posting onto SAP. The remaining four payments were all confirmed to have approved purchase orders and invoices, with totals that matched SAP records, although in one instance the purchase order was raised after the invoice date. • The Home Inventory list was obtained for review. We identified that this was a manual paper record which had many amendments made by hand. We were also informed that the list had not been updated to include new purchases made. Upon review of the Inventory list, we identified that ICT assets are not consistently security marked and there was insufficient details regarding serial number, make and model of all ICT equipment. • There is no formal Disposal procedure in place and no records of disposed items. • Residents personal belongings were confirmed to have been detailed within a list provided by the Senior Improvements	

Audit area	Scope	Status/key findings	Assurance
		Officer, however this list was not available at the Home, was not signed off by the Home Manager, and did not include belongings that are kept on the resident (such as earrings). We were informed that all residents' belongings are noted upon admission, however we were unable to evidence this via review of resident files. • We selected five pieces of mechanical equipment and five built in systems within the home for testing. We identified that of the 10 selected, six did not have a current contract in place and eight did not have evidence of regular maintenance as per service agreements. • All current residents have their own personal evacuation plan. However, there have been no fire/ evacuation drills conducted since 15 September 2016. • We identified one complaint which was first made 11 January 2016 and a Stage One response issued 21 January 2016. The complaint was escalated to Stage Two on 22 June 2016 and closed 27 July 2016. We could not obtain any documentation to identify any explanation for the five-month delay to escalate the complaint. As a result of our audit work we have raised eleven Priority 1, eight Priority 2 and three Priority 3 recommendations which should assist in improving the control environment. Our priority 1 recommendations are as follows Payroll reconciliations should be undertaken on a monthly basis. Once completed, the reconciliation should be signed off by the Home Manager. Agreed: This is part of the monthly budget monitoring process and is completed with the Home Manager and Finance. At the time of the audit the manager was new and the process not fully embedded. Already Implemented	

Audit area	Scope	Status/key findings	Assurance
		A Central Employee Record should be created to include both agency and permanent staff. The Central Employee Record should include DBS and any medical certifications required to evidence checks have been conducted prior to employee start date. Agreed: A central record to be established. Deadline June 2017. All required checks should be completed for all new staff in advance of their employment. A record should be retained of all such checks completed. Partly Agreed: Agency staff that have been sourced though the Hays framework agreement requires these to be completed and so will be accepted in accordance with the agreement, this will be reviewed pending the planned outcome of the Hays audit. A record for all agency staff not recruited through Hays will be created and maintained. Deadline June 2017. A record should be retained of the terms and conditions as confirmed through the agency website authorised by the Home Manager. A formal signed contract should be retained for each member of staff and specify pay scale of starter and date of employment. Part Agreed. A shared electronic folder has been established with access limited to managers this will include Terms and conditions by each agency and details of employees. Deadline June2017 Residents level of dependency should be formally conducted to ensure appropriate numbers of staff are available to care for resident needs. Agreed: Dependency assessment has now been completed and implemented. Clinical routine and structure and rotas etc. being finalised Deadline June 2017 The Home should develop a schedule which identifies all residents and when a MUST is required, with the result of each MUST recorded as and when completed subject to periodic review by the Home Manager to ensure completion. Agreed: A timetable for all key plans and assessments has been established and the MUST assessment is an aspect of this. Deadline June 2017	

Audit area	Scope	Status/key findings	Assurance
		All medication received for residents should be maintained within a suitable locked container, accessible only by the registered nurse on duty. Agreed. A new room has been identified for storage and is being fitted with a lock and we are arranging for air conditioning and shelving to be installed. To note all control drugs are signed for but a registered nurse and stored in the lockable medicine cabinet. Deadline July 2017 Current contracts should be maintained for all pharmaceutical needs. Agreed – already identified as an action as part of the home improvement plan. This is a possible procurement process. And is likely to take 3 to 6 months. Deadline Dec 2017 Current contracts should be maintained for all equipment needs. All equipment should be serviced regularly as per contract service agreement and records of this servicing should be retained. Agreed: we have since located evidence of the servicing of the equipment however not all servicing contracts were in place at the time of the audit. These are now in place. Resident personal belongings should be recorded upon admission and list secured within the safe along with relevant belongings if appropriate. Any belongings not stored within the safe should specify reason and location of item. Any changes made to the list should be authorised by an appropriate officer. Resident money records should be fully completed, detailing all cash received and spent, and authorised by an appropriate officer. Agreed: The admissions procedure is to be reviewed and updated to include this. An audit will be done of all current residents' possessions to ensure that an accurate record is in place. Deadline July 2017 A list of risk assessments should be created for the Home, including a schedule of review for each. Agreed. Will be created annual review and as required. Deadline June 2017	

Audit area	Scope	Status/key findings	Assurance
		Our priority 2 recommendations are as follows Documentation relating to complaints made, should be retained on file and reasons for delays in complaints handling should be noted. This is already in place. The complaints handing process and associated information is managed centrally and held within the Respond system. Escalation is instigated by the complainant. Official order forms should be raised for all purchases prior to placing orders with suppliers. Agreed. And this is in accordance to the council's process. These were historical invoices and the home is already following the correct procedure. Already Implemented The Inventory list should be maintained electronically with access to the document restricted to key individuals responsible for maintenance of the list. The list should be updated as new items are purchased or old items written off, and should include the serial numbers, make and model details for all ICT equipment. The inventory should be checked to actual assets on an annual basis and a record of the check retained. Agreed: the asset list is currently being updated and a new process developed. Once in place the list will be updated monthly to reflect disposals and new acquisitions. Deadline July 2017 A catering stock record should be created and maintained, with a periodic reconciliation to actual stock held, to reflect up to date stock levels. Agreed. There is a system that has been implemented and is being reviewed. Deadline June 2017 A disposal policy should be created and detail disposal procedures, method of disposal and an appropriate officer for approval of any disposal. Records of disposed assets should be kept for a clear management trail. Agreed. Procedure being developed and will align with the risk register procedure. Deadline July 2017 Record of all keys to drug cabinets should be maintained and signed off to evidence hand over of keys between shifts.	

Audit area	Scope	Status/key findings	Assurance
		Agreed: Update of handover sheet to record it. Regular fire/evacuation drills should be conducted and documented. Lessons learned from drills should be documented and incorporated into the next drill. Roll call lists should be updated to include the names of all current residents and staff. Agreed. The Home manager has now ensured that fire safety arrangements are in place A list of fire wardens should be identified and list placed in an easily observable area. Agreed. This will be the Nurse on duty and advertised as such. Training is to be provided. Deadline July 2017 An updated Business Continuity Plan should be implemented, to include heating and evacuation procedures. The BCP should be reviewed and updated on an annual basis with the date of the last review recorded. Agreed. Plan has been updated in accordance with the Corporate Deadline and includes the heating and evacuation procedures	

Statement of Responsibility

We take responsibility for this report which is prepared on the basis of the limitations set out below.

The matters raised in this report are only those which came to our attention during the course of our work and are not necessarily a comprehensive statement of all the weaknesses that exist or all improvements that might be made. Recommendations for improvements should be assessed by you for their full impact before they are implemented. The performance of our work is not and should not be taken as a substitute for management's responsibilities for the application of sound management practices. We emphasise that the responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management and work performed by us should not be relied upon to identify all strengths and weaknesses in internal controls, nor relied upon to identify all circumstances of fraud or irregularity. Even sound systems of internal control can only provide reasonable and not absolute assurance and may not be proof against collusive fraud. Our procedures are designed to focus on areas as identified by management as being of greatest risk and significance and as such we rely on management to provide us full access to their accounting records and transactions for the purposes of our work and to ensure the authenticity of such material. Effective and timely implementation of our recommendations by management is important for the maintenance of a reliable internal control system.

Mazars Public Sector Internal Audit Limited

London

September 2017

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