REPORT TO SHEFFIELD CITY COUNCIL AUDIT AND STANDARDS COMMITTEE
11th January 2018

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 and Standards Committee.

4. This report also details those high opinion audits that Internal Audit propose 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:
   - External Funding (Corporate Review)
   - Intermediate Care Assessment Team (ICAT) to Short Term Intervention Team (STIT)
   - Delivery of Capital Schemes and Capital Gateway Approvals (Place)
   - Strong Economy Projects (Place)
   - Deprivation of Liberties Safeguards (DOLS) (People)

SHEFFIELD CITY COUNCIL
UPDATED POSITION ON HIGH OPINION AUDIT REPORTS AS AT JANUARY 2018

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**	**High**	**Medium**
Parking Services -cash income collection contract		7	5			2	2			5	3			
Training Centres		12	12	3		3	5	2		1		1	8	7
Subject Access Requests		7				4				3				
Controls in Town Hall Machine Room	2	3			1	2			1	1				
Continuing Health Care in Learning Disabilities	1	14	10	2		5	2	1	1	9	8	1		
Strong Economy Projects		5	4			5	4							
PCI DSS Compliance	2	1			1				1	1				
Apprinteeship Service	1	5	2		1	2	2			3				
ICT to STIT		1	2			1	2							
SCAS - Residential and Nursing Agreements		1	2				1			1	1			
The Markets Service		4				2				2				
Council Processes for Management Investigations		5	1			1				4	1			
Payroll Pension Arrangements			1								1			
Capital Schemes and Capital Gateway Approvals		2				2								
DOLs	1				1									
Safeguarding Administration		2	3				3			2				
External Funding		1				1								
Total	**7**	**70**	**42**	**5**	**4**	**30**	**21**	**3**	**3**	**32**	**14**	**2**	**8**	**7**

Shaded items to be removed from the tracker

In total, updates have been provided on 124 recommendations. Of these, 58 (47%) have been implemented and 51 (41%) are ongoing, indicating work has been started but not yet fully completed. 15 recommendations were considered to be outstanding (12%).

1. Pro-Active Work - Staff Expenses Claims (Corporate) (issued to Audit and Standards Committee 13.7.17)

As at Jan 2018
This report was issued to management on the 16.6.17 with the latest agreed implementation date of 31.12.17. 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. Pro-Active Work – Declaration of Interests (Corporate) (issued to Audit and Standards Committee 16.8.17)

As at Jan 2018
This report was issued to management on the 7.8.17 with the latest agreed implementation date of 31.3.18. An update on progress with recommendation implementation will be included in the next tracker report.

3. Revenues and Benefits Contact Centre (Resources) (issued to Audit and Standards Committee 24.10.17)

As at Jan 2018
This report was issued to management on the 10.10.17 with the latest agreed implementation date of 31.12.17. Due to the timescales for completion of this report, an update on progress with recommendation implementation will be included in the next tracker report.

4. Executor Services (People) (issued to Audit and Standards Committee 27.11.17)

As at Jan 2018
This report was issued to management on the 13.11.17 with the latest agreed implementation date of 30.4.18. An update on progress with recommendation implementation will be included in the next tracker report.

5. Pro-Active Fraud Work - Appointeeships (People) (issued to Audit and Standards Committee 4.12.17)

As at Jan 2018
This report was issued to management on the 13.11.17 with the latest agreed implementation date of 31.1.18. An update on progress with recommendation implementation will be included in the next tracker report.

6. The Licensing Service (Place) (to be issued to Audit and Standards Committee 22.11.17)

As at Jan 2018
This report was issued to management on the 22.11.17 with the latest agreed implementation date of 31.3.18. An update on progress with recommendation implementation will be included in the next tracker report.

7. Parking Services Cash Income Collection Contract (Place) (issued to Audit and Standards Committee 7.11.17)

As at Jan 2018
This report was issued to management on the 30.6.17 with the latest agreed implementation date of 30.9.17. An Internal Audit follow-up review has been completed and the results are included below.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position as a result of Internal Audit follow-up work 27.11.17.
7.1	All relevant Parking Service's SOPs should be reviewed and revised to account for changes arising due to the cash collection contract. Once revised, these should be rolled out and issued to all staff involved in the procedures in question.	Medium	Parking Services Manager	31.7.17 Revised implementation date 30.11.18	All SOPs now updated and distributed. <u>Internal Audit opinion</u> Internal Audit viewed the updated SOPS, held on the G drive. Additionally, management informed Internal Audit that 4 out of 7 staff had signed and returned acceptance of the SOPS. The 3 remaining staff was to action these on Monday 27th November. **Action ongoing**
7.2	The contractor should be required to provide a deadline for the immediate review and implementation of cash collection routes. This should be monitored by Parking Services and escalated where necessary. On-going monitoring arrangements should be established to confirm the quarterly review in line with the contract.	High	Parking Services Manager	31.7.17 **Revised Timescale** 31.12.17	The contractor couldn't provide a confirmed date for completion of collection routes at the Q2 meeting. They have been asked to supply date by week commencing 20 November 2017. The contractor has already taken the step to collect data that will help inform the new routes. They have installed electronic tags in the machines that accurately track date & time when a machine is visited. This data will help inform new route proposals. <u>Internal Audit opinion</u> **Action ongoing**
7.3	Management should look to re-establish the interface with the parking company back-office system as soon as possible, thereby enabling the identification of (and collection from) parking machines holding	Medium	Parking Services Manager	31.7.17 **Revised Timescale** 31.3.18	Place Change Programme has now started. The initiative to replace pay and display machines and connect all the back office systems to the cloud has begun.

	excessive cash balances. The facility should also be used for contract performance monitoring purposes - to determine whether individual machines were being emptied in line with the predetermined routes.				The next steps are to go to Capital Programme Group and Cabinet for approval to spend capital and run procurement. Expected completion subject to this timescale but likely to be towards start of next financial year. Current processes to manually plan cash collection will continue until then. <u>Internal Audit opinion</u> **Action ongoing**
7.4	Spot checks should be carried out to ensure that the contractor maintains appropriate key security arrangements. Management should consider security options to minimise the risk of loss of keys. Recommendations relating to the increased incidence of damaged keys are raised as contract performance monitoring issues elsewhere in this report.	High	Parking Services Manager	31.7.17	First key spot check took place in October**.** Key safes purchased for 3 maintenance vans. To be fitted after vehicles changed for new fleet in November. Pouch and belt purchased for keys to be clipped to an individual. Bluetooth tracking device fitted to one set of regularly used keys, awaiting 3 more devices to cover all key use. Damaged keys raised in meeting with the contractor on 15 August 2017. Further training for staff agreed. <u>Internal Audit opinion</u> Internal Audit viewed the purchase order for the items listed, evidence of a spot key check in October 2017 and an email between the team and the contractor showing the points agreed at the meeting dated 15 August 2017. **Action complete**
7.5	The Parking Services Risk Management Plan should be reviewed to take account of the revised cash collection arrangements as well as the impact of service reviews. Risk Management Plans and Registers should be	Medium	Parking Services Manager	31.8.17	Service level risk plan was reviewed and updated on 17 November 2017. PLACE risk register last reviewed 17 November 2017**.** <u>Internal Audit opinion</u>

	reviewed at least annually to ensure that the risk profiles are accurate and that mitigation strategies are operational and effective.				Internal Audit viewed the risk management plan at service and portfolio level and found that the risks were reviewed in November 2017. **Action complete**
7.6	Parking Services management should work with the contractor to develop a basket of suitable performance indicators for the collection contract. Once defined, independent source documentation should be used, or Parking Services management be given access to the contractor's management systems to validate and verify the figures quoted (e.g. customer complaints procedures).	High	Parking Services Manager	30.9.17 **Revised Timescale** 31.12.17	Request for updated suite of KPI's was sent 7 July 2017. Contractor agreed to review on 10 July 2017. As part of the Parking Services MER the manager responsible for Maintenance and Cash collection left Parking Services 27 July. Interim acting up arrangements have been put in place since then. Those interim arrangements have been focussed on resolving the key risks in this report. So although new KPI's have been discussed and agreed regular reporting hasn't yet taken place. This will begin with the arrival of the new manager on 4th December. It is expected the first review of KPI's then takes place. <u>Internal Audit opinion</u> Internal Audit was provided with an email confirming that KPI's were to be agreed and an example of possible KPI's. **Action ongoing**
7.7	The contractor should be required to formally report back to the Parking Services Manager: • Setting out the reasons for the failure to meet the contractual KPIs; and • Providing an agreed action plan for the improvement in performance within a defined	High	Parking Services Manager	31.7.17 **Revised Timescale** 31.3.18	The contractor was contacted on 7 July and responded on 10 July. They clarified that the contact spec. was for 77 boxes per day, based on 1 visit to cashiers per day to deliver the boxes. They identified Parking Services now required 2 deliveries to cashiers, which impacted on amount of boxes that can be collected in the second delivery period. This equates to approximately 7 collections. This means they can collect 70 boxes on average per

	deadline. The action plan should set out a timetable for the provision of revised collection routes and the attainment of agreed target of 80 cash box pulls per day. This should form the basis for monitoring by Parking Services management. Consideration should be given to whether the contractor has shown sufficient commitment to improvement or whether contractual penalties should be levied.				day based on Parking Services altered requirements. This new target doesn't significantly increase the risk to the quantity of cash held in machines as long as the revised route developed by Parking Services is adhered to. Actions still to take place are to formally amend the contract with procurement to reflect change in specification. It is relevant to note that the acting manager and her supervisor in Parking Services responsible for managing this contract have identified a further issue to manage regarding collections. They have identified that in order to attain the target figures required, cash collection operatives were not always following the recommended routes. This meant a greater risk of larger cash amounts building up in machines. This has been addressed in a meeting on 15 August 2017, and adherence to routes as well as number of boxes collected will be measured and discussed at the quarterly contact meetings. <u>Internal Audit opinion</u> Internal Audit was provided with an excel spreadsheet showing the tracking of machine collections and evidence of the meeting outcomes for 15 August 2017 which supported the comments made. **Action ongoing**
7.8	Applicable recommendations are raised at 7.10, below.	Medium	Parking Services Manager	31.7.17 **Revised Timescale** 31.3.18	See 7.10 for manager's progress comments. **Action ongoing**

7.9	Parking Services management should review the need for, and frequency of, the contract performance meetings. Following this diary entries should be established for the meetings with the contractor's nominated officer.	Medium	Parking Services Manager	31.7.17	Quarterly dates have been established for contract meetings. The first of which took place in August. Agendas produced and action points produced and shared with contractors, although this was on email as opposed to a minute template. In summary this has begun, but to be improved upon when the new Operations Manager for maintenance and cash collection beginning on 4 December 2017 <u>Internal Audit opinion</u> Internal Audit viewed the agenda template and an email with meeting actions from the meeting held on 02.08.17. **Action completed**
7.10	An appropriate contract performance monitoring framework should be established. This should include: • Regular scheduled meetings with named officers from the contractors management team; • A defined agenda for those meetings; • The incorporation of comment and feedback relating to contractor performance from TT&PS Business Management and Cashiers; • The review of current performance indicators; • Formal minutes setting out issues discussed and actions agreed, together with any applicable deadlines and officer responsibilities; • Escalation procedures for contract disputes.	High	Parking Services Manager	31.7.17 **Revised Timescale** 31.3.18	As above at 7.9. Transport Traffic and Parking Services (TT&PS) business management and Cashiers were contacted for input prior to August meeting. The escalation procedure has been clarified. In summary this has begun, but to be improved upon when the new Operations Manager for Maintenance and Cash collection beginning on 4 December 2017. <u>Internal Audit opinion</u> Internal Audit viewed the agenda template and an email with meeting actions from the meeting held on 02/08/17. Further work is required to ensure that the meetings held are recorded in line with the original recommendations made. **Action ongoing**

	Minutes should be approved by both parties and made available for review by the Parking Services Manager. Over and above this, the Parking Services Manager should seek assurances from the contractor that the issues noted at 7.8 will be addressed as part of the required contract performance improvements.				
7.11		High	Parking Services Manager	30.6.17	A form to analyse the contractor's performance has been devised. It includes expected number of box "pulls". Number of box "pulls" reported by the contractor and number of box "pulls" reported by cashiers. It allows analysis of where discrepancies lie, and the ability to analyse trends through excel. It has been used to challenge invoiced figure from the contractor. Further discussion has taken place, following advice from Commercial Services, on detail in contracts which allow the contractor to charge for visits to "pull" boxes from machines, which the contractor can access through no fault of their own. e.g. the machine door is stuck and Parking Services maintenance team is required to open the door with the assistance of tools. Parking Services are recording these instances and using their existing maintenance recording system to check any instances of this of this happening as part of the invoice price agreement process. <u>Internal Audit opinion</u> Internal Audit was provided with performance analysis sheets and email evidence of challenge.

					Action complete
7.12	Given the audit findings, the Parking Services Manager should further investigate whether the Transport, Security and Maintenance Manager validated the figures provided in the contractor's invoices without sufficient evidence or authority. Discrepancies should then be taken up with the contractor and adjustments made in subsequent invoices for any overpayments made. Invoices should not be authorised as complete, or approved for payment were the figures provided as the basis for invoice calculation cannot be verified to independently obtained source totals.	High	Parking Services Manager	30.6.17 **Revised Timescale:** 31.3.18	Investigations have been taking place and final totals will be agreed by both parties before payment is agreed. The contractor agreed that payment could only be made against the treasury totals when further investigations had taken place. <u>Internal Audit opinion</u> Internal Audit was provided with an email that showed the actions agreed from the August meeting which confirmed the above statement. However, due to the fact that further investigations have yet to take place this action is considered ongoing. **Action ongoing**

8. Training Centres - Recovery Planning and Monitoring (People Services) (issued to Audit and Standards Committee 27.6.17)

As at Jan 2018
This report was issued to management on the 13.6.17 with the latest agreed implementation date of 30.9.17. An Internal Audit follow-up review has been completed and the results are included below. 15 of the original 27 recommendations remain outstanding and this is largely linked to the changing context of SCC and the People Portfolio priorities and the refreshed vision for Learning, Skills and Employment. In addition both the previous Director and the Assistant Director have retired.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position as a result of Internal Audit follow-up work 10.11.17.
8.1	Service Management need to agree and articulate the key financial objectives of the training centres – be that to achieve a balanced budget, or be self-financing/sustainable. A 'recovery plan' for 17/18 and 18/19, setting out the	High	C.Charnley - Operations & Development Manager, CYPF Business Strategy.	30.6.17 **Revised Timescale:** 31.12.17	**Outstanding** Since the original audit both the Director of Lifelong Learning, Skills and Communities (LLSC) and the Assistant Director for Lifelong Learning have retired.

	detailed actions required that would achieve the financial objectives need to be developed as soon as possible.		Dee Desgranges - Assistant Director for LLSC (retired) Replaced by Emma Beal – Assistant Director for LLS. Eve Waite - Head of Employment and Skills, CYPF		The initial findings of the incoming Director indicated the need to reconsider the recovery plan in the context of changing SCC and People Portfolio priorities and a refreshed vision for Learning, Skills and Employment. The 2016-19 recovery plan, that was approved by the Recovery Group on 27 April 2017 and submitted as part of the original audit requires review. It is to be replaced with a Lifelong Learning & Skills (LLS) development plan which reflects the planned actions going forward and the impact on the financial position. The plan will be further developed to cover three years from April 2017. The full three year plan to be completed for approval at the Strategic Group by 31 December 2017.
8.2	An 'action plan' containing all ongoing actions relating to the production of a viable recovery plan and also reflecting the latest position of any key financial targets should be created and reviewed/updated on at least a monthly basis as part of the planning and development group meetings. To accompany any narrative recovery plan and budget forecast, specific savings targets should be documented in a tabular 'monitoring document' and progress of these should then be monitored and updated monthly, to ensure that where there are issues/shortfalls, alternative proposals can also be considered, documented and monitored.	High	C.Charnley - Operations & Development Manager, Business Strategy. Dee Desgranges - Assistant Director for LLSC. (retired) Eve Waite - Head of Employment and Skills.	30.6.17 **Revised Timescale:** 31.12.17	**Outstanding** A new timeline for key milestones will be developed to reflect the new Lifelong Learning & Skills development plan. The initial timeline to be completed for approval by the strategic group by 30 November 2017 with the full three year timeline by 31 December 2017.
8.3	Details of budget assumptions that have historically proved to be incorrect should be thoroughly reviewed before they are used to in subsequent recovery plans. Any assumptions found to be unachievable should be revised, and the new assumptions clearly	High	C.Charnley - Operations & Development Manager, Business	30.6.17 **Revised Timescale:**	**Outstanding** These will be reviewed as part of the Lifelong Learning & Skills development plan.

	documented.		Strategy. Dee Desgranges - Assistant Director for LLSC (retired). Eve Waite - Head of Employment and Skills	31.12.17	
8.4	The recovery plan should be adjusted to reflect the current known position regarding income from room hire at Sheaf.	High	C.Charnley - Operations & Development Manager, Business Strategy	30.6.17 **Revised Timescale:** 31.12.17	**Action ongoing** Adjustments in all income are reflected in Q Tier budgets for 2017-18. The Lifelong Learning & Skills development plan will reflect these together with any other income changes.
8.5	When learner targets and profiles are being set for 17/18, and used as the basis for future recovery plans/budgets, lessons learned from the actual take-up in 16/17 should be taken into account.	High	D.Desgranges - Assistant Director for LLSC (retired) E.Waite - Head of Employment and Skills.	30.6.17 **Revised Timescale:** 31.12.17	**Outstanding** Work is underway by the leadership team to redefine the vision Lifelong Learning & Skills (LLS). This will then drive choices over the range of programmes to be delivered for the 2018-19 academic year, commencing September 2018. These will be underpinned by resource plans that the heads of service will produce, in accordance with the overall timeline for the revised recovery plan. For the current financial year assumptions there is clarity as to the number of learners that we need to recruit to maximise available income within contract allocations, ensure sufficient additional Study Programme learners to increase future “lagged” allocations and to provide sufficient growth in apprenticeship and traineeship numbers.

					The operational group will retain oversight for the ongoing recruitment to programmes which start within year. Resource plans to be completed for approval by the Strategic Group by 31 December 2017.
8.6	Management need to ensure that the reasons as to why the 2015 MER did not achieve the planned savings, are fully understood and documented, in order to ensure that lessons can be learned and applied to any future MER's.	Medium	C. Charnley – Operations & Development Manager, Business Strategy – to document lessons learnt in revised Recovery Plan, 2017 and D.Desgranges - Assistant Director for LLSC to incorporate lessons learnt into MER process	31.8.17	**Implemented** The 2015 MER has no relevance to the current situation. However as part of the handover process for the incoming Director a timeline of the training unit history was produced which does provide the reasons why the 2015 MER did not make the original level of planned savings. A copy of this document has been provided to Internal Audit. In terms of the current year's MER, this will not now be launched until January 2018 (as per the Lifelong Learning and Skills development plan) as we need to link our revised staff resource to our planned delivery from September 2018. The MER also needs to cover the wider remit of Learning Skills and Employment. Draft MER document to be completed for Strategic group approval by 30 November 2017. <u>Internal Audit opinion</u> The LLSC, Learning, Skills and Employment – Training Unit Recovery History was reviewed by Internal Audit and records the 2015 MER and issues encountered. **Action complete**
8.7	Going forward, as part of any budget setting/recovery planning process, Management should document all of the assumptions used to compile their budget and submit this to their Finance Business Partner (FBP)	Medium	C.Charnley - Operations & Development Manager,	30.6.17	**Recommendation related to specific issue for 2016/17 and therefore no longer relevant** This was a specific issue for 2016-17 financial

	and the Strategic Support Manager within LLSC to obtain their review/feedback and confirmation that the assumptions being made are 'reasonable', before formally setting their budget/recovery plan.		Business Strategy. S.Bulman - Strategic Support & Development Manager, LLS		year and as such no longer applies. Internal Audit opinion: **Action complete**
8.8	Given the overlap of content, and the ongoing deficit position of the training centres, the FBP should be included on the circulation of all meeting minutes and provided with performance documentation used as part of the planning and development group meetings.	Efficiency/ Effectiveness	A.Scott - Head of Strategic Development and Support, LLS	30.5.17	**Implemented** Finance Business Partner has been attending both Strategic and Operational Group meetings since June 2017**.** We are continuing to redefine the governance and associated meeting structure for the recovery plan process to become a Lifelong Learning & Skills development plan process which integrates and aligns with governance structures for the wider Learning, Skills and Employment service. This will take into account the findings at 2.2, 2.3 and 8.11. Internal Audit opinion: Meeting minutes for both the operational and strategic group meetings were provided and FBP had been invited to both. **Action complete**
8.9	A spreadsheet should be created in order to provide a log/record of all ongoing action points and their status. These should contain clear deadlines and allocated responsibility to individually named officers where possible. Follow up/review of progress should then take place on at least a monthly basis, and narrative updates recorded to evidence this. To provide a full history and comprehensive audit trail of	Efficiency/ Effectiveness	A.Scott - Head of Strategic Development and Support, LLS	30.5.17 **Revised Timescale:** 30.11.17	**Implemented** An Action Log has been developed and presented to Recovery Group meetings Internal Audit opinion A copy of the Recovery Group Action Log (updated 15.11.17) was provided to Internal

	action taken to date, the spreadsheet should contain separate worksheets for current and closed actions.				Audit and considered adequate. **Action complete**
8.10	There should be a standard agenda item within the recovery and planning group meetings (on at least a monthly basis) to report the ongoing financial position of the training centres and of any positive action taking place to drive costs down and increase income.	Medium	A.Scott - Head of Strategic Development and Support, LLS	30.6.17 **Revised Timescale:** 31.3.18	**Outstanding** The revised governance structure will link in reports from the monthly revenue reporting process produced by Finance Business Partner to the Strategic Group Dawn Shaw Head of Libraries, Communities and Learning and Skills. Emma Beal Assistant Director of LLS. Eve Waite Head of Employment and Skills
8.11	Management should look to develop a simple, concise 'financial performance dashboard/report' that can be prepared on a more regular/timely basis. If possible the information included should still include a breakdown of the actual expenditure and forecasted outturn position for individual areas of income and expenditure, as this provides useful information that Management can use when evaluating progress against recovery plans, and determining areas where further savings could potentially be made (if necessary).	High	S.Bulman - Strategic Support and Development Manager, LLS	31.7.17 **Revised Timescale:** 31.3.18	**Outstanding** This requires review as the previous version that was under development is no longer fit for purpose. This needs to take into account the difficulty of providing real time information due to the time lag between learner recruitment, learner commencement and learner registration on the system It is unlikely to be resolved without the planned replacement data system. Position to be reviewed by the Strategic Group by 31 March 2018.
8.12	Given the current financial position of the training centres as a whole, consideration should be given to treating each as a separate 'trading centre' and coding income and expenses accordingly. This will enable Management to obtain a more accurate picture of the costs/income associated to each centre.	High	C.Charnley - Operations & Development Manager, Business Strategy	30.6.17 **Revised Timescale:** 31.12.17	**Outstanding** Progress in this area has been hampered by the lack of clarity around how the apprenticeship and non-apprenticeship budgets would be split. This has been redefined by the new Leadership Team and work is underway to prepare proposals.

					A structure to be proposed to the Strategic group for approval by 31 December 2017.
8.13	Management should ascertain and document the reasons why the reported outturn is significantly higher in 16/17 than the original recovery plan. The issues identified should then be addressed where possible or taken into consideration as part of 'lessons learned' when producing all future recovery plans, in order that the plans are realistic and achievable.	Medium	C.Charnley - Operations & Development Manager, Business Strategy.	30.6.17	**Implemented** As part of the handover process for the incoming Director a timeline of the training unit history was produced this summarises the key assumptions made at budget setting each year and any assumptions that proved to be incorrect. A copy of this document was provided to Internal Audit. Internal Audit opinion**:** The Learning, Skills and Employment – Training Unit Recovery History was reviewed by Internal Audit and records the assumptions. **Action complete**
8.14	A cost/benefit exercise, and consideration of the mid/long term future of the training centres should be undertaken prior to committing to the procurement of any new systems for the training centres.	Medium	E.Waite - Head of Employment and Skills	30.8.17 **Revised Timescale:** 31.3.18	**Outstanding** This remains work in progress.
8.15	Mitigation action/systems should be put in place to ensure that there is no reoccurrence of eligible funding not being claimed due to a lack of awareness by staff. There should be a documented audit trail created where decisions are taken to utilise existing reserve balances. Reserves that are held to cover any risk of future clawback, should not be used to offset against training centre losses, and should be documented within the LLSC risk management plan.	High	S.Bulman - Strategic Support and Development Manager, LLS. P.Jeffries – Finance Business Partner now Karen Hesketh – Finance Business Partner.	30.6.17 **Revised Timescale:** 31.12.17	**Outstanding** Current assumptions around the use of reserves will form part of the new Lifelong Learning & Skills development plan.

8.16	Management should take steps to clarify with their FBP whether this funding is in addition to their 'known balances' that are available within reserves. Any over achievement of income during the year should be used to off-set in year expenditure, where losses are forecast. Steps should be undertaken to ensure transparency, and prompt/timely notification of such balances in future.	Medium	S.Bulman - Strategic Support and Development Manager, LLS.	30.6.17 **Revised Timescale:** 31.3.18	**Outstanding** This is an historic issue. FBP will be fully engaged with both the operational and strategic group meetings within the new governance structure as well as producing monthly revenue budget reports to feed into the group.
8.17	All rooms/locations at each of the training centres should be recorded on the utilisation calendar, in order to provide a complete picture of room usage across the sites. To aid Management review, and ensure that rooms are being used in the most efficient manner, details of the room capacity, and also of the numbers of learners booked to attend the individual sessions should be recorded on the utilisation calendar.	Efficiency/ Effectiveness	A.Scott - Head of Strategic Development and Support, LLS. Emma Beal Assistant Director LLS.	31.7.17 **Revised Timescale:** 31.3.18	**Action ongoing** This remains work in progress but will be an operational level issue in terms of future governance.
8.18	Whilst awaiting the return of signed SLA's, invoices to the schools using Sheaf should still be raised on a quarterly basis. Once invoices have been raised, these should be actively pursued to ensure that the income is received promptly by the training centres, as a proportion of any income received after 60 days is retained centrally.	High	S.Bulman - Strategic Support and Development Manager, LLS.	30.6.17	**Implemented** Completed for 16/17 academic year. 2 schools rent rooms at Sheaf Training Centre. Invoices have been raised for both; however 1 is being disputed and has been referred to the Deficit Steering Group for a decision about the payment of outstanding amounts. The current position to be reported to the Operational Group to confirm that invoicing is up to date by 30 November 2017. <u>Internal Audit opinion</u> SLA provided for Bents Green dated 11.9.17 for period 11.9.17 – 20.7.18 and outlined costings. Invoices were not provided so assurance based on manager comments. **Action complete**

8.19	Management should consider whether 'partners' should be given an indication as to the likelihood, and of the maximum potential financial liability that they could face if strategic funding cannot be secured, in order for them to make an informed decision as to whether they wish to sign the SLA's that are outstanding and continue with their use of Sheaf.	High	D.Desgranges - Assistant Director for LLSC (retired) Emma Beal Assistant Director for LLS.	30.8.17	**Implemented** Agreements reviewed by Assistant Director for the 17/18 academic year with this reference removed. <u>Internal Audit opinion</u> This paragraph has been removed from the SLA provided for Bents Green dated 11.9.17. **Action complete**
8.20	Quarterly invoices should be raised with the school in respect of ongoing room hire incurred, whilst awaiting confirmation (or otherwise) as to whether the costs will be paid centrally going forward. The school themselves can then liaise with SEN to recover invoices paid to date.	Medium	C.Charnley - Operations & Development Manager, Business Strategy. S.Bulman - Strategic Support & Development Manager, LLS.	30.6.17 **Revised Timescale:** 31.3.18	**Outstanding** This remains an outstanding issue but is part of a more complex scenario involving other parts of the portfolio. Emma Beal, Assistant Director is going back to School Deficit Group on 14 November for a further discussion which will inform service decisions on future arrangements for this tenant.
8.21	Given the 'relatively' small number of times that the Red Tape studio has been hired, Internal Audit recommend the potential to increase income is explored by looking at ways to actively market/advertise this facility, including making the facility available during non-working hours in the week and on weekends.	Medium	A.Scott - Head of Strategic Development and Support. Emma Beal Assistant Director for LLS.	30.6.17	**Implemented** This was reviewed by the Recovery Group on 22.6.17 but not felt to be a viable option in terms of significant income levels. However, this will continue to be reviewed and considered as part of the plan for delivery for the 2018-19 financial year. <u>Internal Audit opinion</u> Planning and Development Group meeting held on 22nd June, 2017 had an agenda item discussing 'Review of Red Tape rental income and charging Policy across all Training Centres' which costs were reviewed and action agreed.

					Action complete
8.22	The annual revision of the schedule of charges should take place before 1st April each year, or alternatively move it to commence on 1st September each year and then ensure the policy is updated and re-issued over the summer.	Medium	A.Scott - Head of Strategic Development and Support, LLS. Emma Beal Assistant Director for LLS.	30.6.17	**Implemented** This was reviewed by Recovery Group 22.6.17 when it was agreed to increase by level of inflation for 17/18. Charges will continue to be reviewed on an annual basis and will be considered as part of the plan for delivery for the 2018-19 financial year. However, it is not significant in terms of the level of income possible. <u>Internal Audit opinion</u> Refer to 8.19 above. **Action complete**
8.23	To mitigate the risk of fraud/irregularity and ensure good governance arrangements are in place, Management need to perform periodic independent review/reconciliation of income and banking.	Medium	A.Scott - Head of Strategic Development and Support, LLS. S. Bulman Strategic Support and Development Manager, LLS.	30.6.17 **Revised Timescale:** 31.3.18	**Outstanding** Recovery Group agreed 22.6.17 to transfer to Pay.NET and following recruitment of new Project Support and Development Officer this will be actioned by 31st March 2018.
8.24	Benchmarking of staff cost ratios should be undertaken on a regular basis, and where Sheffield appears high, action should be undertaken to identify and document the reasons why, and to take action to reduce costs where possible.	Medium	D.Desgranges - Assistant Director for LLSC (retired) E.Waite - Head of Employment and Skills.	30.6.17 **Revised Timescale:** 31.3.18	**Outstanding** The central issue here, is the affordability of staff structures set against the profitability of individual programmes, with a need to cover the overhead of three centres. This will be addressed in the resource plans that the heads of service will produce, in accordance with the overall timeline for the revised recovery plan.

8.25	Management should consider whether staff time spent on delivery/admin elements needs to be revised to be in line with benchmarking data, or whether any future staff requirement calculations/ MER's take into account 'actual time' spent, in order to ensure that these are as accurate as possible.	Medium	D.Desgranges - Assistant Director for LLSC (retired) and E.Waite - Head of Employment and Skills.	30.5.17 **Revised Timescale:** 30.9.18	**Outstanding** Plans to inform an MER to be launched in January 2018 for resources required to deliver from September 2018.
8.26	The staff utilisation spreadsheet should be updated on at least a quarterly basis and produce information relating to the profitability (or otherwise) of subject areas resulting from the actual costs and learner numbers to enable analysis/review at the planning and development group meetings.	High	S.Bulman - Strategic Support and Development Manager, LLSC	30.7.17	**Recommendation no longer relevant** This analysis was designed to inform the split of resources and budgets as part of separating the apprenticeship and non-apprenticeship delivery. We have a sufficiently clear picture now and the level of overlap of staff between apprenticeship and non-apprenticeship is now minimal negating the need for this analysis to continue. <u>Internal Audit opinion</u> **Action complete**
8.27	Management should review the viability of courses which do not cover their direct costs, and consider increasing the minimum numbers of learners to ensure that value for money is improved. The uplift percentages applied should also be reviewed to assess whether the value created is sufficient, if it is to be used as a benchmark as to a courses viability.	High	D.Desgranges - Assistant Director for LLSC (retired) and E.Waite - Head of Employment and Skills S.Bulman - Strategic Support and Development Manager, LLS	30.6.17 **Revised Timescale:** 31.3.18	**Outstanding** Please refer to the response at 8.24

9. Subject Access Requests (CYPF) (issued to Audit and Standards Committee 28.4.17)

As at July 2017
This report was issued to management on the 18.1.17 with the latest agreed implementation date of 31.10.17. 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 2018
A follow-up audit was undertaken in December 2017. The results are reproduced below. Of 7 agreed recommendations, 4 are complete and 3 are ongoing.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position as a result of Internal Audit follow-up work 2.12.17.
9.1	The Corporate SAR process should be reviewed and roles and responsibilities clearly re-defined where necessary. The specialised role of the Information Governance team in the process should be fully defined and documented. This role should be advisory in nature and not form part of the business as usual process. Any issues noted should be recorded to try to ensure that they can be included in future training and development.	2 - High	Elyse Senior-Wadsworth, Service Manager - Business Support	31.10.17 **Revised Timescale** 31.3.18	**Action Ongoing** A review has been undertaken whilst the CYPF portfolio was still in place. There are still separate SAR processes in place for the 'children and adult services' which have now been amalgamated under 'People portfolio', but we intend to review and combine these in the longer term. Defining the role of the Information Governance team is an area that is still outstanding.
9.2	Subject access requests should be recorded and monitored on one system only (preferably the SharePoint site). All officers who are involved in the SAR process should have appropriate access to the SharePoint site.	2 - High	Elyse Senior-Wadsworth, Service Manager - Business Support	31.10.17	**Implemented** A single CYPF tracker is now held on Sharepoint. We intend to create a single 'People' tracker in the longer term. **Action complete**
9.3	A Portfolio data map should now be produced for responding to subject access requests. This should	2 - High	Elyse Senior-Wadsworth,	31.10.17	**Ongoing**

	clearly detail the routine information that should be checked when a subject access request is received, where this can be located and who is responsible for this source of information.		Service Manager - Business Support	**Revised Timescale** 31.3.18	A 'basic' CYPF portfolio data map is now in existence, however, we feel that this should be a living document and in the longer term, could expend it to reflect the location of, and retention periods for historical data. We also intend to create a single 'People' map in the longer term. **Action ongoing**
9.4	Management should now consider the need to have in place an officer with the designated responsibility of 'triaging' SAR requests as they are received, ensuring that they are sent appropriately to the relevant officers/services for information gathering/response and monitoring responses as deadlines approach. The officer responsible should have the necessary professional knowledge to undertake this role. This is a co-ordination role and would likely fit with an officer's main responsibilities. However, the demands of the role need to be clearly assessed and then attributed to one officer. However, it is important that there are adequate cover arrangements in place to ensure continuity.	2 - High	Elyse Senior-Wadsworth, Service Manager - Business Support /John Curtis, Head of Information Management.	31.10.17	**Implemented** The triage role (as recommended) is now in place. In the longer term, we would like to see an expansion of the tasks this role performs to include more 'initial fact finding'. **Action complete**
9.5	It is recommended that current staffing arrangements are reviewed for resilience in light of the fact that the numbers of SARs are unlikely to decrease over time. Appropriate continuity arrangements should be in place for when the Access to Information Officer is on leave/absent.	2 - High	Elyse Senior-Wadsworth, Service Manager – Business Support /John Curtis, Head of Information Management.	31.10.17 **Revised Timescale** 31.1.18	**Alternative action undertaken** Some progress with this has been made, as the main body of redaction is now undertaken by Business Managers. In the short term, backlogs are being addressed via external contractors, and regarding longer term solutions, PLT have asked for an options appraisal by January 2018. **Action ongoing**
9.6	The issues of inconsistencies in the quality of responses should now be reviewed. The need for a	2 - High	Elyse Senior-	31.10.17	**Alternative action undertaken**

	quality check prior to information being sent out should be considered. If this is not deemed feasible, the training requirements of staff involved in this process need to be reviewed and where gaps are identified, appropriate training put in place.		Wadsworth, Service Manager – Business Support.		The main body of redaction is no longer part of the Information Governance Team, and so this has freed up resource for them to undertake Quality Assurance. At the present time, there are no longer plans in place to recruit Social Work Support Officers. **Action complete**
9.7	Internal Audit recommends that the role of the social worker is reviewed in the subject access request process, ensuring that this involvement is as effective as possible and takes in to account the workloads of social work colleagues.	2 - High	Elyse Senior-Wadsworth, Service Manager – Business Support.	31.10.17	**Implemented** Following workload review, the involvement by Social Workers has been revised, and they now advise on impact only. Redaction is undertaken by the Business Support Manager, and this process is working well. **Action complete**

10. Controls in Town Hall Machine Room (Resources) (issued to Audit and Standards Committee 24.5.17)

As at July 2017
This report was issued to management on the 27.4.17 with the latest agreed implementation date of 31.12.17. An update on progress with recommendation implementation will be included in the next tracker report.

As at Jan 2018
An update on progress with recommendation implementation was requested. It is acknowledged by Internal Audit that not all the recommendations are due for implementation as at the date of update.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position provided by Senior Technical Solutions Architect, BCIS 15.11.17.
10.1	Senior Managers should now work with Capita to ensure that the roles and responsibilities in relation to the Town Hall server room/machine room are clearly documented and agreed. This should be communicated to all relevant Officers.	1 - Critical	Mike Weston, Assistant Director ICT Service Delivery	Full review to be completed by the end of June 2017 (this will be undertaken by	The roles and responsibilities for the Town Hall Machine room have now been established. The process to report faults with equipment supported by SCC Facilities Management, Air-

	As part of the definition of roles and responsibilities, only one Officer/service should be responsible for the access processes and policy. This is vital if access to the room is to be strictly controlled.		Mark Cummins, Facilities Manager – to confirm process should Capita wish to raise issues with the air conditioning/ gas suppression systems.	officers from Capita/BCIS/UTC and Facilities Management). Access policy/procedures to be updated fully by end September 2017. **Revised Timescale** 19.12.17	Conditioning, Fire Suppression, Intruder Alarm, Mains Power and back-up generator has been confirmed and will be documented in a Room Management Safety file. The file will also include the induction process for individuals on the access control list. In addition should one stakeholder notice an issue with another's equipment, the reporting procedure is also included in the document. Notices have been up in the machine room confirming the reporting procedures. The process managing requests to be added to the Machine Room access control list has been reviewed. Capita are responsible for the upkeep of the access control approval procedure, authorising addition/removal of individual to the access control list. Changes to passes are physically made by SCC Facilities, providing a dual approval step. The contract change has not been raised to transfer formal responsibility of the room to Capita, however the service is operating in the spirit that the change has been made for access control. **Remaining Actions:** **Documentation** **Action One:** The documentation is scheduled to be completed by the middle of December 2017 1. The Room Management Safety File including RACI. (Mark Cummins SCC)

					2. Access control request process document. Lee Parkin Capita (Rob Craine SCC) **Action ongoing**
10.2	An immediate training plan needs to be put in place for staff at the Porter's Lodge at the Town Hall. They should always follow the access control policy for the room. The Council needs to work with Capita to ensure that appropriate access controls are in place. These can be strengthened when roles and responsibilities for the room have been clearly defined and documented.	1 - Critical	Mike Weston Assistant Director ICT Service Delivery – to direct the completion of the audit and the update of the access policy/procedures. Mark Cummins, Facilities Manager – to ensure that rigour is applied to signing in process so that details can be captured on why access is required to the room. (This will simply require more space on the signing in sheets). Training as appropriate to be provided once the access control policy and procedures	30.9.17	The Town Hall Attendants at the porter's lodge, who are responsible for signing the key out and in, have been re-briefed on the critical nature of the services held in the machine room, and the protection the access control procedure provides. Dual access control is now in place on the machine room door. An individual who is approved to access the machine room has their badge enabled for access but must visit the porter's lodge to sign out a key to the outer door and complete the access request sheet. This fail safe will prevent access past the second door should an individual get unauthorised access to the key. The new door access control system provides a technical control for access. Reports can be run to confirm who has accessed the room in a given period, and failed attempts. These reports are made available on a monthly basis or on request. The Town Hall Attendants do not have access to the room directly. If an emergency situation occurs senior facilities staff are on the access control list for the room. Additional contractor access cards are held in the Town Hall safe. At the time of writing the reviewed access control procedure document is being written up, however the technical controls have been put in place. The documentation is expected to be

			have been reviewed and updated.		completed by the end of November 2017, (Action One above). The delay has been due to some difficulties getting the new door access control implemented in the Town Hall. **Action complete**
10.3	It is believed that the fire door at the back of the Town Hall Server room is not alarmed. Management, in conjunction with Capita, should now assess the risk associated with this and implement appropriate action.	2 - High	Mark Cummins, Facilities Manager	30.6.17	The door sensor is linked to the alarm system. If the door is left open the alarm cannot be armed. If the door forced open, (break in), the alarm would not activate, however the PIR sensor would detect unauthorised entry and trigger the alarm. **Action complete**
10.4	The Council should work with the Capita Security Manager to ensure that the risks associated with the positioning of the air conditioning units/back-up generator are appropriately assessed and action is implemented where required.	2 - High	Mike Weston, Assistant Director ICT Service Delivery	30.6.17	Due to fire regulations fix hard barriers could not be installed.  Portable maximum safety crash barriers, (sand filled), have been installed to protected the Air-Conditioning units, (photo above.) **Action complete**
10.5	Working in conjunction with the Capita Security Manager, management should ensure that there are appropriate business continuity arrangements in place for the room following a full business impact analysis. This should be completed once the roles and responsibilities in relation to the room have been clearly formalised and documented.	2 - High	Mike Weston, Assistant Director ICT Service Delivery	31.12.17 **Revised Timescale** 31.3.18	The strategic plan is to move the councils ICT infrastructure into a cloud based hosting service, so reducing dependency on the Town Hall Machine Room. The migration process has started and the expected to complete by end of March 2018. **Action ongoing**

11. Continuing Health Care in Learning Disabilities (People) (issued to Audit and Standards Committee 8.5.17)

As at July 2017
This report was issued to management on the 24.4.17 with the latest agreed implementation date of 31.3.18. An update on progress with recommendation implementation will be included in the next tracker report.

As at Jan 2018
An update was requested from the Head of Service, Future Options, which is reproduced below – Internal Audit acknowledged in following up this report that not all the recommendations had passed the implementation date. Management stated that the outcomes from the current CHC project and the Whole Case Family Management system implementation would address most of the recommendations in this report. As a result of the Adults Social Care reorganisational change, the Learning Disability Team no longer exists and so recommendations have been reassigned to the Head of Service, Localities. Internal Audit will conduct a follow-up review next year.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position - provided by Andrew Wheawall, Head of Services, Future Options 1.12.2017.
11.1	Service managers to work with the CCG to formalise, agree and jointly sign a service specification which sets out the arrangements in place. This should be subject to periodic joint reviews (SCC & CCG) and state the process for implementing and agreeing amendments and changes.	1 - Critical	Karen Mosgrove – Interim Service Manager, Learning Disabilities Now Robert Broadhead, HoS Localities	30.6.17 **Revised Timescale** 31.3.18	**Ongoing** This piece of work required has been added to the overall area of CHC \ Panel issues \ concerns and procedures, this includes all adults with fully funded continuing health care (CHC) needs \ health needs and joint packages of care (JPOC). We are still developing this process. There has been some very positive movement here. This follows due to the recent Adults Social Care reorganisational change. Therefore all of the below is now subject to change. The current CHC project addresses several of the recommendations in this report. Throughout 2017, SCC has been working towards improving and streamlining the CHC process, starting from the point at which a health need is identified through to sign off at resource panel. There are three elements to this project:

					1. Training and upskilling SCC staff on CHC and the process in Sheffield following the move to the Locality model. 2. Reviewing internal processes, both administration and finance (SCAS) to ensure robustness and that funding is claimed from the CCG. 3. Reviewing and improving the current process from start to finish, removing the various panels and seeding the process up.
11.2	Management to develop joint policies, procedures and forms in conjunction with the CCG for all jointly funded CHC service users in LD. The documents/forms to be used should capture all information required in appropriate formats for both SCC and CCG system recording purposes. Input should be sought from the Business Service and Systems Manager to ensure all funding information is recorded clearly, accurately and on a timely basis. Changes to funding packages should be transparent and this should facilitate accurate recharging and budgetary monitoring. The documents to have stated review dates which should be adhered to. All documents once produced and agreed to be posted, and clearly identifiable, on ELMA.	2 - High	Karen Mosgrove – Interim Service Manager, Learning Disabilities Now Robert Broadhead, HoS Localities	30.6.17 **Revised Timescale** 31.3.18	**Ongoing** A jointly agreed process is being developed with the CCG which includes information capturing and improvements to internal business support and SCAS processes to ensure accuracy is improved.
11.3	Management should develop formal terms of reference for meetings for the parties outlined. The terms of reference should ensure that membership roles and responsibilities, decision making arrangements, reporting arrangements, etc. are appropriately detailed.	2 - High	Karen Mosgrove – Interim Service Manager, LD Now Robert Broadhead,	30.6.17 **Revised Timescale** 31.3.18	**Ongoing** A terms of reference and standard operating procedures will be written for the new process and the meetings/Panel arrangements

			HoS Localities		
11.4	Management to review all policy and procedural documents developed by CCG to ensure they are appropriate. Management to then meet with the CCG to agree and update these documents as appropriate. Once these policies and procedures have been agreed, all staff are to receive training in the policies and procedures. All policies and procedures should be made available to all staff (and clearly identified) on ELMA. All policies and procedures to be regularly reviewed.	2 - High	Karen Mosgrove – Interim Service Manager, LD Now Robert Broadhead, HoS Localities	30.6.17 **Revised Timescale** 31.3.18	**Ongoing** See 11.2
11.5	Management to develop clear procedures for the management and escalation of disputes by SCC staff/clients. Once the procedures have been agreed, all staff to be trained in the application and management of the procedures. The procedures and guidance should also be suitable for use by clients or their families, which staff should be able to advise as appropriate. All cases in dispute should be logged and managed centrally by senior managers to ensure a prompt response and resolution of the dispute.	3 - Medium	Karen Mosgrove – Interim Service Manager, LD Now Robert Broadhead, HoS Localities	30.9.17 **Revised Timescale** 31.3.18	**Ongoing** The new process includes a dispute resolution function, the details are still to be fully developed.
11.6	Management should revisit the recharging framework/agreement for CHC care provision, to ensure a more equable agreement is set up. To ensure that when a dispute or a review is ordered by the CCG, health funding is maintained at a certain level.	2- High	Karen Mosgrove – Interim Service Manager, LD Now Robert Broadhead, HoS Localities	30.6.17 **Revised Timescale** 31.3.18	**Ongoing** Recharging will be looked at as part of the second element of the project mentioned above.
11.7	All records for each client to be centralised within carefirst/wisdom. Carefirst/wisdom should be the first point of reference for ALL records relating to clients, records should not be kept on individual's G drives, as this will impact on service delivery to the client.	2 - High	Karen Mosgrove – Interim Service Manager, LD Now Robert	30.6.17 **Revised Timescale** 31.10.18	**Ongoing** More robust information storage and governance will be introduced as part of the Whole Family Case Management implementation.

			Broadhead, HoS Localities		
11.8	Management to decide on the preferred document to be used to record the details/funding decisions made by the CCG panel. This should be formalised, and communicated to all relevant staff via procedural documents and training. The document to be retained as a formal record of acceptance of the funding agreed by either the SCC, CCG or a joint agreement between both parties, and to be formally signed and dated by the relevant officers. The signed formal document recording the funding decisions made should be copied to client records to ensure consistency and provide one source of reference for each client. See also recommendation made at 11.7 regarding use of Carefirst/Wisdom for all client records.	3 - Medium	Karen Mosgrove – Interim Service Manager, LD Now Robert Broadhead, HoS Localities.	30.9.17 **Revised Timescale** 31.3.18	**Ongoing** As in 11.2
11.9	Management to ensure that staff accurately record the funding agreements within Carefirst and input the 'end' date as required to ensure funding ceases. In cases where it is anticipated that funding will be required for a longer period than originally agreed, then a review is to be performed promptly to ensure it is presented to CCG panel in ample time to enable no breaks in funding that result in SCC covering the costs.	3 - Medium	Karen Mosgrove – Interim Service Manager, LD Now Robert Broadhead, HoS Localities.	30.9.17 **Revised Timescale** 31.10.18	**Ongoing** To be included in the WFCM project.
11.10	Linked to the recommendations at 11.1 and 11.2, all decisions and agreements regarding client care packages and funding arrangements should be communicated to SCC. Following changes to funding, full details should be amended in Carefirst by the relevant team. Management to ensure enforcement by periodic, random checks of information held for clients.	2 - High	Karen Mosgrove – Interim Service Manager, LD Now Robert Broadhead, HoS Localities.	30.6.17 **Revised Timescale** 31.3.18	**Ongoing** Better communication between SCC and CCG needed and will be addressed in the CHC project and new end to end process.

11.11	Client records to be updated with their unique NHS numbers to ensure accuracy and completeness in records.	3 - Medium	Karen Mosgrove – Interim Service Manager, LD Now Robert Broadhead, HoS Localities.	30.9.17 **Revised Timescale** 31.10.18	**Ongoing** To be included in the WFCM project
11.12	Management should undertake a review/analysis of care packages where the review date has not been met and prioritise them for a review, on a risk basis eg: cost. All new packages of care that are entered into Carefirst should state either an end date where appropriate, or a date of review. All packages of care entered into Carefirst should have an annual review date unless the package of care is for a period of 1 year or less, and they are not extended. Additionally, review dates agreed with the CCG should be clearly entered within the client records and the Carefirst system should be used to issue a reminder to the relevant social worker. The review to be prioritised, performed and reported to CCG panel for funding decision within the agreed timescales Where a time limited care package has been agreed, and the care is required for a longer period, the case should be returned to CCG panel for approval, unless the cost falls within the agreed tolerance/parameters.	2 - High	Karen Mosgrove – Interim Service Manager, LD Now Robert Broadhead, HoS Localities.	30.6.17 **Revised Timescale** 31.10.18	**Ongoing** Ongoing now and to be included in the WFCM project.
11.13	Client Carefirst records to be clearly updated as to the source of funding for the care packages agreed by CCG panel, to enable ease of identification of funding source.	3 - Medium	Karen Mosgrove – Interim Service Manager, LD	30.9.17 **Revised Timescale** 31.10.18	**Ongoing** Ongoing now and to be included in the WFCM project

			Now Robert Broadhead, HoS Localities.		
11.14	Management should raise the issue of CCG paying providers direct, to ensure the accuracy of cost information regarding each client held in Carefirst.	2 - High	Karen Mosgrove – Interim Service Manager, LD Now Robert Broadhead, HoS Localities.	30.6.17	**Complete** This is already happening with customers that are in residential \ nursing home placements.
11.15	All records relevant to each client should be held within Carefirst. This should routinely include all documentation covering formal handovers from one service area to another such as children to adults. Carefirst (or its replacement) should be the first point of reference for all client records.	3 - Medium	Karen Mosgrove – Interim Service Manager, LD Now Robert Broadhead, HoS Localities.	30.9.17 **Revised Timescale** 31.10.18	**Ongoing** To be included in the WFCM project
11.16	Management within children's and adults services to agree the age ranges and responsibilities for clients aged 16-18 years. SCC to communicate this to the CCG. Ideally the starting age for adult care should correlate across all service areas and providers.	3 - Medium	Karen Mosgrove – Interim Service Manager, LD Now Robert Broadhead, HoS Localities.	30.9.17 **Revised Timescale** 31.3.18	**Ongoing** In development now within the 0-25 services

11.17	Requests for reviews of care packages fully funded by the CCG where the client is progressing from children's to adult care services should be allocated and performed within appropriate timescales. The timescales should be determined by management and communicated to all relevant officers. The CCG should also be informed of these timescales to ensure they provide adequate notice for the review requests they make.	3 - Medium	Karen Mosgrove – Interim Service Manager, LD Now Robert Broadhead, HoS Localities.	30.9.17 **Revised Timescale** 31.3.18	**Ongoing** In development now within the 0-25 services
11.18	In the interests of providing a 'seam free' service, which causes least disruption to the client, it would be prudent for SCC and the CCG to negotiate and agree a way forward to have a mutually agreed list of providers that can deliver the services required for each client.	4 – Efficiency/Effectiveness	Karen Mosgrove – Interim Service Manager, LD Now Robert Broadhead, HoS Localities.	31st March 2018 **Revised Timescale** 31.3.18	**Ongoing** This will be addressed in the CHC project.
11.19	As good practice on a monthly basis SCC to inform the CCG of CHC funded clients who have died or no longer require funding to ensure that funding streams are ceased in respect of these clients.	4 – Efficiency/Effectiveness	Karen Mosgrove – Interim Service Manager, LD Now Robert Broadhead, HoS Localities.	31st March 2018	**Complete** Happening and ongoing.
11.20	Management to negotiate and agree with the CCG a reasonable annual percentage increase range in costs to cover small changes in care package delivery and annual price increases. This would mean that increased costs within the agreed tolerance range would not require a re-presentation of the client package to CCG panel. Increases outside these set parameters should require a review by panel. These tolerances should be communicated to all relevant staff to ensure that this requirement in understood and adhered to.	2 - High	Karen Mosgrove – Interim Service Manager, LD Now Robert Broadhead, HoS Localities.	30.6.17	**Complete** Happening and ongoing

11.21	Officers should attend all CCG panel meetings to ensure that accurate details are recorded for the decisions made on each client's case presented. The decisions recorded should accurately reflect what services are to be provided, and whether SCC or the CCG will pick up the relevant associated costs. The CHC funding tracker should be used to record these details and reviewed and developed further to ensure it can capture all the required information that cannot be recorded in Carefirst. Carefirst replacement system should capture all information.	2 - High	Karen Mosgrove – Interim Service Manager, LD Now Robert Broadhead, HoS Localities	30.6.17 **Revised Timescale** 31.3.18	**Ongoing** The CHC project is looking to reduce the number of meetings and Panels needed which will free up capacity to ensure the right officers can attend. The membership of Panels is being picked up as part of the project and process redesign.
11.22	Management to agree and determine a consistent and appropriate method of recording CCG panel decisions regarding funding in Carefirst/wisdom. This information to be communicated to officers who should also be reminded of the necessity for accuracy and consistency in inputting information into Carefirst/Wisdom.	2 - High	Karen Mosgrove – Interim Service Manager, LD Now Robert Broadhead, HoS Localities	30.6.17	**Complete** Happening and ongoing
11.23	Management to ensure that all packages that are fully funded by the CCG are transferred in their entirety to the CCG. Outstanding disputes to be resolved within a deadline timescale agreed by management with the CCG.	2 - High	Karen Mosgrove – Interim Service Manager, LD Now Robert Broadhead, HoS Localities	30.6.17	**Complete**
11.24	Management should prioritise queries and undertake analysis to determine the reasons for the outstanding payments.	2 - High	Karen Mosgrove – Interim Service Manager, LD Now Robert Broadhead,	30.6.17	**Complete** Happening and ongoing

			HoS Localities		
11.25	Management to explore the feasibility of working with care providers within the city to provide appropriate and fair cost care packages for each client, which meet the particular needs of each client, rather than the label of the care grouping the client falls within. Each package of care should be tailored to the individual concerned with appropriate risk assessments etc. supporting the decision making process, however the decision process should include an assessment of the progression of the medical, mental and physical needs of the client and the risks they pose to themselves as well as to others involved in their care. This assessment should explore if these needs are best met within a specialist (e.g. learning disability) facility or within a more mainstream facility (e.g. dementia care).	3 - Medium	Karen Mosgrove – Interim Service Manager, Learning Disabilities Now Robert Broadhead, HoS Localities	30.6.17	**Complete** Happening and ongoing
11.26	All care packages where the care provided to a client exceed the parameters agreed (as per recommendation made at 11.21) to be subject to review and re-presenting to CCG panel for approval.	3 - Medium	Karen Mosgrove – Interim Service Manager, LD Now Robert Broadhead, HoS Localities	30.9.17	**Complete** Happening and ongoing
11.27	Management should develop and document a data-sharing protocol with the CCG regarding sharing of data on CHC care packages (including how to treat security breaches). Once this protocol has been agreed staff should be trained to follow the protocol. The protocol should be made available on ELMA.	2 - High	Karen Mosgrove – Interim Service Manager, LD Now Robert Broadhead, HoS Localities	30.6.17 **Revised Timescale** 31.10.18	**Ongoing** Ongoing in line with the WFCM process change.

12. Strong Economy Projects (Place) (issued to Audit and Standards Committee 8.5.2017)

As at July 2017
This report was issued to management on the 22.2.17 with the latest agreed implementation date of 29.9.17. An update on progress with recommendation implementation will be included in the next tracker report.

As at Jan 2018
A follow-up audit was undertaken in Nov 2017. The results are reproduced below. Of 9 original agreed recommendations, 8 have been implemented and 1 cannot be implemented (as explained below).

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position as a result of Internal Audit follow-up work 7.11.17.
12.1	Deadlines should be set for the review, revision, approval and publication of the Regeneration Masterplans. Once drafted, the Masterplans should be submitted to the Stronger Economy Programme Board (SEP Board) for review and approval. Timescales should be adopted for the future review of the Masterplans.	High	Ed Highfield – Director of Creative Sheffield	30.06.17	The new City Centre Masterplan has been produced and we are well underway with Member briefings. The intention is to take the plan to Cabinet in December, although this date may slip depending on decisions made about the Local Plan. The action is however substantively complete. <u>Internal Audit opinion</u> Internal Audit viewed the City Centre Masterplan and evidence of submission to the SEP Board for endorsement and onward submission to Cabinet. **Action Complete**
12.2	Representations should be made to the Sheffield City Region to raise concern at the tight application deadlines for SCRIF funding (and the impact that this has on the Council's internal capital approval processes), requesting that these be amended to ensure that those internal processes can be applied and projects developed with suitably levels of	High	Ed Highfield – Director of Creative Sheffield	28.02.17	It has not been possible to align SCR and SCC time scales and processes. They remain 2 separate and different processes. To address this, we have tightened up internal processes via the Place Programme Office and Strong Economy programme Board to ensure

	scrutiny and governance.				that business cases do not go to SCR before they have been through SCC's Gateway process. <u>Internal Audit opinion</u> Given the statement made by the Director, the actions taken are viewed as a compensatory control. Therefore Internal Audit regards the action as complete. **Action Complete**
12.3	Internal Audit considers that the stated development and implementation of a SCRIF Programme Operating Model would address concerns regarding current non-compliance with the corporate Capital Gateway Framework. It is therefore recommended that deadlines be set for the early completion and roll out of Operating Model. Consideration should be given to whether training should be provided as part of the roll out of the Operating Model. Responsible managers should then be held accountable for its implementation and the embedding of the processes.	High	Ed Highfield – Director of Creative Sheffield	30.09.17	The new Programme Manager is in post and having a positive effect. Board structures and operating models have been reviewed by the new Programme Manager with changes currently being agreed with the Exec Director. The roll out of new arrangements e.g. board structure and membership, presents another opportunity to raise awareness of expectations, roles and the operating model <u>Internal Audit opinion</u> Internal Audit was provided with the presentation given by the new Place Programme Manager and the new model and arrangements. **Action Complete**
12.4	Having reviewed the contents, Internal Audit considers that the adoption of the SCRIF Programme Operating Model would be a suitable response to a number of findings raised in this Audit Report and would provide robust control and governance for the delivery of SCRIF Projects. On that basis Internal Audit re-iterates its previous recommendation - that the SCRIF Programme Operating Model be finalised and promptly rolled-out to all relevant services as the basis for sound	High	Ed Highfield - Director of Creative Sheffield	30.09.17	The Strong Economy Board has ensured and oversees the operating model's implementation. For example, roles are clearer and there a much reduced instance of SCC Gateways being missed. The key is sustaining this improvement with the new board structures outlined above. <u>Internal Audit opinion</u> Linked to 12.3, Internal Audit was provided with SEP Board minutes that evidenced monitoring of projects as part of the revised model.

	management of those projects. The Programme Board should then monitor all projects against the model to ensure procedures are fully embedded.				**Action Complete**
12.5	The requirement to submit changes or variations for approval by the CPG is outlined within the Capital Approvals procedures set out in the SCRIF Programme Operating Model. Therefore the recommendation raised at 12.4 regarding the completion and timely roll-out of the Operating Model, further applies.	High	Ed Highfield – Director of Creative Sheffield	30.09.17	As 12.4 **Action Complete**
12.6	All future SCRIF projects should include within their costings an agreed budgetary provision for the recharging of the anticipated Programme Managers costs. Management should determine how this recharge is to be secured in relation to on-going projects, where no budgetary provision has been made.	Medium	Ed Highfield - Director of Creative Sheffield	30.04.17	Retrospective recharges have been resolved between CDS and Creative Sheffield. The new Place Programme manager is core funded and has taken on responsibility for many of the functions that were identified at 3.1 so the issue has been resolved. <u>Internal Audit opinion</u> **Action Complete**
12.7	Where project benefits are considered to be achieved over several years, consideration should be given to recharging the individual projects with a "levy" to fund future benefits determination, or to alternative methods of funding this work carried out by CRD officers.	Medium	Ed Highfield - Director of Creative Sheffield	30.09.17	This will not be possible. The way to resolve it would be to have a core funded element of the regeneration function. This is unfortunately not possible in the current financial climate. The regeneration team is a fully project-funded resource; therefore we have an inherent weakness in non-project chargeable tasks like long term strategic planning and benefits tracking. This is an acknowledged vulnerability that is being managed on a day-to-day basis by the service as best as the resources allow. <u>Internal Audit opinion</u> Given the statement above, no further action to

					take on this recommendation. **Action Complete**
12.8	Under existing CRD and CDS service strategies, staff costs should be fully recharged to the respective projects, ensuring that: • All costs are fully recovered by the service; and that • Project accounts accurately record all associated costs, enabling further investigation of any adverse variances to budgeted expenditure.	Medium	Ed Highfield - Director of Creative Sheffield	30.04.17	A cleansing of Time Master codes took place after the audit; providing greater clarity at each Gateway stage about what development costs are being approved allowing more accurate controls and reporting. Project highlight reports are submitted to the Place Programme Office, covering the associated costs and variances etc. Project teams are now better established with earlier involvement of finance colleagues. As a result, budgets are more accurate before they come to the Programme Board. Budget variances are flagged by the Place Programme Office and discussed at each Board meeting via the highlight reports. <u>Internal Audit opinion</u> A programme dashboard for September 2017 was provided for review. It was stated that all variances had been investigated and there were no issues to report. In addition, minutes provided for the September Board meeting supported the statement made by the Director. **Action Complete**
12.9	Management should carry out a lessons learnt review of the Porter Brook Pocket Park project, incorporating representation from all Council services involved in the project. Findings from the review should be considered for incorporation in to the SCRIF Programme Operating Model. Lessons learnt reviews should be programmed for each project to take place promptly following completion of delivery and settlement stages.	Medium	Ed Highfield - Director of Creative Sheffield	30.04.17	The specific lessons learned sessions took place, were written up and were fed back to the Board. A number of valuable improvements were made as a result. The appointment of the new Place Programme Manager has significantly helped with this and has created a more open, reflective and learning culture at the Board as the board matures. <u>Internal Audit opinion</u> Internal Audit were provided with the lessons

	Consideration should be given to the need to carrying out additional reviews where project benefits and outcomes are accrued over a longer term (as with "regeneration" projects).				Learned session date 6.1.17. **Action Complete**

Internal Audit proposes to remove this item from the tracker

13. PCI DSS Compliance (Corporate Review) (issued to Audit and Standards Committee 8.12.16)

As at July 2017
This report was issued to management on the 18.11.16 with the latest agreed implementation date of 30.6.17. 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 2018
An update on progress with recommendation implementation is included below.

Ref	**Recommendation**	**Priority**	**Original Responsible Officer**	**Original Implementation Date**	**Updated position provided by Senior Business Analyst, Business Change and Programme Delivery 22.11.17**
13.1	The implementation of Call Secure is a vital part of the Council's plan to achieve PCI DSS compliance. Under no circumstances must Council Officers key in transactions. This should be clearly communicated throughout the project phase.	1 - Critical	Dave Phillips, Head of Strategic Finance	30.06.16 (or in line with project timescales)	**Action Complete** Call Secure began its roll out to services when it went live on 25.9.17 and is on track for completion by 30.11.17. A clear communication and training programme has been adopted to ensure that officers are using Call Secure correctly.
13.2	The roles and responsibilities for PCI DSS compliance must now be clearly formalised and resourced as appropriate. The roles and responsibilities should be clearly recorded within the relevant job descriptions.	1 - Critical	Dave Phillips, Head of Strategic Finance This is being progressed via the PCI working group	31.03.17 **Revised Timescale** 31.1.18	**Action Ongoing** A corporate PCI working group has been established to address this recommendation with membership from officers of all relevant services. Terms of reference for the group including roles and responsibilities have been provided to Internal Audit. This supports a model going forward. The group's overall accountability is to ensure SCC has a PCI compliant card environment, including the key task of delivering

					an annual PCI DSS survey, taking action to address any gaps as required. As such, there is a plan in place detailing owners' actions, dependencies and delivery dates. It is proposed that overall ownership should rests with SCC's delegated 151 Officer as detailed in the PCI TOR. The Draft PCI Policy was submitted to Internal Audit to evidence action take. The policy will be finalised/agreed at the PCI working group on the 20.12.17. It will then go to the IGB on the 18.1.18 for approval.
13.3	It is important that any outstanding actions relating to completed penetration testing are fully reviewed and appropriate action is taken.	2 - High	Dave Phillips, Head of Strategic Finance This is being progressed via the PCI working group	31.03.17 **Revised Timescale** 31.12.17	**Action Ongoing** A plan to address internet site vulnerabilities is in place to be completed by the end of December 2017. An independent penetration test is planned to be carried out by certified agency, Security Metrix, to ensure compliance.

14. Appointeeship Service (People) (issued to Audit and Standards Committee 22.7.16)

As at Jan 2017
This report was issued to management on the 11.7.16 with the latest agreed implementation date of 30.11.16. 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 July 2017
A follow-up audit was undertaken in Feb 2017. Following this review, a number of recommendations were given revised implementation dates which have since passed and so the Head of Service has been contacted. The results reproduced below are a therefore a combination of the outcome of the follow-up review (where an audit opinion is given), and the managers update. Of 36 agreed recommendations, 28 have been completed, 7 are ongoing and 1 is outstanding.

As at Jan 2018
Internal Audit: An update of progress with the 8 recommendations ongoing in the last report was provided by the SCAS Service Manager, the results are reproduced below. It should be noted that the SCAS service has moved to the People Portfolio and is now overseen by the Head of Business Planning, Strategy and Improvement, People Services rather than the Head of Neighbourhood Intervention and Tenant Support. 5 recommendations were stated to have been implemented with 3 remaining as ongoing.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position provided by Charles Crowe - SCAS Service Manager 7.12.17.
14.1	Internal Audit recommends that the business case is revisited to confirm and clarify the project plan and supporting plans to ensure a robust transition of service from the external providers. There should be a revised costing completed for the service, highlighting proposed costs versus actual costs including the direct costs of the new Card Payment System. Clarification is required as to what service users will be charged and what the impact of not charging clients will be on budgets.	High	Maxine Stavrianakos - Head of Neighbourhood Intervention and Tenant Support, Communities Charles Crowe - SCAS Service Manager, People Services	31.8.16 **Revised Timescale** 31.3.18	The business case has been reviewed and is under consideration by senior management. **Action ongoing**
14.2	Management should validate the records of clients transferring in to SCC, to ensure that DWP have the correct details. This should mitigate the risk of future claw back of funds. This risk should also be included on the risk management plan. It is the responsibility of the Service to inform the DWP of client changes in circumstances to avoid benefit claw back. Management should develop a process for notifying changes to the DWP to mitigate the risk in future.	High	Maxine Stavrianakos - Head of Neighbourhood Intervention and Tenant Support, Communities Charles Crowe - SCAS Service Manager, People Services	31.8.16 **Revised Timescale** 31.8.17	A procedure has been drawn up and is in use. New cases are still limited to Safeguarding support. **Action complete**
14.3	Management need to establish the exact number of clients that have transferred, those yet to transfer, and the capital involved. A review of the timescales also needs to be conducted. With regard to those clients that have already transferred, a reconciliation of their accounts needs to be undertaken to ensure SCC have sound financial information going forward.	Critical	Maxine Stavrianakos - Head of Neighbourhood Intervention and Tenant Support, Communities Charles Crowe - SCAS Service	31.5.16 **Revised Timescale** 31.8.17	Reconciliations of the existing cases have been completed. All cases have now transferred. **Action complete**

			Manager, People Services		
14.4	An SLA should be developed and put in place. It should cover the services the team will provide, to whom, when and at what level. It should spell out the differences for residents in care homes and those in the community. Additionally, it should include the setting up of direct debits, providing advice on household providers, how the clients will be referred to the service and the relevant forms required for requesting services/payments etc. Once complete, this should inform the staffing requirements for the service.	High	Maxine Stavrianakos - Head of Neighbourhood Intervention and Tenant Support, Communities Charles Crowe - SCAS Service Manager, People Services	31.8.16 **Revised Timescale** 1.4.18	The SLA is under review to fit with new business case. This has been delayed until signoff of new model of support. The SLA will be part of implementation of new business model. **Action ongoing**
14.5	Job descriptions for all staff who deal with appointeeships should be put in place. Each job description should be complete, cover all expected aspects of the appointeeships process and be reviewed on a regular basis.	Medium	Maxine Stavrianakos - Head of Neighbourhood Intervention and Tenant Support, Communities Charles Crowe - SCAS Service Manager, Communities	31.8.16 **Revised Timescale** 31.8.17	Post/JDs have been taken to Grading panel and approved. Approved recruitment now in process. **Action complete**.
14.6	Management should formalise the stakeholders for the appointeeships service. This should include a full and up to date listing of external and internal stakeholders. It should specify how, when and what method of communication is preferred. This list should be reviewed on an annual basis.	Medium	Maxine Stavrianakos - Head of Neighbourhood Intervention and Tenant Support, Communities Charles Crowe - SCAS Service Manager, People Services	Agreed **Revised Timescale** 31.8.17	Stakeholders are recorded by client and the method of communication is recorded against the stakeholder on their record. **Action complete**

14.7	Management should ensure that the issues raised are addressed and data being held on appointees is held more securely. Findings - documents were not password protected - personal data was being sent via unsecure email and again not password protected - client records were not stored consistently; some were in locked cupboards, some were in a locked room. - client records were mainly stored as paper records, via loose leaf not secured in manila folder - paperwork was not referenced with regard to client name, number, - the executor services safe was located on a corridor, not in an available locked room - records were stored by client manager rather than alphabetically.	High	Maxine Stavrianakos - Head of Neighbourhood Intervention and Tenant Support, Communities Charles Crowe - SCAS Service Manager, People Services	31.8.16 **Revised Timescale** 31.8.17	Update provided by Executor Services Manager 8.6.17 All staff now have GCSX emails and the spreadsheets we use can only be accessed by this team. 80% of the paperwork has now been referenced. All client files are labelled and are stored in alphabetical order by worker. Client records kept in locked storage. Keys are locked in a key cupboard at end of each day. Safe has to stay where it is due to weight bearing floor. **Action complete**
14.8	Fraud awareness training should be undertaken, for all staff, ideally to be completed before the start of the next financial year.	High	Maxine Stavrianakos - Head of Neighbourhood Intervention and Tenant Support, Communities Charles Crowe - SCAS Service Manager, People Services	31.8.16 **Revised Timescale** 31.3.18	All staff have received data protection and fraud prevention training. Still awaiting revised corporate fraud training, and external training was not possible due to budget constraints, will be requested as part of next years' training plan. **Action ongoing**

15. Intermediate Care Assessment Team (ICAT) to Short Term Intervention Team (STIT) (People) (issued to Audit and Standards Committee 22.7.16)

As at Jan 2017
This report was issued to management on the 11.7.16 with the latest agreed implementation date of 30.11.16. 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 July 2017
A follow-up audit was undertaken in Feb 2017. Following this review, a number of recommendations were given revised implementation dates which have since passed and so the Head of Service has been contacted. The results reproduced below are a therefore a combination of the outcome of the follow-up review (where an audit opinion is given), and the managers update.

As at Jan 2018
Internal Audit: An update of progress with the 3 recommendations ongoing in the last report is provided below. Please note, 1 recommendation will be actioned with the implementation of the new Whole Family Case Management system in 2018.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position - provided by Head of Access and Prevention, Communities 7.11.17.
15.1	It is recommended that a service or operational plan (or similar) is developed with more detail than existing documentation, to include items such as budgets, objectives, targets etc. with clear links to Council and City Outcomes.	Medium	Sara Storey – Head of Access and Prevention, Communities	30.11.16 **Revised Timescale** 30.9.17	The ICAT team no longer exists following the re-structure. Therefore we will not be writing a detailed operational plan for it. **Action no longer required**
15.2	All job descriptions should be updated in line with current council templates and standard information. There should be an additional section which details the worker's responsibilities in the ICAT team.	Medium	Sara Storey – Head of Access and Prevention, Communities	30.11.16 **Revised Timescale** 30.9.17	The ICAT team no longer exists following the restructure. Therefore there are no jobs within the ICAT team to review. **Action no longer required**
15.3	A data cleanse of the open service packages on CareFirst with regards to STIT/in-house packages should be undertaken with old service packages being closed and a differentiation made on the packages between these two types of packages. Once this data cleanse is complete, packages on CareFirst should be checked periodically to ensure that data is correct on an ongoing basis. This should be instigated once the data cleanse has taken place.	High	Sara Storey – Head of Access and Prevention, Communities	30.11.16 **Revised Timescale** 1.7.18	No update – Whole Family Case Management (WFCM) is due for implementation in 2018 and this action will not change before then. **Action dependent on introduction of new system – ongoing but with a long implementation date**

Internal Audit proposes to remove this item from the tracker

16. SCAS - Residential and Nursing Agreements (People) (issued to Audit and Standards Committee 1.8.16)

As at Jan 2017
This report was issued to management on the 12.7.16 with the latest agreed implementation date of 30.04.17. An update on progress with recommendation implementation will be included in the next tracker report.

As at July 2017
A follow-up audit was undertaken in May 2017 and the results are reproduced below.

As at Jan 2018
Internal Audit: An update of progress with the 3 recommendations ongoing in the last report is provided below. 1 recommendation was stated as implemented with 2 remaining as ongoing.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position - provided by SCAS Service Manager on 7.12.17.
16.1	A review of key performance indicators should be completed to enable more relevant management information to be available. Relevant measures to determine how many packages have been completed within different time brackets for example within 8 weeks, between 8-12 weeks, between 12–24 weeks, and how many over 6 months. The breakdown of package type i.e. short term/long term care should be included. Structured KPI's would highlight where issues are and assist management to establish if there are training and communication requirements which would help speed up the process.	Medium	Maxine Stavrianakos- Head of Neighbourhood Intervention and Tenant Support Charles Crowe - SCAS Service Manager	31.12.16 **Revised Timescale** 30.9.17	KPI's have been revised and now show different types of support. **Action complete**
16.2	Monthly reconciliation should be completed of RA1 forms submitted against OEO payments made to ensure that the anticipated expenditure for care home provision has actually been paid and that the Carefirst reconciliation matches. A payment period tolerance should be introduced and where contracts are exceeding this, explanations why	High	Maxine Stavrianakos - Head of Neighbourhood Intervention and Tenant Support	30.9.16 **Revised Timescale** 31.3.18	Sample checks of Carefirst payment and the RA1 forms are underway. A system check of link between Integra and Carefirst is under investigation. This is delayed by implementation of Integra and system issues caused. **Action ongoing.**

	and what affect this will have should be reported to management. More awareness is required about the contract dates covered when processing invoices for payment. It should be considered when looking at the future Carefirst system requirements, that it should be able to provide invoice and payment analysis so that it can support more robust budgeting and reconciliations.		Charles Crowe - SCAS Service Manager.		
16.3	Fraud awareness training should be undertaken by all staff as soon as possible, to ensure that all staff are aware of the process in place.	Medium	Maxine Stavrianakos - Head of Neighbourhood Intervention and Tenant Support Charles Crowe - SCAS Service Manager	30.9.16 **Revised Timescale** 31.3.18	This remains ongoing, awaiting corporate roll out of revised fraud training. External fraud awareness training considered but cost prohibitive. **Action ongoing – due to the corporate roll out of e-learning package.**

17. The Markets Service (Place) (issued to Audit and Standards Committee 28.9.16)

As at Jan 2017
The final report was issued to management on the 9.9.16 with the latest agreed implementation date of 31.3.17. 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 July 2017
A follow-up audit was undertaken in May 2017 and the results are reproduced below. Of 18 recommendations agreed, 14 have been implemented and 4 are ongoing. Please note: Internal Audit have not conducted further onsite testing to validate the assurance provided by the Head of Service.

As at Jan 2018
Internal Audit: An update of progress with the 4 recommendations ongoing in the last report is provided below. 2 have now been completed and 2 are ongoing.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated Position & Revised Timescale from Richard Eyre, Head of Markets. 23.11.17
17.1	Internal Audit notes the intentions of the Head of Markets and recommends that arrangements be put in place for the systematic replacement of all Moor Market Tenancies at Will with the preferred 5-year leases. Arrangements should include the monitoring of responses from traders to ensure that all leases are implemented on a timely basis and that no traders continue to operate on Tenancies at Will after an agreed date.	High	Head of Markets	30.12.16 **Revised Timescale** 31.3.18	**Action ongoing** Arrangements are in place to move all traders onto a lease after their initial start-up period (no longer than 12 months). It has proven to be difficult to implement across the market especially as there is no financial incentive for the trader to move onto a new lease (as it will cost the trader more). Currently 10% of traders have Tenancy At Wills with no renewal date so Head of Service has agreed with Markets Manager to extend the 100% implementation date to 31st March 2018.
17.2	Markets Management should carry out a thorough review of all Crystal Peaks Market traders to identify all of those without a current 5-year lease. All such traders should then be placed on a 5-year lease or removed from the Market. Robust arrangements should be put in place across the Markets Service for the monitoring of traders leases to ensure that: - No trader is given access to market stalls without first having returned a fully signed lease; and - All leases due for renewal are identified and actioned in advance of the termination date. Over and above this, Markets management should seek guidance from Legal & Governance as to the recoverability of arrears relating to traders without a current lease, as well as the Council's vulnerability to legal obligations in relation to prolonged occupation by	High	Head of Markets	31.03.17 **Revised Timescale** 31.01.18	**Action ongoing** Review completed and work ongoing to move traders onto leases. It has proven a long process due to the lack of clear incentive for the trader. However only 7% are outstanding which aren't on a lease or license due to being a new trader. The outstanding ones are being addressed by the Markets Manager with Legal advice. A revised target of full compliance by end of January. No traders are given access to stalls without returning a license and made fully aware that no later than 6 months after the date of occupancy they will be required to move onto a lease. All leases/licenses are now tracked on a spreadsheet and actions reviewed monthly by the Markets Manager. L&G have provided advice and on-going

	traders without lease or licence. Where arrears were considered to be irrecoverable, arrangements should be made to write-off the income.				guidance. This includes that any trader who doesn't have a licence or a lease is automatically switched to a Tenancy At Will. This means that we have landlord rights and can terminate after 7 days' notice.
17.3	The monthly Markets debt management arrangements should be extended to incorporate the review and administration of debts in Crystal Peaks and Parkway Wholesale Markets.	High	Head of Markets	31.08.16 **Revised Timescale** 30.06.17	**Action complete** All sites now form part of the Monthly Debt Management Group attended by ICAMs, Legal and Markets.
17.4	Markets management should systematically review Crystal Peaks and Parkway Wholesale Markets traders' arrears on a case-by-case basis and determine action to be taken to address the arrears. Particular attention should be given to whether sufficient, timely and appropriate management action had been taken to recover the most significant levels of arrears following the previous Internal Audit report in January 2015. Procedures reflecting those in place for the Moor Market should be adopted for the Crystal Peaks and Parkway Wholesale Markets: The Markets Manager should be required to review arrears on a monthly basis and report to the debt recovery meeting on the current position and action taken. All action should be formally set out to the trader in question and retained on the respective tenancy file Once defined the situation should be monitored to ensure agreed action is followed Prompt review and action should be taken in line with the 60-day rule so as to maximise income retained by the Service.	High	Head of Markets	31.08.16 **Revised Timescale** 30.06.17	**Action complete**. As above

	Consideration should be given to referring cases on to debt collection agencies or initiating legal action through the Legal & Governance team. Over and above this, all other recommendations raised in respect of the management of arrears and debt recovery should automatically apply to Crystal Peaks and Parkway Wholesale Markets.				

18. Council Processes for Management Investigations (Corporate) (issued to Audit and Standards Committee 21.11.16)

As at Jan 2017
This report was issued to management on the 20.9.16 with the latest agreed implementation date of 31.12.16. 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 July 2017
An update on progress made with the recommendation implementation is included below. Of 16 recommendations agreed, 10 have been implemented and 6 are ongoing.

As at Jan 2018
Internal Audit: An update of progress with the 6 recommendations ongoing in the last report is provided below. 1 has been completed and 5 are ongoing – all of these relate to the same action to refresh and roll-out guidance and training.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position - provided Finance Manager, Internal Audit 27.11.17.
18.1	The Code of Conduct should be reviewed with specific reference to fraud awareness. Consideration should be given to using MyView or the Learning Development Hub to obtain confirmation from all employees that they have read the updated Code of Conduct. A full refresh of the fraud Internet site should be undertaken and then details published on the homepage to raise fraud awareness.	High	Lynsey Linton, Head of Human Resources Stephen Bower, Finance Manager, Internal Audit	31.12.16 **Revised Timescale** 15.2.18	**Action ongoing** The documentation has now been fully reviewed and updated. Additional policies have been drafted for Anti Bribery and Knowing your Customer. There is also an overarching policy and framework that draws the other elements together. There is also a document to assist schools in identifying and managing fraud risk. These documents are being reviewed by the governance solicitor in Legal Services and will

					then be presented to the Audit and Standards Committee for ratification. This should be with the Audit and Standards Committee in the new year.
18.2	Internal Audit should review and update the counter fraud training course on line. There should be a corporate mandate for all employees to undertake this training by the end of the year.	High	Stephen Bower, Finance Manager, Internal Audit	31.12.16 **Revised Timescale** 31.3.2018	**Action ongoing** Now that the policy and procedure documents have been updated. The e-learning package will be updated to tie in with the new/revised policies. This will be available by the end of march to tie in with the annual training and development cycle.
18.3	Senior management should request that all service areas review their risk registers, to ensure that the appropriate fraud risks have been identified and risk mitigation strategies put in place.	High	Stephen Bower, Finance Manager, Internal Audit	31.12.16 **Revised Timescale** 31.3.18	**Action ongoing** Services review their risk register on a regular basis and fraud is included in this. The revised fraud risk document should encourage new areas to be examined.
18.4	The fraud reporting process should be updated on both the internet and the intranet, part of the refresh recommended in 1.5.	Medium	Stephen Bower, Finance Manager, Internal Audit	31.12.16 **Revised Timescale** 31.3.18	**Action ongoing** The internet pages will be refreshed, when the new policies go live. This will also be at the same time that the whistle blowing policy is republished.
18.5	The method of recording of cases should be reviewed and all cases should include the relevant details including name of the investigating manager, hearing officer, a brief outline of both the allegation and the outcome.	High	Peter White, Human Resources Service Manager	31.12.16 **Revised Timescale** 30.9.17	**Action complete** This has now occurred; reports from the system are used as the basis for discuss of ongoing cases in regular meetings with the Monitoring Officer, Head of HR and Internal Audit. The detail of the reports is evolving.
18.6	The fraud e-learning should be updated and be mandatory for all service staff to complete. This will ensure that all staff have adequate training and knowledge to identify potential fraud at early stage and take the appropriate action, further aiding consistency	High	Lynsey Linton, Head of Human Resources	31.12.16 **Revised Timescale** 31.3.18	**Action ongoing** As above The e-learning package will be updated to tie in

	across the Council.		Stephen Bower, Finance Manager, Internal Audit		with the new/revised policies. This will be available by the end of march to tie in with the annual training and development cycle.

19. Payroll Pension Arrangements (Resources) (issued to Audit and Standards Committee 21.6.16)

As at July 2016
This report was issued to management on the 14.4.16 with the latest agreed implementation date of 1.7.16. 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.

As at July 2017
An update on the 2 remaining recommendations is included below. As per the update in January, a long revised implementation date was given to enable improvements to be implemented within SYPA. This date has still not passed and so the action continues to be on-going.

As at Jan 2018
Internal Audit: An update of progress with the 1 recommendation ongoing in the last report is provided below. Please not that this recommendation will not be fully implemented until April 2018.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position - provided by HR Service Manager 9.11.17.
19.1	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	Medium	Peter White, HR Service Manager/ Shaun Lee – Payroll Manager	21.03.16 **Revised Timescale** 1.4.18	**Action ongoing** SYPA have now shared the monthly returns technical specification and this is being reviewed by SCC. Payroll was in-sourced from Capita on 1.10.17 and a complete systems review has been

	stop the process being unduly delayed.				commissioned by the Councils systems provider Northgate. The Northgate report is due by the end November 2017 and will identify the key areas for improvement.

20. Delivery of Capital Schemes and Capital Gateway Approvals (Place) (issued to Audit and Standards Committee 19.4.16)

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.

As at July 2017
An update on progress with the 2 recommendations that were ongoing in the last report is included below. Both remain ongoing but are due for completion by the end of July 2017.

As at Jan 2018
Internal Audit: An update of progress with the 2 recommendations ongoing in the last report is provided below.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position - Taken from the Place SharePoint tracker system
20.1	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 Framework. In the short term, the acting post holder should be	2 - High	Director of Business Strategy & Regulation, Place	31.03.16 **Revised Timescale** 31.7.17	**Action complete** The CDS Head of Service position has not been recruited to. (15.9.17)

	given suitable support and guidance to avoid unnecessary delays and the effective embedding of the arrangements across the Council.				
20.2	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	31.03.16 **Revised Timescale** 31.7.17	**Action complete** The Assistant Director of Finance confirmed approval to resource the PMO from General Fund.

Internal Audit proposes to remove this item from the tracker

21. Deprivation of Liberties Safeguards (DOLS) (People) (issued to the Audit and Standards Committee 15.4.16)

As at July 2016
This report was issued to management on the 21.03.16 with the latest agreed implementation date of 30.9.16. 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. 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.

As at July 2017
A follow-up audit was undertaken in Feb 2017. Following this review, a number of recommendations were given revised implementation dates which have since passed and so the Head of Service has been contacted. The results reproduced below are therefore a combination of the outcome of the follow-up review (where an audit opinion is given), and the managers update. 11 recommendations were deemed to be complete and 1 was ongoing.

As at Jan 2018
Internal Audit: An update of progress with the 1 recommendation ongoing in the last report is provided below.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	**Latest update provided by Simon Richards, Head of Quality and Safeguarding on 23.11.17**

21.1	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	31.03.16 **Revised Timescale** 31.07.17	Risks associated with the DoLS backlog are understood and proactively managed, taking into consideration the nationally acknowledged deficit between demand and available resources to meet that demand. Progress on clearing the backlog is reported monthly to ASCLT. Increases in outputs have been achieved following a business improvement cycle and additional funding agreed by PLT/Cabinet for the DoLS Standard Assessment Project. This has enabled the team to continue to manage resources to ensure the most urgent cases (new and renewals) are prioritised, but to also to start to reduce the numbers of outstanding Standard cases (many of which have been in place for long periods of time). The project (which started in August 2017) is performing well and has made an impact on the overall DoLS backlog. Given Standard cases make up 54% of the total backlog then a concerted focus on reducing the numbers of outstanding Standard cases should have the biggest impact on the backlog. These cases are currently assigned the lowest priority for allocation to a BIA because the person is likely to be settled in the placement with no objections from family and no issues that need addressing. As these cases are also more straightforward there is an option to conduct a 'light touch' assessment, which is being used in the project. Some progress has also been made in improving management of Court of Protection (Community) DoLS. ASC continues to work with Legal to progress Community DoLS and focus

					on higher risk cases. ASCLT has recently asked Legal to provide some up to date advice/recommendations on the service's approach to Community DoLS, to help ASCLT to re-assess risk levels, and prioritise next steps, for this area accordingly. **Action Complete**

Internal Audit proposes to remove this item from the tracker

22. Safeguarding administration and governance (People) (issued to the Audit and Standards Committee 15.4.16)

As at July 2016
This report was issued to management on the 21.03.16 with the latest agreed implementation date of 31.3.17. 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.

As at July 2017
A follow-up audit was undertaken in Jan 2017. Following this review, a number of recommendations were given revised implementation dates which have since passed and so the Head of Service has been contacted. The results reproduced below are a therefore a combination of the outcome of the follow-up review (where an audit opinion is given), and the managers update. Of 17 recommendations, 12 have been completed and 5 are ongoing.

As at Jan 2018
Internal Audit: An update of progress with the 5 recommendations ongoing in the last report is provided below. 3 of these recommendations have been completed and the remaining 2 will be finalised very early in the new year.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position - provided by Head of Quality and Safeguarding 30.11.17
22.1	Internal Audit recommends that the safeguarding processes explicitly include that there is no	Medium	Simon Richards, Head of Quality	30.6.16	As part of reviewing the Safeguarding Practice Guidance, this recommendation has been

	separate near misses policy and that near misses go through the same process as safeguarding.		and Safeguarding	**Revised Timescale** 31.8.17	reviewed. However, as advised by the Associate Designated Nurse for Safeguarding Adults, it is not clear what additional assurances would be realised by including the recommended phrasing. This is because - • Under the Care Act definitions and the 3 point test – this mitigates for people at risk of harm or experiencing harm. • Under the old definitions (No Secrets) we used to consider "significant harm " for inclusion in our workings out as to whether we progressed the case in safeguarding. This was always difficult and very subjective. • The Care Act attempts to simplify when we should act and by definition this could be interpreted as including near misses e.g. incorrect moving and handling is considered neglect/poor practice but no harm may arise (in effect a near miss) – however the poor practice still needs addressing • The current practice and the principles of safeguarding one of the key ones being prevention – is to prevent harm where possible rather than wait for a crisis. Therefore while we accept that it is important that safeguarding practice should address 'near misses', on reviewing the current Care Act compliant guidance, we do not intend to include any additional content using the phrasing 'near miss' as this is not required, and is not the current terminology used within the Care Act. **Action Complete**
22.2	Management should introduce a more robust checking system, whereby a proportion of screened	Medium	Simon Richards, Head of Quality	31.7.16	This is now in place and the first checking audits were piloted in July 2017 and then in

	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.		and Safeguarding	**Revised Timescale** 31.3.17	November 2017. A sample of cases will be reviewed each time: • Where a case has been screened out of safeguarding because it does not meet the 3 stage test, is this being appropriately followed/applied • Where a case has been screened out of safeguarding because another route is more appropriate have the correct actions been taken to address the person's needs • Re-referrals – to check assurance that they are 'legitimate' re-referrals These exercises have provided some assurance of current practice as well as identifying some learning, which can help us continue to strengthen Safeguarding Practice (including training and support within service). These sampling exercises were the first of a rolling quarterly programme of Safeguarding quality assurance exercises. We are reviewing the piloted audit approach to make sure it is proportionate and not unnecessarily risk averse and it will then be embedded in the new Quality Assurance Framework (2018/19). <u>Internal Audit opinion</u> Evidence provided to demonstrate quarterly file audit from July. **Action Complete**
22.3	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	30.9.16 **Revised Timescale**	Adults Safeguarding Office, ASC First Contact and Commissioning now work more closely together when dealing with safeguarding concerns about care providers, therefore helping to ensure that teams are more aware

	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.			15.1.18	of any problem or potential problem with a provider. A draft protocol between First Contact and Commissioning is in place which reflects current practice and governance arrangements. Examples of current practice are: *ASC First Contact / Commissioning interface:* • The process of Incident reporting by professionals working with home care/care home using an incident reporting form (IRF) provides a point of contact to raise concerns which may require quality monitoring visits. If the Commissioning team assess the concern to constitute a potential safeguarding response is required then the IRFs are passed to First Contact for screening and allocation to relevant locality. • The reciprocal arrangement is when a safeguarding concern is received by first contact which does not meet the threshold – this will be passed to contracts as an IRF for information and action by Commissioning These arrangements ensure that concerns regarding incidents related to an independent provider are recorded/captured and actioned on appropriate systems for both First Contact and Commissioning. *Locality Teams:* • Now that ASC have the locality teams in place, the local intelligence relating to care providers in a specific locality will enhance

					information sharing (for example on problems with providers) between the team managers, First Contact and Commissioning. • This will help operational teams have a stronger link with both Adults Safeguarding Office and Commissioning, and will complement the ongoing work of the Adult Safeguarding Office ensuring operational teams are kept aware of policies and procedures. Governance of joint working arrangements will sit with the ASC safeguarding group (with the oversight of the Adults Safeguarding Office and support from Business Strategy as appropriate/required). Monitoring and performance management of the effectiveness of the protocol will be reported to this group. The draft protocol is scheduled for sign off at the next ASC safeguarding group meeting 15/01/17 – following this we would propose closure of this action. **Action ongoing**
22.4	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	31.3.16 **Revised Timescale** 31.8.17	We have an established process in place to take account of feedback and learning from complaints: - There is a quarterly analysis of complaints (including at Safeguarding) at Adult Social Care Leadership Team. - This includes looking at themes and learning, with appropriate follow up by Adults Safeguarding Office <u>Internal Audit opinion</u> The ASCLT complaints report provided as evidence.

					Action Complete
22.5	It is recommended that all data sharing agreements are logged with the Council's Information Sharing Agreements Sharepoint site.	High	Simon Richards, Head of Quality and Safeguarding	30.4.16 **Revised Timescale** 31.12.17	The South Yorkshire Safeguarding Procedures includes a section on information sharing section (see SharePoint ISA 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. An Information Sharing Agreement has been developed to further support detailed information sharing arrangements. This will be formally endorsed as a working document at the Safeguarding Operational Board on 15 December 2017 (and will be uploaded onto the SharePoint ISA site following this – following this we would propose closure of this action). **Action ongoing**

23. External Funding (Corporate Review) (Issued to the Audit and Standards 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.

As at July 2017
Internal Audit: An update of progress with the 2 recommendations ongoing in the last report is provided below.

As at Jan 2018
Internal Audit: An update of progress with the 1 recommendation ongoing in the last report is provided below.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position - provided by External Funding Manager 8.6.17
23.1	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 Timescale** 30.9.17	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 in relation to external funding has now been delivered to all Portfolio Leadership Teams. - **Action complete** 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** In agreement with Legal, a speedier approval process has been agreed whereby new non-

					EU grants below £100k can be signed off more efficiently without diminishing Finance and Legal controls. The scheme has operated from April 2017. Intranet updates are under review and are something that External Funding will be looking into during 2017/18 to coincide with the intranet provider refresh. In the meantime update information is included on FinancePoint. **Action complete**

Internal Audit proposes to remove this item from the tracker

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