REPORT TO SHEFFIELD CITY COUNCIL AUDIT COMMITTEE
14th July 2016

Internal Audit Report on Progress Against High Opinion Audit Reports.

Purpose of the Report

1. The purpose of this 'rolling' report is to present and communicate to members of the audit committee progress made against recommendations in audit reports that have been given a high opinion.

Introduction

2. An auditable area receiving a high opinion is considered by internal audit to be an area where the risk of the activity not achieving objectives is high and sufficient controls were not present at the time of the review.

3. This report provides an update to the audit committee on high opinion audit reports previously reported. Where internal audit has yet to undertake follow up work, the relevant portfolio directors were contacted and asked to provide internal audit with a response. This included indicating whether or not the recommendations agreed therein have been implemented to a satisfactory standard. Internal audit clearly specified that as part of this response, directors were to provide specific dates for implementation and that this was required by the audit committee.

   This report also details those high opinion audits that internal audit plan to remove from future update reports. The audit committee is asked to support this.

FINANCIAL IMPLICATIONS
There are no direct financial implications arising from the report.

EQUAL OPPORTUNITIES IMPLICATIONS
There are no equal opportunities implications arising from the report.

RECOMMENDATIONS
1. That the audit committee notes the content of the report.

2. That the audit committee agrees to the removal of the following reports from the tracker:

- Outcome Planning (corporate review)
- Activity Sheffield (pro-active fraud review) (Resources)
- Petty Cash Controls (Resources)
- Waste Management Contract (Place).
- Parking Services (Place)

Kayleigh Inman
Senior Finance Manager, Internal Audit.

SHEFFIELD CITY COUNCIL
UPDATED POSITION ON HIGH OPINION AUDIT REPORTS AS AT JULY 2016

1. Payroll Pension Arrangements (issued to audit committee 21.6.2016)

As at July 2016
Internal Audit: This report was issued to management on the 14.4.2016 with the latest agreed implementation date of 1.7.2016. Due to the timescales for completion of this report, an update on progress with recommendation implementation will be included in the next tracker report.

2. Delivery of Capital Schemes and Capital Gateway Approvals (Place) (issued to audit committee 19.4.2016)

As at July 2016
Internal Audit: This report was issued to management on the 29.03.16 with the latest agreed implementation date of 31.12.16. An update on progress with recommendation implementation will be included in the next tracker report.

3. Deprivation of Liberties Safeguards (DOLS) (Communities) (issued to the audit committee 15.4.2016)

As at July 2016
Internal Audit: This report was issued to management on the 21.03.16 with the latest agreed implementation date of 30.9.2016. An update on progress with recommendation implementation will be included in the next tracker report.

4. Safeguarding administration and governance (Communities) (issued to the audit committee 15.4.2016)

As at July 2016
Internal Audit: This report was issued to management on the 21.03.16 with the latest agreed implementation date of 31.03.17. An update on progress with recommendation implementation will be included in the next tracker report.

5. Mailroom processes (pro-active fraud review) (Resources) (issued to the audit committee 18.4.2016)

As at July 2016
Internal Audit: This report was issued to management on the 19.02.16 with the latest agreed implementation date of 1.06.16.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position - provided by Head of Service, Facilities Management.

5.1	A review should be undertaken of the procedures for processing incoming recorded mail and special deliveries, to include deliveries made by non-Royal Mail couriers. Corporate Mail staff should be made aware of the new procedures and implement the changes.	High	Mark Cummins, Facilities Manager, Kier	31.10.15	**Action complete** New Standard Operating Procedure (SOP), including non-Royal Mail courier deliveries, is in place and implemented by Corporate Mail staff. **Internal Audit comment** Evidence has been seen my internal audit to confirm new SOP.
5.2	Management in P&FM should work with Corporate Mail and Kier management to review and agree all Standard Operating Procedures to ensure they are fit for purpose and relevant to the service being housed at Moorfoot, prior to the transfer of the service to SCC.	High	Nathan Rodgers, Head of Service, Facilities Management	1.6.2016 Revised implementation date 31.7.16	**Action ongoing** The Kier and Client Team have investigated recent incidents and identified the following changes • Implementation of revised processes for recorded, signed for mail and travel ticket to ensure a more secure and robust audit trail to the requesting customer- **Completed Jan 16** • Implementation of revised staff process to ensure recorded, signed for and travel tickets are passed to the appropriate person in a timely manner **Completed Jan 16** • Implementation of revised Mail Room reception activities to ensure mail room security, customer

					service interaction is improved and support revised processes - **Completion date 31st July 16.** In addition SCC Business Analysis were requested to review the current Kier process as part of the insourcing project. This review included the requirements of this Audit report and identify if any changes were recommended. This report did not identify any issues with current or recently revised processes. It did make some technical or IT replacement suggestion which will be resolve via the insourcing project after July 16.

6. Activity Sheffield (pro-active fraud review) (Resources) (issued to the audit committee 18.4.2016)

As at July 2016
Internal Audit: This report was issued to management on the 19.02.16 with the latest agreed implementation date of 30.04.16. The update below was established as evidence of implementation was provided to Internal Audit following issue of the final report.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position - provided by Head of Physical Activity.
6.1	All staff should use myView to record annual leave. It is understood that management need an accessible overview of all staff leave for work planning / cover requirements and should therefore ensure that the Activity Sheffield Outlook calendar is maintained and kept up to date.	High	Jo Pearce, Operations Manager Lisa Bows, Community Activity Team Leader	30.4.2016	**Action complete** Use of MyView is compulsory for all staff from 1.4.16
6.2	Management should undertake a review of attendance to sessions on a quarterly basis and adjust the	High	Jo Pearce, Operations	30.4.2016	**Action complete** No longer applicable – no direct

	offer/approach accordingly to ensure that take up of the target group is optimised in relation to the equalities targeted and the cost of the service.		Manager Lisa Bows, Community Activity Team Leader		delivery
6.3	Management should undertake regular and timely reviews of the banking records (red book) in conjunction with Community Activity Delivery Officer (CADO) work programmes to ensure banking is taking place within 5 days of a session being run, in line with the Cash Handling policy v2.	High	Jo Pearce, Operations Manager Lisa Bows, Community Activity Team Leader Diana Radford, Head of Physical Activity	31.10.2015 31.12.2015	**Action complete** Spot checks are completed weekly by Team Leaders. **Action complete** Checkpoint reporting has been designed and implemented.
6.4	Management should ensure all staff are aware that use of correction fluid is not permitted in financial records. For clarity, any errors should be simply crossed through and the correct entry made in the next available space.	Medium	Lisa Bows, Community Activity Team Leader	31.12.2015	**Action complete**
6.5	Management should implement a review process which would include checking the number of activity attendees from the registers, to the number of attendees recorded on the system, to the amount of money banked in the red book. To ensure the money collected at the activity is accurately recorded and subsequently banked.	High	Jo Pearce, Operations Manager Lisa Bows, Community Activity Team Leader	31.10.2015	**Action complete** Spot checks are completed weekly by Team Leaders by cross checking registers with Information Management System.
6.6	Management should ensure that all staff are aware of the Filing Retention & Disposal Policy and that registers are retained accordingly.	High	Jo Pearce, Operations Manager Lisa Bows, Community Activity Team Leader	31.10.2015	**Action complete** Central electronic file identified and communicated. **Action complete** Policy recirculated.
6.7	All Activity Sheffield policies and procedures should be reviewed and updated to ensure robust version control.	High	Jo Pearce, Operations Manager Lisa Bows,	31.10.2015	**Action complete** Review approach refined.

			Community Activity Team Leader		
6.8	All acknowledgement forms signed by staff on receipt of a policy to confirm their understanding should contain not only the title of the policy but also the version number and / or date of the policy. This will ensure clarity regarding what information staff have received and acknowledged that they understand.	High	Jo Pearce, Operations Manager Lisa Bows, Community Activity Team Leader	31.10.2015	**Action complete**

Internal Audit proposes to remove this item from the tracker

7. Highways Maintenance Client Monitoring Arrangements (Place) (issued to audit committee 5.1.2016)

As at July 2016
Internal Audit: This report was issued to management on the 15.12.15 with the latest agreed implementation date of 31.3.2016. A follow-up audit was undertaken in March 2016 and an update on progress made with recommendation implementation is included below.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position - internal audit follow-up review undertaken in March 16.
7.1	Internal Audit supports the on-going review of the monitoring requirements. In order to ensure that appropriate levels of assurance are provided by the Contractor's self-monitoring regime, all monitoring requirements set out for each contractual Method Statement/Performance Monitoring Requirement Table should be systematically reviewed and revised where necessary. Appropriate timescales should be set for the completion of the exercise and the agreement with the contractor for the implementation of any revised requirements.	Medium	Head of Highways Maintenance	31/03/2016 Revised Implementation date 31.5.16	**Partially complete** Regular service improvement meetings are taking place with the contractor. These meetings feed into the Service Operations Board where escalations from those meetings are discussed as a standing agenda item. The Monitoring plan isn't in place as yet, although discussions are ongoing on specific issues. **Internal Audit comment** On-going process was demonstrated but impacted by the vacancy situation and need

					to respond to the tree campaign. The revised Monitoring Plan remains outstanding. Updated deadline for the production of the revised Monitoring Plan. **Audit Opinion** Agreed actions partially implemented. New target date set as above.
7.2	The Client Team should carry out a periodic review of the interface between the two partners' management systems so as to ensure that Performance Requirements are being accurately transferred and reported as part of the assurance process.	Medium	Head of Highways Maintenance	31/03/2016 Revised Implementation date 31.5.16	**Partially complete** The review of the interface between the two systems is going well. In total, 233 errors have been identified. The two parties have now agreed all but 13 lines (we need to finalise the wording that accompanies the coding). Once this has been done, these will be passed to Capita for implementation. This issue is discussed regularly at Change Board. The next Board meeting is expected to confirm implementation of the amendments. Because this work is still not fully completed, we have not yet carried out an annual review but we will do so each year, on or about the anniversary of the final sign off. **Internal Audit comment** Some elements of the agreed action remain outstanding at the time of the follow-up due to the

					impact of the trees campaign on staff workloads.
7.3	Management should continue to review the situation and consider the on-going impact of staff vacancies on the effectiveness of the Client Team and the operational performance of the contract. Consideration should be given to alternative recruitment strategies.	High	Head of Highways Maintenance	31/12/2015	**Partially complete** The vacancies have been approved for filling and recruitment is underway. Further work on the Activity List has been delayed due to the amount of work needed to address the tree issue (including dealing with an injunction and a Judicial Review). **Internal Audit comment** Action has been taken to address the vacancy situation. However, the Activity Review has been delayed due to the impact of other, exceptional, issues. The nature of these issues prevented the Head of Highways committing to revised target date for the completion of the Activity Review.
7.4	Management should consider: • Removing the requirements for duplicated testing of the monthly non-core charges; & • The merits of transferring responsibility for the validation of the monthly contract payments to the Commercial Services Team in the light of the vacant posts in the Operational Processes Team and that team's increased responsibilities for performance monitoring and assurance.	Medium	Head of Highways Maintenance	31/12/2015	**Action complete** The duplication of the validation work carried out by Client and Commercial Services staff has been address. Over and above this Commercial Services now accept the validity of the Completion Certificates produced by Client technical officers. **Internal Audit comment** The recommendation as it

					stands has been implemented. As previously noted, the Activity Review has not been completed; but this was over and above the Audit Recommendation.
7.5	Place management should continue to work towards the identification and implementation of contract budget savings. Account should be taken of the impact of Department for Transport and Amey entitlement to any of the savings identified.	Critical	Head of Highways Maintenance	31/3/2016	**Action complete** The 2015/16 targets have now been replaced – the savings shortfall in 2015/16 formed part of Place budget outcome and there are new targets for the 2016/17 budget. The budget savings required for 2016/17 have now been agreed and implementation plans are in place. As a consequence the risk has been de-escalated from the EMT Risk Register. **Internal Audit comment** The recommendation was effectively dealt with at the point of original reporting – confirmed cash limit agreement for 2015/16 with Director of Finance & Exec Director, Place.

8. Petty Cash Controls (Resources) (Issued to the audit committee 5.11.2015)

As at January 2016
This report was issued to management on the 27.8.15 with the latest agreed implementation date of 31.10.15. Management provided an updated position. In addition, EMT has commissioned a review to challenge the continued use of petty cash to support service delivery.

As at July 2016
Internal Audit: Since the last update, the Cashiers Service has been moved in-house and is now part of Customer Services. As a result the original responsible officer has changed. The Head of Customer Services was contacted and the following update of progress with the 5 recommendations

outstanding is provided below. It should be noted that Internal Audit are currently conducting a further review of Cashier Service which will include the review of new processes and procedures.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position - provided by Visiting Team Manager, Capita 9.5.16
8.1	Petty cash reimbursement procedures should be documented and periodically reviewed to ensure they are fit for purpose. Procedures should include all aspects of petty cash reimbursements including but not exclusively, the process of paying out (including identification verification), retention of authorised documents and collation of year end data.	High	Andy Jarvis, Capita Contract Manager Hayley Dolling, Financial System Support Group	31.10.15 – originally Capita Contract Manager. Revised implementation date : 31.3.16	**Action complete** New procedures have been documented.
8.2	The Cashiers service should collate and maintain a list of petty cash floats held for every portfolio throughout the Council, including value, nominated float holder name and Finance Business Partner. The list should also be updated when a float is repaid and no longer used.	High	Andy Jarvis, Contract Manager	30.09.15 Revised implementation date : 31.3.16	**Action complete** A petty cash float holder audit has been undertaken and a new petty cash float holder spreadsheet created. The returned completed forms detailing monies held by float holders have been sent to the relevant Finance Business Partners.
8.3	To ensure consistency and completeness the Cashiers service should issue, co-ordinate and collate the year end petty cash returns for all portfolios.	Medium	Andy Jarvis, Contract Manager Hayley Dolling, Financial System Support Group	31.10.15 Revised implementation date 30.4.16	**Action complete** Year-end petty cash float audit completed.
8.4	Capita should instigate and co-ordinate a review of petty cash authorisation. An exercise to review and update the electronic lists of the names of the authorised signatures should be undertaken by all services who have a petty cash float to ensure all leavers are deleted.	High	Andy Jarvis, Contract Manager Progress monitored and completion	30.09.15 Revised implementation date : 31.10.16	**Action ongoing** Since the last update a new process has been outlined to replace the old existing signatory list and the need for signed signature forms to be replaced

	New authorised signature lists should be completed and then submitted to Heads of Service for authorisation. Capita should create new electronic lists of the names of the authorised signatures for every portfolio and file the corresponding authorised signature lists. An email should be issued to all business unit managers to remind them that it is their responsibility to inform Cashiers of any leavers. Cashiers should delete leavers from the list as and when notifications are received. Cashiers should undertake an annual review of the lists.		verified by John Squire, Finance Manager, Revenues & Benefits		using Org Plus as a means of identifying petty cash authorising officers and collecting petty cash officers. The proposed process will be assessed by Internal Audit during the current Cashiers Service audit.
8.5	Heads of Service to ensure all authorised signature lists are correctly completed and authorised before submitting them to Cashiers.	2 - High	Relevant Head of Service Hayley Dolling, Financial System Support Group	31.10.15 Revised implementation date : 31.10.16	**Action ongoing** Since the last update a new process has been outlined to replace the old existing signatory list and the need for signed signature forms to be replaced using Org Plus as a means of identifying petty cash authorising officers and collecting petty cash officers. The proposed process will be assessed by Internal Audit during the current Cashiers Service audit.

Internal Audit proposes to remove this item from the tracker

9. Outcome planning (corporate review)

As at January 2016
Internal Audit: The outcome planning review was a corporate review. The report was discussed with the Chief Executive as well as the appropriate senior officers. It was issued to management on the 03.02.15. It was agreed that the report gave an accurate reflection of the current position. The recommendations were also agreed as a positive way forward. The issues raised were not confined to simple process changes and many of the recommendations required a cultural shift within the organisation. These recommendations will therefore in some instances take a longer period to fully embed. The Chief Executive has agreed to produce an annual report in June to the audit committee on the progress made in this area. This report will be timetabled into the work plan for the committee. It is therefore proposed not to update on this report in detail as part of this tracker.

As at July 2016
Internal Audit: A report is on the agenda for today's meeting to outline progress made in this area.

Internal Audit proposes to remove this item from the tracker, as progress is being monitored via alternative methods.

10. Transitions – governance arrangements (Communities) (Issued to the audit committee 27.04.15).

As at July 2015
Internal Audit: This report was issued to management on the 17.04.15 with the latest agreed implementation date of 30.09.15. Therefore an update will be provided in the next high opinion update report.

As at January 2016
An internal audit follow-up review was scheduled for quarter 3 of 2015/16. A new Head of Service (Andrew Wheawall) in Communities was appointed in Oct 2015 and this has led to slippage in the original agreed implementation dates. He provided a management update on progress.

As at July 2016
Internal Audit: An update of progress with the 11 recommendations outstanding in the last report is provided below. It should be noted that the findings from this review are being addressed as part of a wider corporate project establishing integrated transition arrangements.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position - provided by Phil Holmes, Director of Adult Services, Communities and Christine Bennett, Assistant Director of Children and Families, CYPF (17.6.2016)
10.1	Service Plans should include clear objectives for the Transitions service, which includes targets to be met for improvement of the service, and timescales and monitoring arrangements for this. Plans should be in line with Corporate and legislative objectives, be consistent within CYPF and Communities, and	3 - Medium	Anne Flanagan, Interim Head of LD. Dorne Collinson,	30/06/2014 Revised implementation date : 30/9/2016	**Action ongoing** Service Plans are currently being developed that will fully incorporate recommendation 10.1. Joint objectives will

	should be agreed by management from both portfolios.		Director, Children and Families.		incorporate the requirements of the Children and Families Act, SEND reforms and Care Act that have all become live since the audit first reported, and provide a clear framework to bring CYPF and Communities much closer together.
10.2	There should be a clear and consistent operational plan in place for the Transitions service which details the objectives of the service, and shows clear pathways for the transition from children's to adult social care. The operational plan should be in line with portfolio service plans, and include details of roles and responsibilities of portfolios and partnerships involved in transitions work, detailed performance targets and timescales and arrangements for monitoring these. Progress against the plan should be monitored and reported to senior management on a regular basis.	2 - High	Anne Flanagan, Interim Head of LD. Dorne Collinson, Director, Children and Families.	30/06/2015 Revised implementation date : 30/9/2016	**Action ongoing** This plan is being developed with the oversight of the Inclusion Board chaired by the Executive Director of CYPF and attended by the Director of Adults Services. The plan is rooted in the new legal requirement for Education, Health and Care Plans and formal arrangements within those plans that enable smooth transition to adulthood no later than the young person's 25th birthday. The operational plan also has full input from the CCG to address health aspects. CYP, Adults and SEN colleagues are currently agreeing performance management targets and timescales, which will be routinely reported. Both Childrens' and Adults Safeguarding Boards will also have oversight of this important area of work. The Independent Chair, who covers both Boards, is keen for transition to be a priority.

10.3	Performance monitoring should include specific outcomes for which performance can be measured against; for example number of days it should take to complete an initial assessment against actual time taken. Outcomes should be set by management, monitored at least quarterly and used to inform service improvement and staff training and development. Results of performance monitoring, and any action taken to improve this should be reported to senior management.	2 - High	Anne Flanagan, Interim Head of LD. Dorne Collinson, Director, Children and Families.	30/06/2015 Revised implementation date : 30/9/2016	**Action ongoing** A jointly owned integrated performance management framework is being developed as above, underpinned by an integrated governance structure. The Inclusion Board already receives regular formal reporting in relation to young people going through transition which combines hard data (e.g. volume of demand, time taken) with discussion and actions in relation to workforce development.
10.4	There should be a risk management plan in place for the Transitions Team which identifies key risks that affect the service and its partners/stakeholders. The plan should be in line with corporate requirements and include actions to be taken to mitigate risks, timescales and monitoring arrangements. The plan should be reviewed for adequacy at least quarterly.	3 - Medium	Anne Flanagan, Interim Head of LD. Dorne Collinson, Director, Children and Families.	30/06/2015 Revised implementation date : 30/9/2016	**Action ongoing** The Inclusion Board operates a risk log and reports on a highlight / exception basis to enable clear escalation of issues and development of remedial plans. The integrated performance management framework described above will also incorporate a more detailed risk log with risk mitigation actions.
10.5	There should be documented processes and procedures in place which detail the different pathways for service users transitioning to adult social care. This should include roles and responsibilities of each partner and portfolio, how each service interacts with each other and the service user, and timescales for each stage of the process. Procedures should be reviewed by the Transitions Working Group (or similar multi-agency group) to ensure consistency across portfolios. As transitions staff work with children's and adult social	1 - Critical	Anne Flanagan, Interim Head of LD. Dorne Collinson, Director, Children and Families.	_30/09/2015 Revised implementation date : 31/12/2016	**Action outstanding** This is accepted. The introduction of new legislative requirements (as referred to in 10.1) has delayed this piece of work while strategy and performance management framework are being put into place. The clear mandate from the

	care systems, a training and development plan should also be considered to ensure that information is recorded appropriately.				Inclusion Board is to develop a 0-25 Service with an appropriate degree of integration between CYPF and Communities. This will be underpinned by single processes and procedures.
10.6	The service responsible for agreeing costs that are generated from transitions activity should ensure that arrangements for financial management and responsibility are documented and agreed by management. This includes identifying responsible officers, and budget monitoring arrangements.	2 - High	Anne Flanagan, Interim Head of LD. Dorne Collinson, Director, Children and Families.	31/03/2015 Revised implementation date : 30/9/2016	**Action ongoing** This is currently implemented through the Adult LD resource panel, where all young people over the age of 18 are presented regardless of whether they have not come across to be case managed by Adult LD. Further work is underway to review Panel processes and more fully incorporate SEN, Education and CCG into the current Joint Commissioning Panel arrangements. This will also include cross-cutting finance and administrative support to record, monitor and review packages effectively.
10.7	There should be an agreed procedure in place for identifying and monitoring spend on service users with a transitional support plan. This can be used to identify and monitor impact on the adult social care purchasing budget.	2 - High	Anne Flanagan, Interim Head of LD. Dorne Collinson, Director, Children and Families.	31/03/2015 Revised implementation date : 30/9/2016	**Action ongoing** CYPF and Communities now share an Assistant Head of Finance who is well-positioned to provide this overview. The focus of joint work between Communities and CYPF is on developing the right practice in line with national legislation and guidance to maximise both independence and opportunity.

10.8	Transitions management should undertake long-term financial forecasting of service users care needs. This would assist in giving a picture of who is likely to use the transitions service in the future, and aid with financial planning of the service.	2 - High	Anne Flanagan, Interim Head of LD. Dorne Collinson, Director, Children and Families.	30/06/2015 Revised implementation date : 30/9/2016	**Action ongoing** Joint commissioning arrangements between, Health, CYP, Education and Communities are incorporating this approach and will include support from finance colleagues who, as above, cover both CYP and Adults.
10.9	A communication plan should be developed which identifies key partners and stakeholders and how the service work with them. The plan should identify what meetings take place and how often, officers responsible for communication, and types of communication that take place. The plan should be reviewed periodically to ensure adequacy.	3 - Medium	Anne Flanagan, Interim Head of LD. Dorne Collinson, Director, Children and Families.	30/06/2015 Revised implementation date : 30/9/2016	**Action ongoing** The Inclusion Board is comprised of a wide range of stakeholders, including from within CYPF, Communities, the NHS, schools and other involved bodies. The Inclusion Board is developing a communication plan that reaches the wider populations that Board Members represent. The Inclusion Board has recognised that more needs to be done to engage with young people and family members, and is developing plans to do this. At a casework level, a significant number of young people have recently transitioned to the adults service with clear communication to support this. However more work needs to be done on further communication to underpin the new policies and ways of working described above.
10.10	Results of feedback from service users and other stakeholders should be collated and reported to management. Any actions taken to inform service	2 - High	Anne Flanagan, Interim Head	30/06/2015 Revised implementation date :	**Action ongoing** Complaints from young people

	planning, or staff training and development as a result of feedback should be documented and agreed.		of LD. Dorne Collinson, Director, Children and Families.	30/9/2016	and their families involved in transition have dropped over recent times. This reflects some of the recent improvements in this area. However further work is required to ensure that feedback from young people and their families is systematically gathered, listened to and drives improvements as part of a "you said, we did" culture. Communities have developed Service Improvement Forums for both family carers and people with a learning disability. These forums are chaired by service users or carers and run to their agendas. Feedback about transitions has already featured on both these agendas.
10.11	Processes and procedures for recording information for service users transitioning from children's to adult social care should be documented and reviewed by management from both portfolios for adequacy and consistency. It should be ensured that all transitions staff are adequately trained in using Carefirst and Careassess for recording information in both children and adult social care capacities.	2 - High	Anne Flanagan, Interim Head of LD. Dorne Collinson, Director, Children and Families.	30/06/2015 Revised implementation date : 31/12/2016	**Action ongoing** Communities and CYPF are currently expanding this training due to changes in the structure of both services that have increased the number of people involved. This is positive in terms of increasing the number of staff who are engaged in transitions work, and is being accompanied by appropriate training and support. The Council will be tendering to replace the current systems in operation. CYPF and Communities are working together on this. The new system

					will be jointly designed and greatly enhance the success of an integrated approach to transitions.

11. External Funding (corporate review) (Issued to the audit committee 01.06.15).

As at July 2015
Internal Audit: This report was issued to management on the 07.05.15, with the latest agreed implementation date of 30.09.15. Therefore an update will be provided in the next high opinion update report.

As at January 2016
An internal audit follow-up review is scheduled for quarter 1 of 2016/17. A key challenge with regard to external funding is getting managers across portfolios to comply with the process, this has resulted in slippage in some of the original implementation dates. An update was provided by service management.

As at July 2016
Internal Audit: An update of progress with the 6 recommendations outstanding in the last report is provided below.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position - provided by External Funding Manager 31.5.16
11.1	It is recommended that where appropriate approval has not been sought for external funding and where there is a lack of clarity with regards to the key funding arrangements (including match funding arrangements), this is clearly detailed and escalated to the relevant Executive Director/Director for information and appropriate action to be taken (where necessary). The External Team should continue to publicise the process across the Council with periodic updates placed on the intranet.	High	Finance Manager, External Funding	Management actions in progress at the time of the discussion meeting. Actions to be confirmed as satisfactory at the time of the follow-up review.	**Action ongoing** Budget holders requiring grant sign off at a late stage with no grant report are refused and required to produce a report before sign off is undertaken. If the grant is time critical and there is a risk of the grant being lost then External Funding will review the grant terms and conditions and advise the applicant accordingly and point out the risks of sign up without approval with the requirement for a retrospective report if needed.

				Revised implementation date 31.10.16 for training to all Executive Directors and Directors Wider roll-out of the presentation to be reviewed in 30.8.2016.	Where necessary excessive delays in Leader's scheme reports are progressed with the appropriate level of management (Example DFE S31 Innovation grant and DCLG S31 Roma Grant). Some grant offers still continue to arrive in External Funding requiring a very quick turnaround from funders. External Funding manage to review these ensuring compliance with the Leader's Scheme, but this often means having to delay/ reschedule planned work to avoid losing a grant offer (example CYPF :Make, Learn, Share EU grant) An External Funding presentation on the operation of the Leader's Scheme has been developed for senior management training. In February 2016 changes to the Leaders' Scheme approvals process began and were approved in May 2016. These changes mean that Cabinet Members will take over Cabinet's role when approving grant offers. Whilst awaiting the results of the scheme changes the training sessions have been delayed. The presentations have now been adapted and the training programme can recommence across Portfolio Leadership Teams and the wider Council.

				Revised implementation date : 30.11.16	The External Funding team have worked with Legal to develop and implement proposals to make decision making more efficient and simpler for all parties. Intranet updates are under review and are something that External Funding will be looking into during 2016/17 as part of the wider process review. During 2015 the External Funding team experienced a high level of staff turnover which impacted on the capacity to undertake process reviews.
11.2	A timescale should be set for the implementation of the use of SharePoint for recording all key grant funding information. A review should be taken on legacy arrangements across the Council and how these can potentially be included on SharePoint using a cost benefit analysis to assess the cost of doing this with potential claw back etc.	High	Finance Manager, External Funding	September 2015 Revised implementation date : Resource levels to be reviewed July 2016.	**Action outstanding** High staff turnover in the External Funding team along with increased workloads have meant that SharePoint was not able to be implemented during 2015/16. External funding is committed to the development of Share Point and work will recommence when time, work load and resources allow.
11.3	Going forward, grant claims should not be signed off by any party where there is any doubt regarding the supporting evidence. In the case of any loss of funding, the service area should make a provision for this. A grant authorisation checklist should always be present when a claim is signed off. If this has not been completed, the claim should be sent back to the project manager for completion. Grant claims should be submitted in such a time as to	High	Finance Manager, External Funding	Management actions in progress at the time of the discussion meeting. Actions to be confirmed as satisfactory at the time of the follow-up review. Revised implementation date : 31.12.15	**Action complete** All grant claims are reviewed and checked first by Finance Business Partner and then by External Funding. The External Funding team will not sign off weak claims and will delay submission where there are significant errors. Where grant submissions do not have the correct documentation or

	allow for appropriate checking. If a claim is submitted late or with little or no time for appropriate checking; again, the Service should make provision for this. Lack of time cannot be a reason to sign off a claim without the appropriate supporting evidence. Where appropriate, it is the project manager's responsibility to agree a time extension with the funder to allow for verification to take place. Going forward, consideration should be given to whether the External Funding Team should re-charge for their time spent on grant funding claims - if verification and checking work goes beyond the level normally expected.				evidence to support the budget holder is informed and the claim is delayed until the evidence requirements are met.
11.4	In the interests of the Council, Internal Audit recommends that an email is sent to the CCG specifying the conditions under which the Council are operating/will operate until the Memorandum of Understanding is signed off.	High	Finance Manager, External Funding	Note – Compensating Controls Revised implementation date : 30.4.16	**Action complete** All memoranda are now signed off by SCC and the NHS for 2015/16. For 2016/17, External Funding will confirm with the CCG that they will operate under the previous year's conditions until the 16/17 memoranda are received and signed up to.
11.5	It is recommended that Project Managers charged with managing external funding sign to confirm that they understand their roles and responsibilities in relation to the external funding scheme at the start of the process when they take on their role. Project Managers who have failed in their duty to administer/manage external funding appropriately should not be permitted to continue in their role until they have received appropriate training. In serious cases, it may be necessary to remove them from managing the external funding schemes completely. Where officers have failed in their duties, this should be reported to the relevant Director/Executive Director (as this is either a capability or a disciplinary issue).	High	Finance Manager, External Funding	September 2015 Revised implementation date : 31.12.16	**Action outstanding** Clarification and documentation of Project Manager roles is being reviewed as part of External Funding's process reviews and will be developed further by December 2016. A pilot of a new grant template where the specific roles of each party are more clearly defined has been tested with some Place grants. The results of this will be reviewed and adaptations made to the form where needed prior to

					wider usage across all Portfolios. Where there have been problems with the management and administration of the grant then External Funding have intervened and advised Project Managers where necessary to ensure the grant terms are adhered to (e.g. Autism Grant).
11.6	It is recommended that a notice is included on the grant claim authorisation checklist (which the project manager must sign off) that states that if an officer knowingly completes a claim which contains false information; this can potentially be treated as a fraud matter. It should be stated that it is the manager's responsibility to obtain, read and comply with all the grant conditions. Where they cannot provide this assurance, they should seek advice immediately from the External Funding Team.	2 - High	Finance Manager, External Funding	June 2015 Revised implementation date : 31.8.16	**Action outstanding** The wording of the grant checklist will be adapted once the finalised version of the template is agreed.

12. Statutory Responsibilities Health Check (Resources). (Issued to the audit committee 14.01.15).

As at July 2015
Internal Audit: This report was issued to management on the 12.01.15, with the latest agreed implementation date of 31.03.15. An update of progress to date is provided below from the interim director of Legal and Governance. A follow up will be undertaken as part of the 15/16 audit plan.

As at January 2016
An Internal Audit follow-up review was undertaken in October 2015. 2 of the 8 recommendations have been actioned and the remaining 6 are ongoing for completion as part of the Annual Governance Statement production for 2015/16.

As at July 2016
Internal Audit: An update of progress with the 6 recommendations stated as being 'on-going' in the last report is provided below.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Update provided from Director of Legal & Governance as at 6.6.16
12.1	Individual service managers should be required to carry out an annual refresh of the data bases as part of each year's AGS process. This requirement should be incorporated in to the AGS Guidance issued by the interim director of Legal & Governance. This will ensure that the data bases remain contemporaneous in relation to current legislation, organisational structure and the appropriate assignment of lead officer responsibilities and can be used as the basis for the corporate-based confirmation processes raised at finding 3.1 in this report.	Medium	Interim Director of Legal & Governance (Initially - with individual directors subsequently picking up responsibility for their own registers).	31.03.15 Revised implementation date 31.03.16	**Action complete** Implemented as part of the AGS process for 2015/16 The information is held in Sharepoint with a requirement to update with the submission of each AGS. **Internal Audit comment** Validation of implementation confirmed through involvement in production of the AGS statement.
12.2	The interim director of Legal & Governance should take forward the agreed actions from the deputy chief executive's original report and work with individual executive directors to ensure their implementation. In doing so, however, internal audit further recommends that guidance should be issued by the director of Legal & Governance as to: • The levels of assurance required by portfolio management from the respective lead officers; • The consideration of statutory responsibilities as part of the service business planning process, budget setting and performance monitoring procedures across all portfolios; • The systematic risk review of all statutory responsibilities to determine the potential impacts of non-compliance (particularly where statutory responsibilities are delivered externally to the service) and their inclusion on service risk management plans where considered significant. Consideration should then be given	High	Interim Director of Legal & Governance	31.03.15 Revised implementation date 31.03.16	**Action complete** See above. The reference to statutory responsibilities has been incorporated into the corporate business planning process. The Council Risk Management team have been involved in the implementation of the new process.

	to the escalation of significant risks as and where necessary.				
12.3	Up to date and accurate registers of statutory responsibility should be maintained at portfolio and service level ensuring that all relevant responsibilities have been identified and assigned. These should then be used as the foundation for monitoring compliance. The registers should be updated to account for new legislation and be reviewed on an annual basis to ensure that they remain up to date (ideally in conjunction with the service business planning process).	High	All Executive Directors Initial agreement with Interim Director of Legal & Governance with individual directors subsequently picking up responsibility for their own registers.	31.03.15 Revised implementation date 31.03.16	**Action complete** There will be an annual review with the AGS process but issues should also be brought to the fore as and when they arise if these are properly considered by services as part of business planning. Internal Audit comment. Validation of implementation confirmed through involvement in production of the AGS statement.
12.4	Corporate service business planning guidance should be revised so as to explicitly require business plans to outline the range of statutory responsibilities anticipated to impact on resource allocation, as well as the actual allocation of resources in ensuring compliance. Business plans should be used to set out management's strategies in addressing its statutory responsibilities including the risks and impact of planned partial or non-compliance. Directors should ensure that all statutory responsibilities have been accounted for before signing-off individual business plans (with reference to the registers of statutory responsibility).	High	Director of Policy, Performance and Communications	31.03.15	Director of Policy, Performance and Communications response as at 09.06.16 **Action completed** Statutory responsibilities are included in the service planning guidance for 2015-17 Service planning guidance.
12.5	Having established registers of statutory responsibility, directors should ensure that these are considered as part of the monthly governance arrangements. Compliance with statutory responsibilities should be incorporated in to the framework of governance meetings covering service managers, heads of service and their respective directors.	High	All executive directors	31.03.15 Revised implementation date 31.07.16	**Action ongoing** The new guidance has been drafted and consultation is being undertaken with the Director of Policy, Performance and Communications, the Director of Commercial Services and the Director of ICT about if and

					when this is being published.
12.6	All portfolios and services should monitor compliance with statutory responsibilities in the context of staff changes and reduced funding levels. This should incorporate: • As part of the annual service business planning process, identifying the service costs required to ensure compliance; • The consideration of alternative strategies for delivering compliance; • The use of appropriate performance indicators where applicable to aid monitoring; & • Incorporation of compliance monitoring in to the monthly governance framework; Over and above this, executive directors should report to EMT annually at the culmination of the service business planning process, setting out the impact of reduced resources on compliance with statutory responsibilities.	High	All executive directors	31.03.15 Revised implementation date 31.07.16	**Action ongoing** To form part of guidance detailed at 13.5 above.
12.7	Guidance for the completion of the 2014/15 AGS should be more explicit in requiring service managers to declare all issues of non-compliance with statutory responsibilities. Service managers should be required to include in the declaration details of any risk/impact assessment and mitigation strategies as a means of evaluating the significance of the non-compliance. This is particularly pertinent where the AGS is to be used as the platform for the annual monitoring of compliance with statutory responsibilities. The AGS guidance package should require the submission of registers of statutory responsibility to the director of Legal & Governance. These should be signed-off where appropriate by the relevant service manager and director as formal confirmation of compliance, or cross-reference to the appropriate declaration in the service AGS. This will enable the director of Legal & Governance to provide EMT with an annual report on compliance with statutory responsibilities when reporting on AGS.	High	Interim Director of Legal & Governance	31.03.15 Revised implementation date part 30.09.15 and fully 31.03.16	**Action complete** Implemented as part of the AGS process for 2015/16. The information is held in Sharepoint with a requirement to update and report non-compliances with the submission of each AGS. Director Legal Services attends EMT with a list of non-compliances annually. **Internal Audit comment**. Validation of implementation confirmed through involvement in production of the AGS statement.

13. Waste Management Contract (Place). (Issued to the audit committee 15.08.14).

As at January 2015
Internal Audit: This report was issued to management on the 04.06.14, with the latest agreed implementation date of 31.03.15. Therefore an update will be provided in the next high opinion update report.

As at July 2015
Internal Audit undertook a follow up review in February 2015, the results are reproduced below.

As at January 2016
An update on progress implementing the actions outstanding at July was requested from management. 3 recommendations were outstanding and management have now confirmed that 2 have been actioned (evidence to support this was provided to internal audit) and implementation of the final recommendation is expected by the end of April 2016.

As at July 2016
A management update has been provided for the final outstanding recommendation, this is included below:

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position provided by Head of Waste Management 18.5.2016
13.1	Both partners should consider all options in relation to lifecycle maintenance accounts. The assistant director of finance (project & commercial) should be included in any discussions and consulted on the decisions taken regarding these funds. Any decisions taken should be formally documented and ratified by both parties.	High	Head of Waste Management & Senior Commercial Manager	31.03.15 Revised implementation date 30.04.16	**Action complete** Project finance and contract management have resolved terms and access to lifecycle maintenance account.

Internal Audit proposed to remove this item from the tracker.

14. Car Parking Services (Place). (Issued to the audit committee 23.09.14).

As at January 2015
Internal Audit: This report was issued to management on the 23.09.13, with the latest agreed implementation date of 31.03.14. Following a piece of follow up work by internal audit in September 14, the director of regeneration and development services attended the November audit committee meeting and provided an update against the outstanding recommendations. At this meeting it was agreed that a further piece of follow up work would be undertaken by Internal Audit. Because of timing issues, internal audit agreed to obtain evidence for those actions stated as having been completed in the November update – with further

updates being provided in the next tracker against actions noted as still being 'in progress'. It was stated that these in progress actions were to be completed by the end of December 2014.
Internal audit were provided with sufficient evidence to confirm that the 8 recommendations stated as being 'complete' in November had all been actioned and these were reported in the previous high opinion report.

As at July 2015
Progress against the remaining outstanding actions was reported to the committee.

As at January 2016
A management update was provided for the 3 outstanding recommendations.

As at Jul 2016
A management update has been provided for the final outstanding recommendation, this is included below:

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position - provided by Transport, Traffic & Parking Services Business Manager February 2016.
14.1	Consideration should be given to whether restricted authorisation levels should be incorporated in to the parking gateway system for cancellation of penalty charge notices (PCN). Alternatively consideration should be given to the potential for management to review a daily log of cancellations processed to confirm legitimacy and correct application of the enforcement policy.	Medium	TT&PS Business Manager	31.10.14 Revised implementation date 31.12.14 Revised implementation date 31.07.15	**Action complete** The benchmarking data from other Core City Authorities on cancellation checking levels (supplied) show that levels of checking vary between one or two monthly per officer (Bristol), up to 5%. (for experienced staff in Newcastle). Parking Services check up to 10 cancellations per officer (evidence has been supplied to Internal Audit) which broadly equates to up to 10% of cancellations being already checked (average 673 per month with 7FTE processing staff). Managers continue with the monthly quality checks (of which cancellations are only one part) and these are discussed with the member

					of staff in monthly 1:1 meetings. No suggestion of any fraudulent activity has been detected to date. **Internal Audit comment** Adequate sample checking of cancellations is now being undertaken.

Internal Audit proposed to remove this item from the tracker.

15. Delivery of Highways Schemes (Place) (Issued to the audit committee 08.04.14).

As at 25th November 2014
Internal Audit: This report was issued to management on the 19.03.14, with the latest agreed implementation date of 30.09.14. The Director of Regeneration and Development Services, Dave Caulfield, provided an updated position against the recommendations and this is provided below. Additionally, he wished it to be recorded that a firm of consultants, Turner & Townsend, were appointed by Sheffield City Council in August 2014 to undertake a review of the council's approach to delivering its non-core transport capital programme (i.e. excluding the Streets Ahead PFI capital maintenance programme). This end to end review has just reported and a full change programme will be implemented over the next 6 months including picking up some early wins in the first three months. The remaining outstanding internal audit recommendations will be captured as part of implementing the change programme.

As at March 2015
A follow up audit was undertaken in March 2015. Internal audit was concerned that adequate progress had not been made against the original recommendations. The majority of the outstanding recommendations relate to the on-going change programme resulting from the independent review of the delivery of highways schemes. However, it should be noted that over and above this the following recommendations remained outstanding: • The analysis of available and allocated funding, • Forward programme capital approvals, • The block procurement strategy and contract waiver and • "Tracker" reporting to Commercial Services Revised deadlines have been agreed with transport, traffic and parking services (TTPS) management for those outstanding recommendations. Internal Audit met with the assistant director of finance on 14.05.15 to get a finance view. With regard to action no 14.3, it was stated that funding had been secured for the 15/16 projects but only after the intervention of finance.

As at Jan 2016
A management update has been provided for the 9 outstanding recommendations from the last report. Management stated that 6 had been actioned and evidence to support this was provided to internal audit. 3 actions are ongoing and are due for completion by the end of the financial year.

As at Jul 2016
A management update has been provided for the 3 outstanding recommendations from the last report. It should be noted that the findings raised in this review are being considered as part of the wider Business Like Place programme. The management update is included below:

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position from Head of TT&PS 18.5.2016
15.1	The Information Commissioner should be invited to review the automated number place recognition (ANPR) data-sharing arrangements prior to their implementation. Subject to the Commissioner's approval, all of the parties (i.e the four south Yorkshire local authorities and South Yorkshire Police) should enter in to a formal arrangement reflecting the approved procedures for each authority.	Medium	Highways Network Manager	30.09.14 Revised implementation date 31.07.16.	**Action ongoing** The Information Commissioner did not visit Sheffield and he has not rearranged the meeting. The data sharing has been taken forward as part of the SY Common Database project. The agreement is being scrutinised by the Interim Head of Place Strategy Team to confirm that it satisfies the requirements of the SCC Corporate data sharing protocol.
15.2	TT&PS management should meet with the Commercial Services construction category manager to determine the levels and frequency of financial data to be provided to him. Once determined, arrangements should be put in place to allocate responsibility and set up timetables to facilitate this information.	Medium	Head of TT&PS	31.05.14 Revised implementation date 31.08.16.	**Action ongoing** Principal Engineer, Business Management has been working with The Category Manager and Project Planner to develop the financial data set.
15.3	The previously recommended operational review (point 14.6) should consider the operational structures required for the effective delivery of highways schemes. Specifically, whether current structures provide the most effective model or whether these give rise to bottlenecks or un-necessary duplication.	Critical	Head of TT&PS	30.06.14 Revised implementation date 31.12.16.	**Action outstanding** The Director of RDS was obliged to prematurely terminate the Turner and Townsend programme

	Once the structure has been clarified, specific roles and responsibilities for all service areas and individual officers should be developed and issued, so as to avoid any ambiguity over those responsibilities or the expectations placed on individuals.				delivery review because of a lack of further funding. Consequently, the project was never formally “closed”. TTAPS staff are now drafting an internal closure report that will summarise the progress made, specifically relating to removal of bottlenecks and duplication within the process. In parallel, the new Head of the Transport service is drafting proposals for restructuring the service – this activity will be ongoing over the next 4-6 months.