REPORT TO SHEFFIELD CITY COUNCIL AUDIT AND STANDARDS COMMITTEE
12th JANUARY 2017

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 and standards 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 and standards 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 and standards 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 and standards committee notes the content of the report.

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

- Firs Hill Primary School – Financial Healthcheck (CYPF)
- Mailroom processes (pro-active fraud review) (Resources)
- Delivery of Highways Schemes (Place)

Kayleigh Inman
Senior Finance Manager, Internal Audit.

SHEFFIELD CITY COUNCIL
UPDATED POSITION ON HIGH OPINION AUDIT REPORTS AS AT JANUARY 2017

The following table summarises the implementation of recommendations, by priority, in each audit review.

Audit Title	Total				Complete				Ongoing				Outstanding
	Critical	**High**	**Medium**	**Ec/eff**	**Critical**	**High**	**Medium**	**Ec/eff**	**Critical**	**High**	**Medium**	**Ec/eff**	**Critical**
Payroll Pension Arrangements		5	2			4	1			1	1		
Capital Schemes and Capital Gateway Approvals		6	2			4	2			2			
DOLs	2	10	17	2	1	8	14	1	1	2	3	1	
Safeguarding Administration		8	7	2		4	3	1		4	4	1	
Mailroom Processes		1				1							
Highway Maintenance		1	2				2			1			
Transitions	1	7	3			3				4	3		1
External Funding		4				3				1			
Statutory Responsibilities		2								2			
Delivery of Highways	1		2		1		2						
Total	**4**	**44**	**35**	**4**	**2**	**27**	**24**	**2**	**1**	**17**	**11**	**2**	**1**

Shaded items to be removed from the tracker

In total, updates have been provided on 87 recommendations. Of these, 55 (63%) have been implemented and 31 (36%) are ongoing, indicating work has been started but not yet fully completed. Only 1 recommendation was considered to be outstanding (1%).

1. Appointeeship Service (issued to audit committee 22.7.2016)

As at Jan 2017
This report was issued to management on the 11.7.16 with the latest agreed implementation date of 30.11.2016. 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. ICAT to STIT (issued to audit committee 22.7.2016)

As at Jan 2017
This report was issued to management on the 11.7.16 with the latest agreed implementation date of 30.11.2016. Due to the timescales for completion of this report, an update on progress with recommendation implementation will be included in the next tracker report.

3. SCAS - Residential and Nursing Agreements (issued to audit committee 1.8.2016)

As at Jan 2017
This report was issued to management on the 12.7.16 with the latest agreed implementation date of 30.04.2017. An update on progress with recommendation implementation will be included in the next tracker report.

4. The Markets Service (issued to audit committee 28.9.2016)

As at Jan 2017
The final report was issued to management on the 9.9.16 with the latest agreed implementation date of 31.3.2017. Due to the timescales for completion of this report, an update on progress with recommendation implementation will be included in the next tracker report.

5. Firs Hill – Financial Healthcheck (issued to audit committee 24.10.2016)

As at Jan 2017
The final report was issued to management on the 22.9.16. The draft report with the audit findings and recommendations were discussed with the headteacher and school business manager at the end of the school visit with the latest agreed implementation date being 30.9.2016. Firs Hill School have now converted to an Academy and as such Internal Audit can have no further involvement with the school. The headteacher and governors are responsible for ensuring recommendations made have been appropriately implemented.

Internal Audit proposes to remove this item from the tracker.

6. Council Processes for Management Investigations (issued to audit committee 21.11.2016)

As at Jan 2017
This report was issued to management on the 20.9.16 with the latest agreed implementation date of 31.12.2016. Due to the timescales for completion of this report, an update on progress with recommendation implementation will be included in the next tracker report.

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

As at July 2016
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.

As at Jan 2017
An update on progress made with the recommendation implementation is included below. 5 out of 7 recommendations have been implemented and with work ongoing on the remaining 2. There are known issues with processes at SYPA and so for the 2 ongoing recommendations a long revised implementation date is expected to enable improvements to be implemented within SYPA.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position - provided by HR Service Manager 1/12/2016.
7.1	SCC should liaise with SYPA to ensure the circumstances where SCC could face extra charges are clearly defined, especially given the current situation which is outlined below, so we are not subject to any more charges.	Medium	Peter White, HR Service Manager	01/04/2016	**Action complete** - as the consultation closed and this is now business as usual. HR Service Manager responded to the SYPA Administration Strategy consultation document verbally at the Joint Pensions Group on 18/1/16 and in writing to the SYPA Pensions manager on 22/1/16. Our response was pulled together with the involvement of our Payroll provider. To date SYPA have still not formally responded and have not defined 'exceptional circumstances', however they have carried out numerous requests for additional work without charge.
7.2	SCC and Capita need to work together to ensure that timescales for submission of information to SYPA are achievable. It is recommended that Capita look at their system and see if there is a practical way they can send data more than once a month. SCC should also	High	Shaun Lee, Payroll Manager and Peter White, HR Service	01/04/2016	**Action complete** As a result of the consultation referenced in 7.1, SYPA agreed to remove the KPI for contract

	discuss with SYPA the impracticality of this timescale and request that the strategy is amended. Alongside this, once the initial strategy comes into place, it is important that performance is closely monitored and that there is a process in place to do this.		Manager		changes as this was deemed an unachievable measure where most employers produce payroll reports linked to payroll cycles (i.e. monthly). SYPA also clarified that fines would only be implemented for late annual returns (SCC returned on time) and that their approach would be to work with employers to improve regular data transfers through systems improvements and training before resulting to fines.
7.3	These timescales SYPA has to respond/communicate with members and SCC should be altered so that they are very clearly defined. It is recommended that SYPA have a period of time from receiving the query to completing an initial verification of all required information, for example, through a checklist. SYPA will then have the timescales outlined in the Pensions Administration Strategy to reply to the query - this will stop the process being unduly delayed.	Medium	Peter White, HR Service Manager	21/03/2016 Revised implementation date: 1/4/2018	**Action ongoing** SYPA disclosed on 30/11/16 at their AGM that they are intending to move towards monthly returns for Payroll data in April 2018. Part of this approach will enable SYPA to have access to real-time Payroll data ensuring they have the necessary information to hand to enable it to perform the task within timescale. Work with SYPA and Capita Payroll is ongoing to resolve current data transfer issues, whilst recognising the future systems approach so they dovetail effectively.
7.4	It is recommended that SCC requests that the new Pensions Administration Strategy is not implemented until the new system is operating effectively and providing the required management information.	High	Julie Toner, Director of Human Resources	01/06/2016	**Action complete** The new Pensions Administration Strategy was implemented by SYPA on 1/4/16 as is their right provided for through statute by Regulation 59 of the Local Government Pension Scheme

					Regulations 2013 (as amended).
7.5	SCC should ensure that the backlog of cases relating to its staff is provided by SYPA and is at an acceptable level before entering into the Pensions Administration Strategy.	High	Peter White, HR Service Manager	01/04/2016	**Action complete** The Pensions backlog of 8000+ enquiries was cleared in preparation for the implementation of their new UPM system in January 2015.
7.6	An agreement should be sought with SYPA regarding the staff based at the SYPA satellite office that results in either Capita/SCC taking control of the tasks they perform, having control over these staff or SCC no longer being held accountable for these performance targets.	High	Peter White, HR Service Manager	01/07/2016 Revised implementation date: 1/4/2017	**Action ongoing** SCC HR met with the Head of SYPA (Gary Chapman) on 13/5/16 to discuss the management and performance of the SYPA Sheffield Office. As a result of these discussions the Head of SYPA confirmed at the AGM that local Pensions Offices will support all Pensions members within their region going forward and not just the Councils' employees/members. HR is to review the funding arrangements for the Sheffield Office as it is currently solely funded by SCC. Recent figures obtained by HR demonstrate that nearly 50% of appointments are now taken by non-SCC employees/members.
7.7	It is recommended that an SLA is agreed with SYPA defining what performance levels we expect from them, to be implemented when the Pensions Administration Strategy is. Alongside this, the SLA will need to be monitored so that we are receiving the service we expect.	High	Peter White, HR Service Manager	01/04/2016	**Action complete** The new Pensions Administration Strategy was implemented by SYPA on 1/4/16 and contains the levels of performance we can expect from them. Their adherence to these standards has been raised with SYPA on 4/11/16 by SCC.

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

As at July 2016
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.

As at Jan 2017
An update on progress made with the recommendation implementation is included below. 6 out of 8 recommendations have been implemented and with work ongoing on the remaining 2.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position - Interim Head of Service, Capital Delivery Service 30.11.16
8.1	In order to maximise the benefits to be derived from the centralisation of capital delivery, the Executive Director of Place should consider the incorporation of all associated services, such as the UED in to a consolidated Capital Delivery Service (CDS). As part of the capital project initiation process both within Place and the other portfolios, consideration should be given to the use of CDS as first call for the provision of project management and associated delivery services. It is further recommended that the Executive Director, Place raise this matter at EMT for discussion with all Executive Directors.	2 - High	Director of Business Strategy & Regulation, Place	30/12/2016	**Action complete – now business as usual.** Discussions have been help with Parks and an Achieving Change is due issued for a proposed transfer of staff and duties to CDS. The potential incorporation of relevant UED functions into CDS will be considered as Place prepares to implement its major change project 'A Business Like Place'. At its meeting on 1st November EMT reconfirmed that CDS are the Council's Centre of Excellence for Capital Project Delivery and are to be used for the delivery of all capital projects. A further detailed paper will be presented back to EMT on implementation and implications of this for services in the Council.
8.2	The roles and responsibilities of the City Regeneration Team's Project Promoters should be clarified so as to	2 - High	Director of Business	31/05/2016	**Action complete – now business as usual.**

	avoid confusion and potential duplication with those of the CDS Project Managers. This should define the limits to the Project Promoters' responsibilities and acknowledge the CDS Project Managers' role in managing the projects (In line with corporate project management and capital delivery procedures). The City Regeneration Team (and any other service) should only charge fees to individual projects subject to the prior agreement of the Project Sponsor and the availability of funding within the project budget to do so.		Strategy & Regulation, Place		A meeting has been held with Director of Creative Sheffield over role and responsibilities between CDS and City Regeneration Division (CRD) and the following was agreed. For physical regeneration schemes, City Regeneration Division (Creative Sheffield) are the client and Capital Delivery Service (BS&R) are Project Managers. There are not considered to be any outstanding issues of principle or structure with this division of roles; however more work is required to implement a positive culture of team work, transparency and collaboration. It is imperative that proper Gateway processes are followed at all times. Leadership from the two services are rolling out a further cycle of training and consultation to implement the required processes. This will reinforce the roles of each team and identify any areas of overlap and duplication. Any identified areas of duplication will result in a transfer of resources from CRD to CDS.
8.3	Transitional and successor planning arrangements should be introduced for the effective hand-over of responsibilities in order to ensure the prompt and effective roll-out of the new Capital Approvals	2 - High	Director of Business Strategy & Regulation,	31/03/2016 Revised implementation date 1/4/2017	**Action ongoing** Following the endorsement at EMT on 1st of November of CDS

	Framework. In the short term, the acting post holder should be given suitable support and guidance to avoid unnecessary delays and the effective embedding of the arrangements across the Council.		Place		as the Capital Delivery Centre of Excellence and resolution of the future of Property following the insourcing of Property Services it is now intended to recruit to the permanent Head of Service.
8.4	Recommendations raised at 1.1, 1.2 & 1.3 further apply to these findings. Consideration should be given to alternative methods of funding the PMO. Actions agreed as part of the Head of CDS's report in to fees and charges should be implemented within appropriate time frames so as to further embed the service as the Council's provider of project design, management and delivery functions.	2 - High	Director of Business Strategy & Regulation, Place	31/03/2016 Revised implementation date 1/4/2017	**Action ongoing** Following EMT on the 1st November a meeting is to be held between the Director of BS&R and Executive Director of Resources to review current CDS fee structure. The detailed paper back to EMT referred to earlier will include the benchmarking of CDS fees both internally with other fee charging services and externally with appropriate consultancy rates.
8.5	The Executive Director, Place should request a mandate from EMT requiring all services initiating capital projects to utilise CDS for project management and delivery, design and contract administration, where ever feasible. Services should be required to formally apply to EMT for exemptions to these arrangements, setting out the cost implications and the benefits in doing so.	2 - High	Director of Business Strategy & Regulation, Place	31/05/2016	**Action complete** This item is covered in the response to 8.1 above.
8.6	Internal Audit agrees with the action proposed by the CPG to reject multiple-gateway applications (ie those skipping Gateways 0 and 1 without Outcome Board & CPG approval). Over and above this, however, the sponsors and service managers in question should be formally reminded of the need to adhere to the corporate Capital Approvals Framework and the benefits in robust project management to be derived from doing so.	2 - High	Director of Business Strategy & Regulation, Place	31/05/2016	**Action complete – now business as usual.** There has been further work at Programme Boards and CPG over ensuring all projects follow the Gateway Process. This has led to improvements in compliance with the process and will continue to be monitored by the PMO and reported to CPG.

	Particular attention should be paid to ensuring all services comply with the requirement for submission at Gateway 3 to ensure appropriate use of all available capital resources.				
8.7	Sponsors not having undertaken training in the new Capital Gateway process should be required to do so as part of the planned roll-out of the revised Framework in April 2016. Over and above this, training should be provided to all new officers nominated to be Project Sponsors.	3 - Medium	Executive Director of Resources & Director of Business Strategy & Regulation, Place	30/04/2016	**Action complete – now business as usual.** Revised training and awareness of the process has now been undertaken with Sponsors and Programme Boards. Any new sponsors will also be trained in the process.
8.8	All Project Managers should be required to comply with the capital delivery and approval procedures and complete the standard monthly monitoring templates.	3 - Medium	Director of Business Strategy & Regulation, Place.	31/05/2016	**Action complete – now business as usual.** A report was taken to EMT on progress with the Capital Gateway approval and monthly performance reporting on 11th October. These reported good progress with completion of monthly reports and this has continued with last month seeing in excess of 90% completion. This will continue to be monitored by the PMO and will be reported monthly to CPG and EMT.

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

As at July 2016
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.

As at Jan 2017
An update on progress made with the recommendation implementation is included below. In summary 24 of the 31 recommendations have been completed and work is ongoing with the remaining 7 recommendations. A follow-up audit is currently underway and will validate the update provided through limited testing.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Update from Simon Richards - Head of Quality & Safeguarding 21/11/16
9.1	Management should establish and formally document the objectives of the section. The objectives should have a clear link to the corporate objectives of the council, and be subject to regular (at least annual) reviews.	Medium	Simon Richards - Head of Quality & Safeguarding	31/03/2016	**Action complete** Service Plan objectives in place.
9.2	It is recommended that an operational plan is produced and documented for the DOLS team which: o Reflects corporate, portfolio and other objectives/requirements: o Reflects statutory requirements o Details how the service is to be delivered o Is regularly reviewed o Is supported by adequate resources.	High	Simon Richards - Head of Quality & Safeguarding	29/02/2016	**Action complete** Service Plan objectives in place.
9.3	Management to bring together all their risk management information into a formal risk management plan in the approved SCC format. The risk management plan to be a regular agenda item and so subject to regular review.	Medium	Simon Richards - Head of Quality & Safeguarding	31/07/2016	**Action complete** Management have brought together all their risk management information into a formal risk management plan in the approved SCC format. The risk management plan is a regular agenda item at the Care and Support Leadership Team (CSLT) meetings and so subject to regular review.
9.4	Management should ensure that all the identified senior managers complete their training as soon as possible and establish an implementation date for the formal quality assurance process by senior management.	Medium	Simon Richards - Head of Quality & Safeguarding	29/02/2016 Revised implementation date: 13/12/2016	**Action ongoing** Training has been delivered to senior managers to enable them to authorise assessments (29.4.16) One senior manager attends scrutiny panel each month to QA. We have 2 more senior managers to attend panel and following this

					we will review formal quality assurance process by senior management.
9.5	The service should develop a detailed action plan to clear the backlog in the DOLS and CoP DOLS requests and reassessments. In clearing the backlog situation, management should also ensure that adequate resources are allocated to expedite new applications and upcoming reviews to prevent these cases being delayed. Progress on clearing the backlog to be reported monthly.	Critical	Simon Richards - Head of Quality & Safeguarding	31/03/2016 Revised implementation date: 31/03/2017	**Action ongoing** Action has been taken to ensure the risks posed by the backlog are fully understood, taking into consideration the reduced resources available. Progress on clearing the backlog is reported monthly. In accordance with the risk assessment, work continues to shift the team's focus from predominantly carrying out reassessments to prioritising the most urgent cases (across new assessments and reassessments). This has included completing the process review (Lean Cycle) work, and piloting an approach based on prioritising the most urgent cases and implementing proposed process efficiencies from the review. Overall the pilot has shown that it is possible to optimise productivity by establishing process timescales and standards. Whilst some increases in output are being achieved with existing resources these are insufficient to make any appreciable difference to the level of risk inherent in the size of the backlog. A Business Case recommending

					additional funding to address DOLS backlog was discussed at PLT 05/10/16. PLT has agreed that carrying the current and projected level of risk is not a preferable option and that the allocation of further resource would be needed to mitigate this. However, as at 28/11/16, PLT has not yet made a decision on the recommendations. The Director of Adult Services is to escalate and pursue this matter. Once finally agreed, this will need to go to tender – hence the revised implementation date.
9.6	A full progress report should be compiled monthly to include all DOLS applications from care homes and DOLS applications in regard of Supported Living which are progressed via the Court of Protection and managed by Legal Services. These should be stated separately to ensure that the performance of the two areas can be monitored. Action to address the poor performance against statutory targets should be identified and monitored.	High	Simon Richards - Head of Quality & Safeguarding	31/03/2016	**Action complete** A full progress report is compiled monthly and reported to CSLT. This includes an update on performance and risk in relation to all DOLS applications (including specific reference to DOLS applications from care homes and CoP DOLS). Action to address the poor performance against statutory targets has been identified and is monitored.
Court of Protection DOLS – Leadership					
9.7	Internal Audit recommends that a lead person should be assigned for Court of Protection DOLS, and they should perform a full review of the current situation and the actions required to address the backlog of cases. This review to be presented to the service management team/portfolio leadership team and the executive management team as a priority.	Critical	Simon Richards - Head of Quality & Safeguarding	31/03/2016	**Action complete** We now have a designated contact in Legal services for CoP DOLS, and work has been undertaken on the current situation and backlog of cases.

9.8	To fully and clearly document the process regarding CoP DOLS.	High	Simon Richards - Head of Quality & Safeguarding	31/03/2016	**Action complete** Process is in place.
9.9	Establish clear lines of responsibilities for the CoP DOLS regarding actions to be taken by the supported living team and those by legal. All CoP DOLS to be detailed and monitored within an appropriate format, with regular reports to senior management produced detailing progression of cases and any issues hindering progress to be noted. The reports should be presented to regular service management team and to the DOLS Task Group.	High	Simon Richards - Head of Quality & Safeguarding	31/03/2016	**Action complete** Legal have in place a file-closing procedure which is sent to clients upon receipt of a final order. This provides detailed instructions on the review hearing date and what is required from the client in order to comply with and meet court deadlines i.e. the date a worker should be allocated by and when statement is due (in practice if there are no significant change in circumstances this will be done on the papers). Legal then diarise these review dates centrally in an outlook calendar accessible by all legal staff to account for changes in personnel, this then alerts us to contact the client and inform them that a review is imminent and to allocate a worker (if not already done so as per the above process).
9.10	Supported Living management and legal representatives to perform a joint review of all CoP DOLS documents required as evidence and report concerns in the quality of this to the relevant Head of Service in order that these concerns can be addressed (and staff completing these given guidance) to ensure they meet the standards required for the CoP.	High	Simon Richards - Head of Quality & Safeguarding	31/03/2016	**Action complete** Training and exemplars where necessary have been provided to the LD and adult client service.
9.11	In order to ensure consistency of information, standard letters should be determined, documented and used to communicate the CoP decisions to the relevant interested parties. These should clearly state	High	Simon Richards - Head of Quality & Safeguarding	31/03/2016 Revised implementation date: 31/01/2017	**Action ongoing** No standard letter in terms of informing interested parties that a

	the decision of the CoP and their responsibilities to notify of changes etc. Copies of the letters sent should then be held on the carefirst/wisdom system file for each client.				DOL in the community has been authorised – to be developed.
9.12	To ensure the completeness of the recording process it is recommended that all forms completed as part of the CoP DOLS process are scanned and copied into the individuals' carefirst/wisdom records.	Medium	Simon Richards - Head of Quality & Safeguarding	31/03/2016 Revised implementation date: 31/01/2017	**Action ongoing** Liaison between Legal Services and DOLs office ongoing to look at access to CareFirst and Wisdom systems to develop a practical solution to this issue. Legal do not have access to Care First, however have proposed that they could incorporate a sentence/paragraph within their initial instructions form requesting that the client upload the form to Wisdom once completed and sent to legal.
9.13	All DOLS requests should be treated consistently; therefore the carers responsible for clients in supported living arrangements should receive a letter acknowledging the CoP DOLS request and the care arrangements for the client pending the decision on the CoP DOLS request.	High	Simon Richards - Head of Quality & Safeguarding	31/03/2016 Revised implementation date: 31/01/2017	**Action ongoing** Confirmed that legal will notify interested parties of any other hearing. Work is ongoing with legal to complete this.
9.14	Establish plans to manage and support those affected by the decommissioning of Supported Living establishments where CoP DOLS had been requested	High	Simon Richards - Head of Quality & Safeguarding	31/03/2016	**Action complete** Process in place. Once supported living establishments are decommissioned, DOLs office notify the service and Legal that they have been ceased under the DOLs process and need to be authorised under the CoP.
Care Home/Hospital DOLS					
9.15	To ensure best practice it is recommended that a formal set of procedures for the management and	Medium	Simon Richards - Head of Quality &	31/03/2016	**Action complete**

	application of DOLS are produced. The procedure notes should incorporate and reflect the best practice guidelines and be subject to regular review.		Safeguarding		It is our assessment that the Association of Directors of Social Services (ADASS) guidance that the team follows provides a comprehensive set of procedures for the management and application of DOLS. Due to this it would be unnecessary duplication to complete separate procedures (particularly in light of the pressure on resources and the imminent release of new Law Commission guidance).
9.16	It is recommended that clear procedures are drawn up to ensure consistency of approach in prioritising both urgent and standard cases.	Medium	Simon Richards - Head of Quality & Safeguarding	31/03/2016	**Action complete** All Standards & Urgent applications that come in continue to be listed and sent to the duty manager at the end of each day to be looked at and prioritised. We now have a process in place to ensure consistency of approach in prioritising both urgent and standard cases. See also 9.15
9.17	The backlog of cases should not impact upon the requirement to inform relevant parties promptly, of the decisions made in regard of DOLS. The section should therefore review the timescales to determine realistic targets for completion of risk assessments, quality assurance and the issuing of letters to communicate the decisions to relevant parties. The revised timescale targets should then be monitored and reported upon.	Medium	Simon Richards - Head of Quality & Safeguarding	31/03/2016	**Action complete** A timescale has been agreed from the point of authorisation to the issuing of communications. This timescale is 10 working days.
9.18	Copies of all correspondence relating to clients should be held within the wisdom section of Carefirst.	Medium	Simon Richards - Head of Quality & Safeguarding	31/03/2016	**Action complete** A dip sample has been undertaken and clarity with regard to business support procedures

					has been issued.
9.19	All persons, especially family members, identified by the Best Interest Assessment as having an interest in the client should be formally informed of the DOLS decision. This should include the starting date and the date of review. Copies of letters should be retained in the carefirst records of the client.	Medium	Simon Richards - Head of Quality & Safeguarding	31/03/2016	**Action complete** A review date has been added to all letters. Business support now routinely upload copies of letters to Wisdom.
9.20	All correspondences should be sent out to inform interested parties within one week of the DOLS decision being made.	Medium	Simon Richards - Head of Quality & Safeguarding	31/03/2016	**Action complete** A realistic timescale has been set for correspondence. (See 2.11). One week is not considered to be realistic with current Business Support staffing.
9.21	All forms used should be formally dated and subject to regular annual review to ensure they meet legal requirements.	Efficiency/Effectiveness	Simon Richards - Head of Quality & Safeguarding	31/03/2016	**Action complete** Date added to form. Annual review of all DOLS forms agreed.
9.22	Management should review the existing contract with the mental health service to ensure it is adequate, considering the number of clients who are still waiting for a paid representative.	High	Simon Richards - Head of Quality & Safeguarding	31/03/2016	**Action complete** A contract is now in place and it is regularly monitored.
9.23	The allocation of relevant person representatives (RPR) to clients should ideally consider which RPR already visits the care home where the client is based, unless the client either requires the skills set of a specific relevant person representative, or is transferring care homes (due to care requirements) where to change the relevant person representative could cause further distress. In all cases, each client should be allocated a named paid representative who will be responsible for visiting them regularly on a one to one basis. This should be added into future funding agreements with Sheffield Citizens Advice Mental Health Unit & Advocacy Service DOLS Relevant Person's Representative Service.	Medium	Simon Richards - Head of Quality & Safeguarding	31/03/2016	**Action complete** RPR service inform DOLS office when they have capacity to take cases from the backlog. Consideration is given to the clients/locations they are already visiting, but the main criteria are priority of the case for allocation using ADASS risk assessment Tool. We are continuing to take account of this recommendation where it does not conflict with the above.
9.24	Management should ensure that a signed Form 25 is	Medium	Simon Richards -	31/03/2016	**Action complete**

	received from the paid representative service for each of the clients they are allocated, and the person signing the Form 25 should be the person allocated to the client. This should be checked by Management before scanning into the client records in carefirst.		Head of Quality & Safeguarding		The process of receiving signed form 25s has been reviewed and revised. A form 25 is now only required at the beginning of the first authorisation, and if there is a change in RPR**.**
9.25	It is recommended that the financial procedures are formally documented and finance business partner to be consulted to ensure the procedures concur with SCC financial guidance.	Medium	Simon Richards - Head of Quality & Safeguarding	31/03/2016	**Action complete** Work has been done with the finance business partner to address this.
9.26	Anyone working for SCC is representing the council and should be made aware of this responsibility. This is the purpose of the staff induction and the signing of the code of conduct acknowledges this responsibility. The service should ensure that all staff have received an appropriate induction and have all signed the code of conduct.	Medium	Simon Richards - Head of Quality & Safeguarding	31/03/2016	**Action complete** All BIAs had signed the code of conduct. All BIA's are supported to access relevant SCC information relevant to their duties.
9.27	There should be a documented training and development plan for the section that is compiled following mentoring/1:1 sessions or team meetings for the section. This would ensure that gaps in training requirements etc. are identified and that specific training can be investigated or developed and the relevant individuals targeted as to their needs. The delivery of training and development should be monitored and reported against the training and development plan at management meetings.	Medium	Simon Richards - Head of Quality & Safeguarding	30/09/2016 Revised implementation date: 31/03/2017	**Action ongoing.** BIA's have to attend specific training to keep their qualification. Training and development is an item in all supervision records, and this is fed in through the Training and Development Plan. We have a buddying process with business support. We are reviewing the service plan to ensure learning and development is covered.
9.28	Management to perform a full review of DOLS and address the current staffing issues by deciding and actioning measures which will create a more robust service. The progress of this review should be a regular	High	Simon Richards - Head of Quality & Safeguarding	31/03/2016	**Action complete** Completed the review and all recommendations have been incorporated into the risk plan. Work continuing on processes

	agenda item in senior management meetings and reported at portfolio leadership team and executive management team levels until satisfactory. The backlog of DOLS should be detailed in the Risk Management Plan.				and performance.
9.29	To formally document the identification of stakeholders and methods of communication with stakeholders within a communication plan. This plan to be subject to regular review to ensure it remains up to date with stakeholder contact information (care homes/hospitals).	Medium	Simon Richards - Head of Quality & Safeguarding	31/03/2016	**Action complete** As part of our shift to focus on the most urgent cases (see 9.5), we formally documented the identification and methods of communication with stakeholders within a communication plan.
9.30	To ensure that suitable guidance on data sharing arrangements and protocols and encryption are also included (or a suitable link provided) on the Elma site.	Medium	Simon Richards - Head of Quality & Safeguarding	31/03/2016	**Action complete** We have now added a link from ELMA to the corporate information sharing and governance intranet pages.
9.31	The new contract for RPRs, to include stated requirements regarding the security of the sensitive information handled by staff used by the contracted supplier, and the procedures to report any such instances of security breaches.	Efficiency/Effectiveness	Simon Richards - Head of Quality & Safeguarding	29/02/2016 Revised implementation date: 31/03/2017	**Action ongoing** Work is ongoing to raise awareness in Commissioning Services about corporate requirement for contracts to detail information security procedures and information sharing arrangements in contracts (in a Data Processing Agreement). We will ensure that the new contract for RPRs includes this.

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

As at July 2016
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.

As at Jan 2017
An update on progress made with the recommendation implementation is included below. 8 out of 17 recommendations have been implemented and with work ongoing on the remaining 9.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position - provided by Head of Quality and Safeguarding 1/12/2016
10.1	Whilst internal audit recognised that safeguarding in Sheffield was part of the Safeguarding Adults Strategic Partnership (SASP), objectives for the service in Sheffield City Council should be considered and put in place. As a minimum it should be recorded that the service follows the objectives as per the SASP.	Efficiency/Effectiveness	Simon Richards, Head of Quality and Safeguarding	31/07/2016	**Action complete** The Safeguarding Adults Strategic Partnership has a 3 year strategic plan in place and an annual business plan. SCC, as the lead partner agency, continues to be signed up to deliver the objectives in these plans. The Safeguarding Adults Office (SAO) Service Plan has been updated to directly reference that the Service follows the objectives as per the SASP.
10.2	Internal Audit recommends that Safeguarding put together a single document to state that South Yorkshire Procedures are followed, with the exception of the Self Neglect Model, which is Sheffield's own. It should also include that there is no 'near miss' process, and that in these cases the safeguarding process should be followed. It should also include that the council-wide Serious Incident Policy is followed.	Medium	Simon Richards, Head of Quality and Safeguarding	30/04/2016	**Action complete** The Safeguarding Adults Office Service plan has been reviewed to cover these points. The existing SCC procures reference the Self Neglect Risk Management Model and the SY Procedures state that each South Yorkshire area is developing or has their own defined policy in dealing with this subject. The Communities Serious Incident Policy clarifies that if at any time a vulnerable person is

					deemed to be at risk then Safeguarding procedures must be instigated (page 5).
10.3	The Managing Self Neglect model should be reviewed and updated to clearly state who the document is aimed at, the process to be followed, and what mandatory information is required. Ideally this should be a step by step user guide that is subject to review on at least an annual basis.	Medium	Simon Richards, Head of Quality and Safeguarding	30/04/2016	**Action complete** The Self Neglect Risk Management Model states who the document is aimed at, the process to be followed, and what mandatory information is required. It is subject to review on an annual basis.
10.4	Internal Audit recommends that the safeguarding processes explicitly include that there is no separate near misses policy and that near misses go through the same process as safeguarding.	Medium	Simon Richards, Head of Quality and Safeguarding	30/06/2016 Revised implementation date: 31/03/17	**Action ongoing** A further review of the South Yorkshire Safeguarding procedures has been commissioned by SASP Board – this action will be considered as part of this review.
10.5	Linked to the above recommendation, once the safeguarding process has been formalised and put in place, management should ensure that all staff and appropriate stakeholders have access to them, either via Elma or the internet/internet.	Medium	Simon Richards, Head of Quality and Safeguarding	30/04/2016 Revised implementation date: 31/03/17	**Action ongoing** The current Safeguarding Process is available via ELMA (Adult Care and Support Manual). The SY Safeguarding Procedures are on the SCC website. A further review of the SY Safeguarding procedures has been commissioned by SASP Board – this action will be considered as part of this review. A South Yorkshire website will also be up and running by March 2017 and this will host all procedures.
10.6	To ensure completeness and accuracy of information, management should provide clear	High	Simon Richards, Head of Quality	31/07/2016	**Action ongoing**

	guidance on the mandatory safeguarding information required. It should be clearly stated what system these must be recorded on and in what format. There should be a requirement for mandatory details on one system eg: carefirst, with notes made stating when other systems may hold supplementary information.		and Safeguarding	Revised implementation date: 31/03/17	The current Safeguarding Process is available via ELMA. The SY Safeguarding Procedures are on the SCC website. We are currently reviewing the internal SCC safeguarding process as part of the wider SY procedures review. This work is designed to simplify the process so practitioners are clearer about what are the mandatory requirements. Once this work is completed we will be able to fully meet this requirement.
10.7	Management should introduce a more robust checking system, whereby a proportion of screened out concerns get revisited by Safeguarding. This will enable Safeguarding to identify any trends and introduce more training within service if the same types of concerns are being screened out when they should be proceeding to the next stage.	Medium	Simon Richards, Head of Quality and Safeguarding	31/07/2016 Revised implementation date: 31/03/17	**Action ongoing** We monitor re-referral rates back into Safeguarding as part of monthly performance reporting to Care and Support Leadership Team. We also now have stronger quality assurance at the point of which Safeguarding concerns are raised, with advanced practitioner direct oversight. However, we are still in the process of developing a case file audit mechanism to review individual cases – progress on this has been inhibited due to the pace of internal change and we will therefore introduce this as part of 2017/18 service planning.
10.8	Internal Audit recommends that the Adults Safeguarding Office and Commissioning work more closely together when dealing with safeguarding concerns about care providers, and that this is included in the processes being put into place in	High	Simon Richards, Head of Quality and Safeguarding	30/09/2016 Revised implementation date: 31/03/17	**Action ongoing** We recognise that once a significant risk occurs, we do have good cross working in place,

	Sheffield. This would ensure that both teams are aware of any problem or potential problem with a provider. In addition, it is advised that operational teams have a stronger link with both Adults Safeguarding Office and Commissioning, so that the operational teams are kept aware of policies, procedures and problems with providers. To ensure that all concerns with regard to safeguarding are captured, a contract concern form should be completed for all incidents related to an independent provider. Management should ensure that this is included as part of the new processes being put in place.				however more structured engagement with Commissioning is still required to achieve necessary assurance once a major issue is identified. SAO is represented at KPI meetings where provider performance is evaluated. Risk assessment for individual providers is informed by Safeguarding activity. Improvement to the Safeguarding screening process means that those Safeguarding issues best dealt with via contract management are now notified directly to commissioning. Protocols are being put in place to support this work – to be completed by 31/03/17 This work has been delayed by the absence of the Head of Service in Commissioning (replacement shortly to take up post and we will prioritise discussion on this).
10.9	Internal Audit recommend that clear, measurable performance measures are put in place, with a clear reporting structure and a clear way of feeding these back to other key stakeholders (e.g. service). This could be, for example, time taken between receiving a concern and a case conference.	High	Simon Richards, Head of Quality and Safeguarding	31/03/2016	**Action complete** A robust and comprehensive Performance Management Framework is now in place, with measurable performance measures (including time taken between all key stages and end to end timescales). We have a clear reporting structure whereby performance is scrutinised on four weekly cycle by Care and Support Leadership

					Team (CSLT) and reported to SASP Board at every meeting. CSLT and SASP are responsible for feeding information back to other key stakeholders (e.g. service) as required.
10.10	Internal Audit recommends that as part of the Sheffield processes, a resolution policy is put in place. In addition, it should be clear within the processes how and who to report problems to and any actions that could be taken as a result of this.	Medium	Simon Richards, Head of Quality and Safeguarding	31/03/2016	**Action complete** We have had a dispute resolution policy in place since June 2014. It clearly states how and who to report problems to and any actions that could be taken as a result of this.
10.11	Internal Audit recommends that all job descriptions be brought up to date with current arrangements. In addition it is recommended that the structure chart be reviewed at least annually, with a review date recorded on the chart.	Efficiency/Effectiveness	Simon Richards, Head of Quality and Safeguarding	31/03/2017 Revised implementation date: 30/6/2017	**Action ongoing** We are working on the basis that we will update Job Descriptions as and when they require review as part of wider change (For example, the Head of Service JD has been reviewed / amended as part of the Care and Support Leadership Team review). This will be picked up as part of the ongoing redesign of ASC (commencing 2017/18), however full review for SAO is not expected until 2018/19. Structure chart has been reviewed and is up to date.
10.12	Internal Audit recommend that succession planning/continuity planning takes place so that all the knowledge, experience and expertise that the service manager has is made available to the wider team and management.	High	Simon Richards, Head of Quality and Safeguarding	31/12/2016	**Action complete** This was addressed at the point which the service manager post was deleted as part of the service manager MER across C&S (summer 2016).

10.13	Internal Audit recommends that management identify those staff who have not had an appraisal in the last 12 months and ensure that they are included in the next round of appraisals.	High	Simon Richards, Head of Quality and Safeguarding	30/06/2016 Revised implementation date: 31/03/17	**Action ongoing** All appraisals are being picked up in the current round of appraisals (Head of Service has now taken over line management arrangements for the team, following deletion of service manager post).
10.14	It is recommended that formal agreements are in place for all partnerships and collaborative workings. In addition, it is recommended that all external partners have formal communication channels in place.	High	Simon Richards, Head of Quality and Safeguarding	30/04/2016	**Action complete** We have a prospectus in place which governs the relationships between partners, as well as the SY Safeguarding Procedures. The SASP provides an opportunity for formal communication channels between external partners.
10.15	Management should ensure that there is a process in place to take account of feedback and learning from complaints.	Medium	Simon Richards, Head of Quality and Safeguarding	31/03/2016 Revised implementation date: 31/03/17	**Action ongoing** The Safeguarding Customer Forum has a regular slot at the Operational Board to raise 3 priorities which the Operational Board then responds to. Complaints are managed through the SCC complaints process. Although we currently review feedback and complaints this continues to be a priority area for development - there is currently a piece of work on improving learning from complaints that is being carried out across Care and Support (this will include Safeguarding).
10.16	It is recommended that all data sharing agreements are logged with the Council's Information Sharing	High	Simon Richards, Head of Quality	30/04/2016	**Action ongoing**

	Agreements Sharepoint site.		and Safeguarding	Revised implementation date: 31/03/17	The SY Safeguarding Procedures includes a section on information sharing. This is now saved on the ISA SharePoint site. . The aim of this section is to facilitate and provide clear guidance on the exchange of personal and sensitive information for the investigation and responding to suspected Abuse and neglect of adults within South Yorkshire. Further work is ongoing to develop detailed Information Sharing Agreements to support the SY Safeguarding Procedures.
10.17	Management should ensure that at process is put place to handle breaches in security, and that all staff are made aware of this.	High	Simon Richards, Head of Quality and Safeguarding	30/04/2016	**Action complete** We continue to follow the Communities Serious Incident process in relation to information security breaches. Staff are aware of the process and the requirement to follow it.

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

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

As at Jan 2017
An update on progress made with 1 recommendation reported as ongoing in the last report, is included below.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position - provided by Senior Facilities Manager 25.11.16
11.1	Management in P&FM should work with Corporate	High	Nathan	1.6.2016	**Action complete**

	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.		Rodgers, Head of Service, Facilities Management	Revised implementation date 31.7.16	All technical and IT changes identified in the review have been implemented. All standard operating procedure have been reviewed and updated as required. Improved controls have been put in place to tracked, sensitive, valuable and signed for items to improve audit trial to the users.

Internal Audit proposes to remove this item from the tracker.

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

As at July 2016
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.

As at Jan 2017
An update on progress made with the 3 ongoing recommendation implementation is included below. 2 recommendations have been implemented and are now business as usual, and 1 is still ongoing. Service management wanted to highlight the significant impact that the current tree campaign has had on the highways maintenance programme, and the delays this has caused in implementing all recommendations.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position provided by the Head of Highways Maintenance 7/11/2016
12.1	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	**Action complete** – business as usual The action has taken a different route. The Refinancing proposal now has as part of it, a Contract Monitoring Protocol that both parties agree to implement, that changes how we monitor the contract. The biggest change is that we agree to bring failures to their attention rather than continue our

					previous approach which was to let them continue as a check of Amey's self-monitoring. The agreement does however require Amey to be more visible about how they self-monitor which will help. In addition we are reviewing customer contacts to identify themes for analysis and also any regular failure areas are subject to specific improvement plans. Customer Service responses in particular are included in the refinancing agreement. Further we have established a new Service Operations Panel to review deductions and failures and that seems to be having a positive effect.
12.2	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	**Action complete** – business as usual There have been many errors in the allocation of customer reports to performance requirements and so meetings have continued plugging away at the issue. Because the situation is continuing, as is the analysis and findings, it is not possible to set a completion date and the work is likely to carry on for a year or two or more. The key thing is that the reviews will continue.
12.3	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.	High	Head of Highways Maintenance	31/12/2015 Revised Implementation date 31.5.17	**Action ongoing** The junior positions have been filled but the Technical manager post is unfilled. Currently an

	Consideration should be given to alternative recruitment strategies.				officer has been seconded from the Capital Delivery Service. The impact of the trees campaign has continued and worsened and so the focus has been on dealing with this.

13. 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 was provided. It should be noted that the findings from this review are being addressed as part of a wider corporate project establishing integrated transition arrangements.

As at Jan 2017
Internal Audit: An update of progress with the 11 recommendations outstanding in the last report was requested. The Head of Learning Disabilities/Mental Health and Transitions, Communities stated that "Communities management are liaising with CYPF management to analyse and determine actions required given the changes to the Transitions team in CYPF; who own the process. A number of the agreed recommendations are ongoing, due to a change of direction and a more positive approach to children's transition to adult social care". Given that 8 recommendations are still classed as ongoing, Internal Audit will re-perform a full review of Transitions as part of the 17/18 work programme.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position - provided by Phil Holmes, Director of Adult Services, Communities and Dawn Walton, Assistant Director of Children and Families, CYPF **(1.4.2017)**
13.1	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	3 - Medium	Anne Flanagan, Interim Head of LD.	30/06/2014 Revised implementation date :	**Action ongoing** Service Plans are currently being developed that will fully

	line with Corporate and legislative objectives, be consistent within CYPF and Communities, and should be agreed by management from both portfolios.		Dorne Collinson, Director, Children and Families.	1/4/2017	incorporate recommendation 13.1. Joint objectives will 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. The overall intention 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.
13.2	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 : 1/4/2017	**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. The transitions service will align with the SEN team to ensure a clear pathway for individuals with an EHCP in Sheffield. Adult Social Care will provide support to this agenda and will have two designated social work posts within the team to improve transitions from the age of 14.
13.3	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 : 1/4/2017	**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.
13.4	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 : 1/4/2017	**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.
13.5	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 care systems, a training and development plan should also be considered to ensure that information is recorded appropriately.	1 - Critical	Anne Flanagan, Interim Head of LD. Dorne Collinson, Director, Children and Families.	30/09/2015 Revised implementation date : 1/4/2017	**Action outstanding** This is accepted. The introduction of new legislative requirements (as referred to in 13.1) has delayed this piece of work while strategy and performance management framework are being put into place. The clear mandate from the 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.
13.6	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 complete** 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.
13.7	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 complete** 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.
13.8	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 : 1/4/2017	**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. An integrated approach to commissioning supported by life cycle planning will be implemented to achieve a more effective profiling of long term support needs.
13.9	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 : 1/4/2017	**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.
13.10	Results of feedback from service users and other stakeholders should be collated and reported to management. Any actions taken to inform service planning, or staff training and development as a result of feedback should be documented and agreed.	2 - High	Anne Flanagan, Interim Head of LD. Dorne Collinson, Director, Children and Families.	30/06/2015 Revised implementation date : 1/4/2017	**Action ongoing** Complaints from young people 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. CYPF: Have a strong Parent Carer Forum that provides good

					feedback on user and carer experience. This is supported through a range of individual child / young person's participation work both internally and externally from the council and voluntary sector providers.
13.11	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 complete** 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.

14. 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 was provided.

As at Jan 2017
Internal Audit: An update of progress with the 4 recommendations outstanding in the last report is provided below. 3 recommendations have been implemented, and 1 has elements that are still ongoing.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position - provided by External Funding Manager 25.11.16
14.1	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. Revised implementation date 31.3.17	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. Where necessary, excessive delays in Leader's scheme reports are progressed with appropriate level of management. **– Action complete** A presentation on the operation of the Leader's Scheme of Delegation has now been delivered to Resources Leadership Team. Further presentations will be delivered to all Portfolio Leadership Teams, during December and January – **Action ongoing** Legal and Governance have

					recently changed the Leaders' Scheme approval levels (June 2016) so that the block approval report for annually recurrent grants, previously intended for Cabinet, can be signed off by the Cabinet Member. The report was approved by the Cabinet Member for Finance and Resources in August 2016. – **Action complete**
				Revised implementation date 31.3.17	In agreement with Legal, a speedier approval process has been developed whereby new non-EU grants below £100k can be signed off more efficiently without diminishing Finance and Legal controls. The scheme has now been submitted for management approval and will go live once it has been signed off.
				Revised implementation date : 31.3.17	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. A number of External Funding process reviews in higher priority areas have already been undertaken resulting in a delay to this one. In the interim new grant applicants are directed to the SCC's web page that explains how the Leader's Scheme works and the documents needed to be completed for grant applications. **Action ongoing**
14.2	A timescale should be set for the implementation of the use of SharePoint for recording all key grant funding information.	High	Finance Manager, External	September 2015	**Alternative action completed** Given the specialist and technical

	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.		Funding		nature of the project along with resource pressures and the increased volume of new grant workloads, SharePoint is not able to be implemented during 2016/17. However, there is full commitment to the use of SharePoint. In order to minimise risks in the interim, current electronic record retention processes have been reviewed and there have been improved checks and controls made on all current grant record keeping with a particular focus and emphasis on record retention for current EU projects.
14.3	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 complete** A new updated grant claims checklist template, where the specific grant roles of each party including Project Managers are more clearly defined, and which requires all parties to sign has been developed and is now being used.
14.4	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	2 - High	Finance Manager, External Funding	June 2015 Revised implementation date : 31.8.16	**Action complete** This recommendation has been adopted and is now operational.

	grant conditions. Where they cannot provide this assurance, they should seek advice immediately from the External Funding Team.				

15. 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
An update of progress with the 6 recommendations stated as being 'on-going' in the last report was provided.

As at January 2017
An update of progress with the 2 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 11.11.16
15.1	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 30.06.17	**Action ongoing** The new guidance is prepared and will be actioned when the Director of Policy Performance and Communications (PPC) issues revised service planning guidance. PPC decided not to issue revised guidance until the strategic business plan was completed. As completion has taken longer than anticipated it is likely to be with the guidance issued for the 17/18 business planning cycle.
15.2	All portfolios and services should monitor	High	All executive	31.03.15	**Action ongoing**

	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.		directors	Revised implementation date 30.06.17	To form part of guidance detailed at 13.5 above.

16. 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 was 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.

As at Jan 2017

An update has been obtained from the Place SharePoint recommendation tracking system for the 3 outstanding recommendations from the last report. All have now been completed.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position taken from the Place SharePoint recommendation tracking site 8.11.16.
16.1	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 complete** The Information Commissioner did not visit Sheffield. The data sharing agreement was reviewed by SCC Legal Team, SYP Legal Team and the legal teams from the other districts before being signed off. Data sharing has now commenced.
16.2	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 complete** The TTAPS Programme Manager met with Commercial Service category manager to resolve and

					agree a way forward. The Corporate Capital Gateway Process includes contract awards with procurement strategies by business case. The hierarchy within QTier is being changed to allow reporting at business case level and the whole TTAPS capital programme will be visible within QTier together with associated reports.
16.3	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. 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.	Critical	Head of TT&PS	30.06.14 Revised implementation date 31.12.16.	**Action complete** This is a legacy action that was completed by January 2015. The notes at the time included: RDS Director and Interim Head of TTAPS currently reviewing the operational structures and contractual arrangements relating to the Streets Ahead core contract – as part of the outcome of from the Turner and Townsend capital programme delivery review. June 2016 Update: TTAPS Capital Programme Manager has been appointed for over a year which has clarified roles. Since the audit was undertake staff have matured into their roles and are performing at appropriate levels to deliver the capital programme effectively.

Internal Audit proposes to remove this item from the tracker.