REPORT TO SHEFFIELD CITY COUNCIL AUDIT AND STANDARDS COMMITTEE
24th Jan 2019

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 work 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 information was required by the Audit and Standards Committee.

4. This report also details those high opinion audits that Internal Audit proposes to remove from future update reports because all agreed recommendations have now been implemented. The Audit and Standards Committee is asked to support their removal.

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:
    - Executor Services, People
    - Continuing Health Care in Learning Disabilities, People
    - Pro-Active Work – Declaration of Interests, Corporate
    - Pro-Active Work - Staff Expenses Claims, Corporate
    - ResourceLink Application Review, Resources

Executive Summary

New High Opinion Reports added

No new high opinion items have been added to the report this time.

As agreed, a revised approach for the opinions was introduced in October 2018, consisting of an assurance statement and an overall organisational assessment of the severity of the findings (detailed below).

Overall Audit Assessment
Substantial Assurance - There is an effective system of internal control in place designed to achieve the Service objectives with only minor issues being identified which require improvement.
Moderate Assurance - There is a sound system of internal control in place with some weaknesses being present which may put some of the Service objectives at risk. Issues require management attention.
Limited Assurance - The system of internal control in place has some major weaknesses which may put the achievement of the Service objectives at risk. Issues therefore require prompt management attention.
No Assurance - There are significant weaknesses in the system of control which could result in failure to achieve the Service objectives. Immediate management action is therefore required.

Risk Rating for the Council – Organisational Impact:

Low - Green	The issues identified have no corporate impact.
Medium - Amber	The issues identified have the potential to impact at a corporate level.
High - Red	The issues identified are of high corporate importance. They are either of high financial materiality, present significant business or reputational risk to the Council, have a likelihood of attracting adverse media attention, are potentially of interest to elected representatives, or present a combination of two or more of these factors.

The Audit and Standards Committee members will receive, in full, reports with no assurance (regardless of the organisational impact) and limited assurance with a red organisational impact. These will be followed up on the tracker report.

Since October 2018, no reports with these opinions have been issued.

Recommendation implementation

In total, updates have been provided on all 95 recommendations due for implementation. Of these, 58 (61%) have been implemented and 37 (39%) are ongoing, indicating work has been started but not yet fully completed. No recommendations were considered to be outstanding.

Context
A significant amount of transformational change is underway across the Council to embed the 2020 vision. A number of work streams are being developed which will capture and address the weaknesses identified in a number of the audit reviews included on this tracker.

Items to Note
Of 5 critical recommendations ongoing in the last update report, 2 of these have now been implemented. 2 ongoing recommendations are contained within the OHMS application review and relate to arrangements for upgrading and maintaining the system, which are both in progress as part of the Tech2020 programme.

The final critical recommendation is contained within the CHC in Learning Disabilities report, which is discussed below.

Continuing Health Care (CHC) in Learning Disabilities (People)
A critical recommendation was raised relating to joint working arrangements with the CCG. Standard Operating Procedures have been completed and were scheduled for sign off in December.

More generally, as a result of the Adults Social Care reorganisational change, the Learning Disability Team no longer exists and CHC processes are integrated into Locality Operating Model. Service management confirmed there has been a lot of activity to implement the Internal Audit recommendations as part of the CHC Process Review project (and other higher level organisational work with the CCG) over the past 6 months. Due to the change in delivery methodology, Internal Audit are proposing to remove this item from the tracker and pick up any issues remaining as part of a wider CHC audit. In particular Internal Audit will check that the critical recommendation has been signed-off.

Housing Benefits Accuracy Rectification Plan (Resources)
4 recommendations were accepted following the original review, 3 of these have been satisfactorily implemented. For the remaining recommendation, whilst an improvement plan is in progress, the error rates still exceed the allowable 10%. A reduction in error rates was shown in June 2018 but since then error rates have steadily increased which continues to be a concern. It should be noted that the Capita Benefits contract will end in 2020, after which the service will be delivered in-house. Responsibility for reducing error rates will then lie with the Council.

Executor Services (People)
This audit was completed and reported on in November 2017 with the latest agreed implementation date of 31.10.18. It was pleasing to note that the follow-up review confirmed all actions had been satisfactorily implemented and so this item can be removed from the tracker.

ResourceLink Application Review (Resources)
This report was issued to management in May 2018 with the latest agreed implementation date of 30.11.18. It was pleasing to note that management have confirmed all actions had been satisfactorily implemented and so this item can be removed from the tracker.

Report to EMT
The high opinion tracker report was presented to the Executive Management Team on the 8th January 2019.

Members of EMT noted the content of the report and that the ongoing recommendations, whilst in-progress, have all exceeded their original implementation dates.

It was acknowledged by EMT members that many of the recommendations are being addressed as part of wider transformation programmes; EMT particularly focused on the 3 critical priority recommendations deemed to be ongoing, and discussed how all were being covered by wider recovery/programme activity.

SHEFFIELD CITY COUNCIL
UPDATED POSITION ON HIGH OPINION AUDIT REPORTS AS AT JAN 2019

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**
Housing Responsive Maintenance Van Stock Controls		6	1							6	1			
Housing Benefits Accuracy Rectification Plan		4				3				1				
IT Resilience/Recovery		3				1				2				
Executor Services		6	4	1		6	4	1						
ResourceLink Application Review	1	5	2		1	5	2							
OHMS Application Review	2	2	1			2	1		2					
Pro-active work - Staff Expenses Claims		2				2								
Pro-active work – Declaration of Interests		3	2			3	2							
Revenues and Benefits Contact Centre		2	2			1				1	2			
Pro-active work - Appointeeships		3	1			2				1	1			
The Licensing Service	1	5	3		1	5	2				1			
Training Centres		4	2			3	1			1	1			
Subject Access Requests		2								2				
Controls in Town Hall Machine Room		1								1				
Continuing Health Care in Learning Disabilities	1	9	8			4	5		1	5	3			
Appointeeship Service		3								3				
Council Processes for Management Investigations		2	1				1			2				
Total	**5**	**62**	**27**	**1**	**2**	**37**	**18**	**1**	**3**	**25**	**9**			

Shaded items to be removed from the tracker

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1. Housing Responsive Maintenance Van Stock Controls (Place) (issued to Audit and Standards Committee 3.5.18)

As at July 2018
This report was issued to management on the 24.4.18 with the latest agreed implementation date of 30.6.18. 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 2019
Internal Audit: A follow up audit was undertaken in late October 18 and an update on progress with recommendation implementation is included below.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position taken from internal audit follow-up work 30.10.18.
1.1	Procedural documentation should be produced (covering the issues listed opposite) and issued to all staff involved with van stocks. The procedural documentation should set out the control framework and the expectations placed on staff. **<u>Management Comment</u>** *Over and above this the Head of Housing Responsive Maintenance, is to produce an Action Plan to be rolled out to management and staff to ensure consistent application of procedures.*	2 - High	Service Manager, Stores, Logistics & Fleet	30/06/18 Revised implementation date: 31/01/2019	**Action ongoing** This work has not progressed due to recent changes within the management arrangements in the RMS Service. A Project Team is now in place within the Service to develop a new target operating model. The Project Team are currently carrying out a detailed review of the stores function which will inform future operating procedures. A resource has been identified to draft the procedures which we aim to complete by the 31st January 2019. The Service has developed its Service Plan with specific emphasis on performance management to ensure that there are clearly communicated expectations in relation to compliance with procedures across the Service.
1.2	The service review should consider the suitability and development requirements of the Callsys management system. The service review should then conclude whether to continue with the development of Callsys or to	2 - High	Head of Housing Responsive Maintenance,	30/06/18 (relates to the interim action re Callsys)	**Action ongoing** A Project Team is now in place within the Service to develop a new target operating model.

	purchase a more suitable management system. In the short term, management should collate a log of all Callsys functionality issues and development requirements. Priority should be given to working with the systems developers to address the most significant of these. **Management Comment** *It was confirmed that the service review would consider the applicability of Callsys, together with the feasibility of procuring a bolt-on stock control package. The review was likely to take 12-18 months to complete.* *In the intervening period, a number of developments outstanding on Callsys are to be raised by management for Cohesis (the system's developers) to progress.* *The Head of Service had prioritised these issues and the stores ones were not considered a priority over operational ones.* *In addition management are now pursuing exploring other warehouse ICT management systems.*			Revised implementation date: 30/11/2018	The Project Team are currently carrying out a detailed review of the stores function which will include a review of the current and future ICT / Business management systems. Early indication is that the existing system will continue to be used and if possible upgraded until a new system is procured which meets the requirements of the Councils ICT Strategy and SCC20 Vision.
1.3	Operational service management should be reminded of the importance of formally transferring all van stocks where vans are transferred between operatives. Operational expediency should not justify the failure to apply key stock controls. Continued failure to do so should result in escalation to the Head of Service.	2 - High	Head of Housing Responsive Maintenance	30/04/2018 Revised implementation date: 30/11/2018	**Action ongoing** Operational managers have been reminded of the procedures and this is being managed within Service. Albeit there is room for improvement and reminders to operational managers will be issued by the HOS.
1.4	Service management should systematically review van stocks' exposure to theft and fraud.	2 - High	Head of Housing Responsive	30/06/2018 Revised	**Action ongoing** The Service is currently updating its Risk

	Suitable mitigation strategies should be developed in line with the risk exposure. The risk mitigation strategies should be periodically reviewed so as to ensure that these remain operational and effective. Head of Housing Responsive Maintenance was further referred to the Council's Corporate Risk Manager, as well as the Place Resilience Team for further guidance on risk management arrangements in the Portfolio. **Management Comment** *Head of Housing Responsive Maintenance confirmed that since reporting, he had met with service management and identified the service risks.* *A risk register had now been set up on the Portfolio Share Point site.* *It was agreed that fraud and theft risks will be identified and mitigation strategies considered in line with anticipated loss calculations.* *Using historic data relating to van stock write-offs, management had established an "acceptable loss" figure of £0.31/van stock/day. Action would be taken to determine whether the service could improve on this.*		Maintenance	implementation date: 30/11/2018	management procedures and will ensure that van stocks are identified as a significant risk and ensure that this is suitably mitigated against.
1.5	Maintenance Managers should be reminded of the need to carry out prompt, thorough and effective investigations in to reported van stock discrepancies. Responses should be monitored by the Service Manager, Logistics, Stores & Fleet and any late or inadequate responses should be escalated to Operational Service Managers.	2 - High	Head of Housing Responsive Maintenance	30/04/18 Revised implementation date: 30/11/2018	**Action ongoing** Procedures are in place and this is being managed within Service. Albeit there is room for improvement and reminders to operational managers will be issued by the HOS.
1.6	Procedural documentation for the control of van stocks (discussed previously in this report) should	3 - Medium	Head of Housing	30/06/2018	**Action ongoing**

	clearly set out management's responsibilities under the Council's Fraud & Corruption Policy to take disciplinary action against any operatives found to have stolen or misappropriated any of those stocks. All staff and management should be made aware of the Council's zero tolerance of fraud and theft.		Responsive Maintenance	Revised implementation date: 31/01/2019	As per 1.1 The HOS will ensure that appropriate disciplinary action is taken where necessary if there is a failure to comply with reasonable management instructions and the Council's Fraud & Corruption Policy.
1.7	Management should introduce arrangements for the systematic review of repairs and maintenance jobs and the materials booked out to them as a deterrent against the misappropriation of van stocks. Management should consider the effective targeting of inspections through the use of specific exception reports. Internal Audit acknowledges that such reports are not currently available via Callsys (see previous Audit Findings), but further recommends that management work with the system's developers to determine whether a short term solution is available to provide equivalent levels of information and control.	2 - High	Head of Housing Responsive Maintenance	30/06/2018 Revised implementation date: 30/11/2018	**Action ongoing** The Service is currently reviewing its QA procedures and will ensure that quality checks are carried out and include physical checks on materials booked to jobs from van stocks against what was installed.

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2. Housing Benefits Accuracy Rectification Plan (Corporate) (issued to Audit and Standards Committee 21.5.18)

As at July 2018
This report was issued to management on the 25.4.18 with the latest agreed implementation date of 30.6.18. 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 2019
Internal Audit: A follow up audit was undertaken and an update on progress with recommendation implementation is included below.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position taken from internal audit follow up work November 18.
2.1	Revenues & Benefits Client Team and Capita management should ensure that any future	High	Emma Hall, Contract	Plan to be implemented in	**Action complete**

	rectification plan should contain more detailed, measureable actions. There should also be a requirement for Capita to report outcomes of the individual actions on a regular basis. Managers comments New improvement plan rather than rectification plan is currently being developed. Agreed, as an aspiration although it may not be possible to attribute specific actions to general or specific improvements.		Director, Sheffield Revenues and Benefits, Capita	March 2018	Accuracy Improvement Plan was introduced in March 2018. This included reference to the original audit recommendations. Actions are more detailed and measurable than those in the original rectification plan. Reporting is included in a monthly performance report. Internal Audit opinion A review of monthly performance report and minutes from the SCC/ Capita Management Board meetings was undertaken and considered adequate.
2.2	Capita should provide Client Team management with evidence of the specific actions being undertaken during regular updates to enable meaningful and effective changes to be made to the rectification plan to ensure the error rates are reduced. Commercial Services Contract Management should ensure any contract penalty is invoked. The contract should be reviewed to the introduction of a penalty system that provides a series of stepped deterrents as error rate increase. If this is not feasible for the existing contract, upon expiry, consideration should be given to the introduction of stepped deterrents for similar ongoing error rate increases in any future contract. Managers comments The contract already caters for performance deductions when the KPI's are not met. The payment mechanism is applied monthly. The PI for accuracy has not been met now on 3	High	Emma Hall, Contract Director, Sheffield Revenues and Benefits, Capita Demi Turner, Senior Procurement & Supply Chain Manager Jon West, Senior Finance Manager, Income Collection & Management and Revenues & Benefits	31st March 2018 Revised implementation date 31.3.19	**Action ongoing** Results are reported monthly and evidence was provided of the initiatives being introduced in stages. Service credits for Q1 (April – June 18) were invoked, which are yet to be received. Results for Q2 are currently being reviewed. The service credits relate to KPI 4 (No. of PI's Achieved) of which missing the target for Accuracy PI forms part of the failure of this KPI. The Capita contract will end in 2020 when the service will be delivered in-house therefore final recommendation is no longer applicable.

	consecutive occasions. Client team and Commercial Services to review next steps under the contract. SCC cannot compel Capita to accept a stepped deterrent system under the current contract. Upon expiry of the Capita contract, consideration will be given to the introduction of stepped deterrents in any future contract.				
2.3	Management board minutes should include and clearly demonstrate the reported error rate figures. Any discussion should be noted to demonstrate a clear understanding of the up- to-date position. It is also recommended that the Head of Commercial Business Development attends the meetings to ensure the Revenues & Benefits Client Team is adequately represented.	High	Jon West, Senior Finance Manager, Income Collection & Management and Revenues & Benefits. Tim Hardie, Head of Commercial Business Development	Ongoing	**Action complete** Error rates are documented in the monthly report (as agreed in 1.1) and cross referenced to the risk log. The Head of CBD attends Management Board. Internal Audit opinion Minutes of Management Board meetings, monthly performance reports and the presentation to Management Board in September 2018 were reviewed. It was noted that performance reports and MB minutes provide more detailed information / context than those reviewed in original audit.
2.4	Revenues & Benefits Client Team and Capita management should ensure that any future rectification plan should include how reductions in error rates will be sustained following the period of implementation.	High	Emma Hall, Contract Director, Sheffield Revenues and Benefits, Capita	To be included in the plan starting March 2018.	**Action complete** There has been a focus on four initiatives that, whilst treated as projects, are to be embedded as business as usual. • *Culture change – the customer at the heart of processing* • *Individual accountability for quality* • *Raising the profile of quality* • *Maximising the use of systems* All 4 initiatives as business as usual feed in to sustainability.

3. IT Resilience/Recovery (Corporate) (issued to Audit and Standards Committee 22.12.17)

As at July 2018
This report was issued to management on the 20.11.17 with the latest agreed implementation date of 31.5.18. Due to the timescales for completion of this report an update will be included in the next tracker.

As at Jan 2019
Internal Audit: An update on progress with recommendation implementation is included below.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position taken from the Place Resilience Tracker 30.11.18.
3.1	The Council's key ICT users (and/or services) and the applications that underpin their work should now be identified. Recovery times for key applications should also be determined. Once these have been agreed, liaison with BCIS should take place to determine the necessary disaster recovery arrangements required and actions put in place to plan for this.	2 - High	Mick Crofts, Director of Business Strategy & Regulation Mike Weston, Assistant Director – ICT Service Delivery	May 2018	**Action complete** The Corporate Resilience Group is now reconvened and includes Assistant Director ICT Service Delivery. An Initial refresh of Core Service business applications with recovery response needs, has been prepared and will inform future ICT resilience arrangements post CAPITA.
3.2	Services need to strengthen and document their continuity arrangements in the event of a serious ICT incident. Services should ask themselves what simple measures they need to take in the event of ICT failure. For example, retaining team contact numbers off the Council's network. A service may work with key clients; again, they would need to ensure that they could contact these clients if required. If payments are made to vulnerable clients, they would need to identify how they could continue to make those payments in the event of a serious incident/ICT failure. This should not require services to produce lengthy written documents, rather request that they retain the core information required and the	2 - High	Mick Crofts, Director of Business Strategy & Regulation via Business Continuity Group	May 2018 Revised implementation date: 31.3.19	**Action ongoing** Most services have something in place; however the continuity of robust Business Continuity arrangements is the issue and can be confirmed by Service Risk Management Plans and Annual Governance submissions. This is work in progress.

	plan to be undertaken. Services should be supported to undertake this planning.				
3.3	It is important that in the event of a serious incident/outage, staff understand the contingency arrangements in place and when they need to enact these. Once plans have been fully updated across the Council, these should be communicated appropriately with all staff. All plans should be tested on a regular basis (at least annually) to ensure that they remain fit for purpose.	2 – High	Mick Crofts, Director of Business Strategy & Regulation via Business Continuity Group	May 2018 Revised implementation date: 31.3.19	**Action ongoing** Testing is taking place in some areas, but this is primarily associated with specific incidents and the local capacity to deal with these. Work continues to progress to achieve confirmation of resilience as a Council rather than just at Service level.

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 31.10.18. An update on progress with recommendation implementation will be included in the next tracker report.

As at Jan 2019
Internal Audit: A follow up audit was undertaken and an update on progress with recommendation implementation is included below.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position taken from Internal Audit follow-up work in November 2018
4.1	Management should ensure that Operational/Service plan are updated on a regular basis to reflect the service needs. The Corporate Risk/Fraud Register should be updated to reflect the risks associated with the Executor Services tasks.	3 - Medium	Charles Crowe - SCAS Service Manager	30/04/2018	This risk is now on the SCAS risk register (Risk 13), however it does require review. A service plan is now in place and is due to be refreshed in February 2019. <u>Internal Audit opinion</u> Internal Audit reviewed the risk register for the service and confirmed that Executor Service risks were recorded. The team manager confirmed that the risk register is to be reviewed at the next managers meeting.

					Action completed
4.2	Management should review the current process documentation and ensure it is fit for purpose. Policies should be written and include staff conduct, property and cash handling as a minimum. Procedure and policy notes should be periodically reviewed and updated to include legislation changes. For example, the recent changes in the Care Act for clients going into residential care.	3 - Medium	Charles Crowe - SCAS Service Manager	30/04/2018	The process documents have been put in a more appropriate style and are currently having further updates, this is an ongoing process. Internal Audit opinion Internal Audit was provided with a complete set of process notes that outlined the processes to be followed end to end. **Action completed**
4.3	All property searches should be undertaken as per documented procedures. Staff should always work in pairs regardless of the size of the property to protect each other from potential fraud implications. Cash should be transferred between property and the office in sealed packets and initialled in situ to protect against loss and potential fraud implications. All property removed eg: laptops, cameras, phones etc should be labelled prior to leaving the property; this will ensure they are identifiable upon return to the office.	2 - High	Charles Crowe - SCAS Service Manager	31/01/2018	Staff carry out the searches in pairs as per audit requirements and the guidance. Cash is now transferred from the property in a padded sealed envelope with the officer's signature and date along the seal. It is not possible to label all items when leaving the property due to the condition of the property and the number of items, dependent upon size, they are also brought back in, in a sealed envelope. Internal Audit opinion Internal Audit was also informed that there were now 2 permanent team members in place that carry out property searches. **Action completed**
4.4	Management should review the process of disposing of client property, including the use of only one house clearance service. Management need to amend the process to ensure suitable controls are in place with regard to unaccompanied visits to properties to collect goods, the completion of an inventory and more detailed	2 - High	Charles Crowe - SCAS Service Manager	30/04/2018	A second company has now been approached for house clearance to be fair to the market. The dealer now provides us with an inventory of items taken from the property and the value he is willing to pay for them. Any monies brought into Executor Services are

	receipts of property removed. Reconciliation of items initially logged and those taken away by the clearance company should also be undertaken and form part of the process. <u>Managers comments</u> We will investigate what the market standards are with regards to house clearance services, especially with regard to the receipting of goods. Disposal of cash will be included in the policy. Payment from house clearances will be banked in the client account where possible, or will be paid to the clients personal spending account (if they are in a care home) or accounted towards their funeral expenses. These will be recorded as income into the council's accounts and marked as a payment on their invoice.				paid into the clients own account wherever possible (account is usually closed upon death). Otherwise it is paid in to Executor Services account where it can be paid towards the funeral if necessary or back to the estate once probate is provided. <u>Internal Audit opinion</u> As per 4.2 **Action completed**
4.5	Management should consider reviewing the storage of client property within the office. All property should be stored in a lockable cupboard regardless of size. Property should be stored in secure/robust packaging to ensure it is safe. The name, date and receipt number should be added to the outside of the package for easy identification. Property should be reconciled to the receipt book every 6 months. Management should also put in place a policy on the disposal of client property from storage, and staff should be informed of this. Photos of the property stored, especially items of value, should be taken and retained with the deceased electronic file for identification purposes.	2 - High	Charles Crowe - SCAS Service Manager	30/04/2018	Retention Periods are included in the process document Items brought into Executor Services are brought in and kept in sealed envelopes or boxes, these are locked in a storage cupboard in a locked room that only Executor Services staff have access to. <u>Internal Audit opinion</u> As per 4.2 **Action completed**
4.6	Management should review the process of removing cash from properties and ensure this is covered	2 - High	Charles Crowe - SCAS Service	31/01/2018	Cash is now banked on a monthly basis; it is kept in a safe and audited until that time.

	adequately in the process notes. Cash should be put into a suitable carrier at the property, recorded and banked at the earliest possibility. All cash should be banked intact and recorded. Loose change should not be retained separately nor added to the office petty cash float. Separate controls need to be put in place for the office petty cash float - as this is used to pay for small items. <u>Managers comments</u> Linked to the previous recommendation, we will ensure that cash is banked on a more regular basis, and that process notes cover cash handling. Cash will be counted and accounted as income against invoices for funeral costs. This will be marked as income on the council's accounts and as a payment towards the funeral invoice (which has first claim on the estate) - and then as a petty cash withdrawal if the money is held in petty cash. If the funeral costs can be fully paid from the clients bank account the cash will be banked in the clients account - if possible - or a client funds account will be created and the sum deposited on that account if not.		Manager		Executor Services no longer have a petty cash tin. Death certificates are paid for on order through the Council as and when needed. Any monies brought into the Council are paid either into the clients account if possible or into executor services account towards the funeral or admin charges. A payment card Is completed for all clients to show where money has been kept. <u>Internal Audit opinion</u> As per 4.1. **Action completed**
4.7	Management need to ensure that the policies surrounding the handling of cash are robust and in line with SCC Financial Regulations. A cap to the amount of cash to be handled by officers should be implemented. Where cash is found in premises that exceed the cap implemented, the use of a security company should be considered.	3 - Medium	Charles Crowe - SCAS Service Manager	30/04/2018	Finding large amounts of money are very rare occurrences; if we are made aware beforehand we would make every effort to pay the money into their account the same day, if not it would be brought back in in sealed envelopes and banked immediately the next day in either the clients account or Executor Services account. Security companies would not collect cash as

					they have to do site surveys before they will collect. <u>Internal Audit opinion</u> As per 4.1. **Action completed**
4.8	Management should follow the guidance as per ELMA. Regular safe audits should be undertaken and recorded.	2 - High	Charles Crowe - SCAS Service Manager	Already completed	Regular safe audits are undertaken <u>Internal Audit opinion</u> Internal Audit was provided with evidence of the last two safe audits. Both were appropriately signed off. Safe audits are now undertaken on a regular basis. **Action completed**
4.9	As part of the process review, management need to ensure there are clear segregation of duties for staff within Executor Services. Management need to consider if the Team Manager attending property searches is both a good use of resources and provides adequate governance of work being carried out by the team. Internal Audit appreciate that resources are limited, however, the use of agency staff in property searches is not advisable. This role should sit with appropriate permanent staff.	3 - Medium	Charles Crowe - SCAS Service Manager	30/04/2018	All staff are now permanent. <u>Internal Audit opinion</u> Internal Audit was further informed that there were 2 permanent, dedicated team members who carry out searches. The team manager only attends if required e.g. to cover sickness etc. This is covered also in the process notes. **Action completed**
4.10	Management should review documentation held on ELMA and the intranet ensuring it is relevant and up to date. Staff should be signposted to the information held on ELMA as it is relevant to the tasks they complete e.g use of worksite safes.	4 – Efficiency and Effectiveness	Charles Crowe - SCAS Service Manager	31/10/2018	Elma was updated April 2018. **Action completed**
4.11	Management should review potential fraud risk within the team and ensure appropriate actions are taken if	2 - High	Charles Crowe - SCAS Service	30/01/2018	Risk added to Risk Register although this now requires a review within SCAS.

	fraud is suspected. The corporate risk register should be updated to include the transfer of cash and items of value from deceased client's properties.		Manager		Internal Audit opinion As per 4.1 **Action completed**

Internal Audit proposed to remove this item from the tracker

5. ResourceLink Application Review (Resources) (issued to Audit and Standards Committee 22.6.18)

As at July 2018
This report was issued to management on the 22.5.18 with the latest agreed implementation date of 30.11.18. An update on progress with recommendation implementation will be included in the next tracker report.

As at Jan 2019
Internal Audit: An update of recommendations is included below.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position provided by HR Service Manager on 23/11/18.
5.1	It is recommended that an access control policy is produced for the ResourceLink application. This should include details of how access can be requested, the access profiles available, who should authorise the access request and how access rights are reviewed. The policy should be applied and reviewed on a periodic basis.	2 - High	Peter White, HR Service Manager	31/07/2018 Revised Implementation date 14.12.18	**Action complete** An access control policy for all HR systems (inc Resourcelink) has been developed in draft by the new HR Applications Manager. The final version will be completed and signed off by 14 Dec 2018.
5.2	A review should now be undertaken of all user access profiles on ResourceLink. All user access should be granted in line with the application's access control policy (as detailed above). As system administrator access will often allow the user to amend the system's parameters, it is important that any review of access includes a review	2 - High	Peter White, HR Service Manager	31/07/2017	**Action complete** The controls itemised in the HR Systems Access Controls policy have been in place since July 2018. New controls are also being developed for the implementation of the Resourcelink replacement

	of those with system administrator rights and limits this to a small number of users who require this enhanced level of access. User access to the system should be reviewed on an on-going basis to ensure that it is appropriate. It is recommended that this takes place on a six monthly basis.				iTrent in Apr-Jun 2019.
5.3	Management should now consider the use of the obsolete function for controlling access to the ResourceLink application. *Management Comments:* *This may not be relevant as most users of ResourceLink are based within service. However, as part of the review of access, the use of the obsolete function will be considered and whether this could be used effectively for any users etc.*	3 - Medium	Peter White, HR Service Manager	31/07/2018	**Action complete** The obsolete function is now used to control access for HR staff. Leavers reports are now being generated that identifies Resourcelink users that have left the Council so their access is obsoleted.
5.4	It is recommended that the actions to be undertaken as detailed in the NGA report are now implemented. The service should decide what audit data is required from the system, how this will be captured and reviewed and how data will be cleared to maintain the system's performance. Where data is required for audit purposes, a clear retention period should be imposed for this data.	2 - High	Peter White, HR Service Manager	Action Complete	**Action complete** HR commissioned NGA to carry a full audit clear down in June 2018. They also trained in-house HR staff to perform regular audit clear down tasks including off system archiving.
5.5	It is critical that there are clear continuity arrangements in place once the contract is novated from Capita to the Council. Continuity arrangements for ResourceLink should now be assessed and defined. An appropriate business continuity plan should be in place for the application and this should be communicated to all relevant parties. *Management Comments:*	1 - Critical	Peter White, HR Service Manager	30/11/2018	**Action complete** The NGA contract novated to SCC from Capita on 1st May 2018

	Continuity arrangements are in place with Northgate and any continuity arrangements for the ResourceLink application need to be considered in line with service wide continuity planning (and in conjunction with Northgate and Capita). This will be fully reviewed over the coming months. A local plan is being considered with Rotherham.				
5.6	It is recommended that the standard reporting from ResourceLink is now reviewed in line with business need and steps taken to amend this if appropriate. *Management Comments:* *There is a difference between exception reporting and MI reporting. Going forward, and in conjunction with the outcomes of the payroll controls audit, reporting from the system will be reviewed and action taken to ensure both exception and MI reporting is effective.*	3 - Medium	Peter White, HR Service Manager	30/11/2018	**Action complete** A full Report Review has been completed with decisions being made to remove reports no longer required. The Resourcelink systems reporting output is now being mapped against reporting from iTrent in preparation for the new systems implementation.
5.7	The licensing arrangements for the ResourceLink application should be fully reviewed when the contract is novated from Capita. *Management Comments:* *The risks in relation to software licensing are acknowledged and a review will be undertaken to ensure that the appropriate licences are in place. It should be noted that ResourceLink is a HMRC approved system - therefore in terms of tax regulations, the system is legally compliant.*	2 - High	Peter White, HR Service Manager	30/11/2018	**Action complete** SCC HR Officers have fully engaged with NGA to review licensing arrangements and the appropriate licenses are in place.
5.8	It is recommended that management continue to pursue detailed explanations for the disruptions so that any learning can be factored in to future system upgrades. *Management Comments:* *The service now has in place a HR Application*	2 - High	Peter White, HR Service Manager	Action already taken	**Action complete** Disruptions have now been minimised with the new HR Applications Manager fully testing all systems changes prior to them going live in the system. The only disruption to date was due to an NGA

	Manager; part of this role will now involve fully testing system releases. The service also has a dedicated point of contact at Northgate; so any future issues will be taken up directly with them.				error which was reported and rectified.

Internal Audit proposes to remove this item from the tracker

6. OHMS Application Review (Corporate) (issued to Audit and Standards Committee 24.5.18)

As at July 2018
This report was issued to management on the 4.1.18 with the latest agreed implementation date of 30.4.18. An Internal Audit follow-up review has been completed and the results are included below.

As at Jan 2019
Internal Audit: An update of progress with the 5 recommendations ongoing in the last report is provided below.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position provided by Service Manager, Systems and Business Information on 23.11.18.
6.1	Management should continue to monitor the progress being made on the production of scripts to anonymise the data on the training copies of OHMS. Any delays should be reported to management within Housing Services so that the risks can be re-assessed and appropriate action taken where necessary.	2 - High	Maxine Stavrianakos, Head of Neighbourhood Intervention & Tenant Support Ken Smith Service Manager, Systems & Business Information, People – PIPS	April 2018 Revised Implementation date: 29.10.18	**Alternative action complete** Access to the training databases was stopped for all users from Monday 30th July 2018. From that date, access was granted to the system, on the agreement that the member of staff received training within the appropriate team.
6.2	Consideration should be given to allowing management within service areas access to the	3 - Medium	Maxine Stavrianakos,	April 2018	**Action complete**

	OHMS generic access profiles. When managers request access for staff, they should specify the generic role that they wish an officer to receive. Any variant to this should be fully supported with evidence to support why an enhanced level of access is required. The administering team should still retain a challenging role in ensuring that requests are appropriate. On an annual basis, a list of staff access should be sent to all relevant managers. This should be checked for appropriateness and confirmation sent to the administering team that all access rights are appropriate and up to date.		Head of Neighbourhood Intervention & Tenant Support Ken Smith Service Manager, Systems & Business Information, People – PIPS	Revised Implementation date: 29.10.18	Following discussions at Housing Operational Managers and Housing Strategic Managers meetings it was agreed to include this on the access request form. Managers can now request the access levels needed for their staff. An annual review list will be issued in April 2019.
6.3	It is recommended that monitoring of log on to the system is undertaken by the team every six months. Where users have not accessed the system for three months, access should be locked immediately.	2 - High	Maxine Stavrianakos, Head of Neighbourhood Intervention & Tenant Support Ken Smith Service Manager, Systems & Business Information, People – PIPS	April 2018 Revised implementation date: 30.06.18	**Action complete** A list of users who have not logged on for over 6 months was sent to Housing Managers following the Operational Managers meeting on 16th March 2018, asking them to review and ensure any staff who do need access log on regularly. Removing staff who have not logged on for 6 months started from June 2018 and will be done quarterly.

6.4	Discussions should now take place between the systems team and BCIS to determine the likely extent of any outage and the implications of this. An options paper should then be prepared to explore the business continuity arrangements required in the absence of formalised disaster recovery arrangements.	1 - Critical	Maxine Stavrianakos, Head of Neighbourhood Intervention & Tenant Support	April 2018 Revised implementation date: 31.3.19	**Action ongoing** Following this audit report, this was raised as a risk as part of the GDPR Data Protection Impact Assessment for OHMS and is on the Place Portfolio Risk register, to be considered by Place SMT. A project to move OHMS out of West Malling has now been started which should be completed by March 2019. The new hosting solution has full disaster recovery, which will mitigate the risk.
6.5	Because the system is not currently up to date and considerable expense and effort will be required to enable this, it is recommended that an options review is undertaken to ascertain what the best method is to take the application forward. This should include the do nothing option, update the current version with a view to moving to the new product or to look at other potential solutions. This will need input from the Housing Service to ensure that the solution adopted is the most cost effective in delivering their service requirements.	1 - Critical	Maxine Stavrianakos, Head of Neighbourhood Intervention & Tenant Support	April 2018 Revised implementation date: 31.10.19	A project to move OHMS out of West Malling has now been started which should be completed by March 2019. OHMS will then be upgraded to the latest version by October 2019. **Action ongoing**

7. 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.

As at July 2018
An Internal Audit follow-up review has been completed and the results are included below.

As at Jan 2019
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 provided by HR Service Manager 23.11.18.
7.1	Capita management should produce and provide accurate high value expense claim (mileage, parking and subsistence) exception reports on a six monthly basis. HR management should ensure that high value expense claim (mileage, parking and subsistence) exception reports are received and reviewed on a six monthly basis.	2 - High	Peter White, HR Service Manager	30.06.2017 Revised implementation date: 31st July 2018	The HR Systems & Performance team produce a quarterly claims exception report. The report identifies claims above a certain value and beyond an agreed variance. The report was produced from Q1 2018/19 and was supplied to the HR Service manager 2 weeks following each quarter's completion. **Action complete**
7.2	HR management should highlight expense claim fraud risk to managers across the Council via intranet messages and manager updates.	2 - High	Peter White, HR Service Manager	31.07.2017 Revised implementation date: 31st July 2018	The Payroll Manager produced a Fraud Risk communication to the business (via Manager Bulletin, Intranet etc) in July 2018. **Action complete**

Internal Audit proposes to remove this item from the tracker

8. 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.

As at July 2018
An Internal Audit follow-up review has been completed and the results are included below. Revisions to the declaration processes, and methods for monitoring compliance will be linked to the introduction of a new HR system (part of the Tech2020 Strategy). The timescales for 'go-live' of the new system is September 2019.

As at Jan 2019
Internal Audit: An update of progress with the 5 recommendations ongoing in the last report is provided below.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position provided by the Head of HR on 16th November18.
8.1	It is recommended that supporting communications are provided when the next round of declarations are to be completed. This communication should include examples of where it would be appropriate to declare an interest - spelling out that officers should declare relatives/spouse/partners as interests even if they feel that they would not use their position to benefit the other person. The declaration of interest form to be completed on MyView should be reviewed to ensure that this information can be appropriately captured. Manager's Comments: Additional communications will be put out with the annual requirement to complete the declaration. This will include suitable examples. The timetabling for this exercise will be discussed with the HR Manager responsible for timetabling. There will still be a requirement to have managers to verify the declarations. The Head of HR will discuss this issue further with the HR manager who is currently reviewing the induction processes as it may be more productive to move the declaration process to the Development Hub and to align it to the PDR process.	3 - Medium	Lynsey Linton, Head of HR	Initial communications will be implemented by 30.09.2017. Revised implementation date: 31.10.18	**Action complete** Declaration of Interest and Gifts and Hospitality declarations are now formally incorporated into the MyView system. Communications have been delivered on this and this will be further reinforced in the expectations which is being delivered in the role of the manager (MMDP) and director responsibilities framework. The corporate induction programme has been updated and the agreed actions are now referenced within its delivery
8.2	The Monitoring Officer, in conjunction with HR should review the current process as detailed within the Code of Conduct. Agreement should be reached regarding how best this process can be monitored going forward and the Code of Conduct updated to reflect this. Manager's Comments at discussion meeting: Monitoring of the process and random sample	3 – Medium	Lynsey Linton, Head of HR/Gillian Duckworth, Director of Legal & Governance	30.09.17 Revised implementation date: 30.9.19	**Action complete** Sampling has now commenced and is incorporated into the referenced quarterly review meetings.

	checking of completed declarations of interest will take place on a quarterly basis at a joint meeting with the Head of HR, Director of Legal & Governance and Internal Audit, where other issues such as whistleblowing and investigations are already discussed and reviewed.				
8.3	Due to the sensitive nature of this issue, it is good practice to regularly review the processes in place to monitor this. It is recommended that the Monitoring Officer, in conjunction with HR, review the processes detailed within the Code of Conduct to ensure that they are fit for purpose and robust enough to defend any challenge made regarding influence exerted on Council Officers by the receipt of gifts and hospitality. Any changes to the process should be updated in the Code of Conduct and appropriately communicated.	2 - High	Lynsey Linton to take forward development of the system to record the returns – timescale in line with project timescales. Review of returns – Lynsey Linton/Gillian Duckworth – in line with quarterly meetings when information available.	Timescale in line with project timescales 30.9.19.	**Action complete** See above
8.4	The policy should now be fully formalised and published as a Council Policy. Appropriate communications should accompany the publishing of the policy. The policy and procedures should be tested to ensure that Officers are operating in line with these. A review should be undertaken in a year to evaluate whether the policy and procedures are being complied with. Post review, any changes to the policy/procedures required should be undertaken as necessary. Management Comments: The Head of HR will request feedback from those	2 – High	Lynsey Linton Head of HR	31/03/2018 Revised implementation date: 31.10.18	**Action complete - no further action required at this time.** This remains a local issue to the Place Portfolio and the director of service relevant to this activity. Local processes are still in place and at present time no formal business reason has been presented to extend this into council policy which would impact the code of conduct of all officers.

	services that have been trialling the process. She will then take forward this policy and seek agreement to the policy through the normal channels for HR policies, including the Unions and will seek an early adoption of this.				
8.5	Communications should be sent to all staff annually reminding them of the need to complete a declaration of interest form on MyView. Appropriate communications should also be sent to managers - prompting them to ensure staff complete the forms and that they are referred to when appropriate - i.e., when letting contracts etc. HR should be consulted to examine the possibility of producing a report for Managers from MyView that details who has/has not completed the declaration of interest form so that on-going monitoring of completion can be undertaken. Completion of Declarations of Interest should be covered as part of one to ones.	2 – High	Lynsey Linton Head of HR	Initial communications will be implemented by 30/09/2017. Potential changes to the processes will take place in line with the existing project timescales.	**Action complete** This is part of ongoing rolling programme of communications on policy updates.

Internal Audit proposes to remove this item from the tracker

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9. 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.

As at July 2018
A progress update on the agreed recommendations is included below

As at Jan 2019
Internal Audit: An update of progress with the 4 recommendations ongoing in the last report is provided below.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position taken from follow up work undertaken in November 18.
9.1	Contact centre management should ensure a service plan is documented and communicated to staff for 2017/18.	2 - High	Andrea Gough, Service Delivery Manager, Customer Services	31st October 2017	2017/2018 service plan finished and completed and 2018/2019 service plan now in place and incorporating all relevant Revenue and Benefits Contact Centre targets. This is in line with targets across all of the Contact Centre. Training has been taking place all staff and new starters and a spreadsheet is available which records details around this. <u>Internal Audit opinion</u> 2017/18 service plan reviewed and found to be adequate. **Action Complete**
9.2	Strategic and operational management in Customer Services and Revenues & Benefits should review Revenues & Benefits contact centre performance and to ensure the KPI is realistic and can be achieved in line with other service pressures and resources.	2 – High	Paul Taylor, Head of Customer Services Andrea Gough, Service Delivery Manager, Customer Services Tim Hardie, Head of Commercial Business Development John Squire, John Squire, Finance Manager Revenues and	31st December 2017 Revised implementation date: 30.4.19	**Customer Service Management Comments** The Revenues and Benefits service continues to struggle to reach its call answering time target. However a number of measures are or have been taken which we expect will have an impact on this situation: A plan of improvement measures was agreed in late 2017; although some timescales have slipped the areas under discussion are still live. This plan was also shared during Briefing Sessions for the staff team and their input was welcomed. SCC's new telephony system is currently being procured and should go live towards the middle of 2019. The new system will give us the facility for all callers to join a queue (rather than some having their call terminated as now) and be told roughly how long they will be waiting for their call to be answered. We believe that people will generally choose to hang on rather than having

			Benefits Client Team		to ring multiple times and this will impact positively on call numbers. The new system will also allow Customer Services to offer a type talk facility. Ahead of the new system going live, Customer Services are working to procure some extra voice channels which will mean that as a minimum no callers to the Revenues and Benefits front-end system will be cut off; all will be given the chance to join the queue. Finally, Customer Services are actively considering whether the KPI for Revenues and benefits should be brought into line with the other Contact Centre KPIs - i.e. answer a minimum of 85% of all calls. A number of other measures are under active consideration including allowing front end personnel to do more processing of changes themselves rather than referring to the back office. **Revenues & Benefits Client Team Comments** The findings of the 2017/18 Revenues and Benefits Customer Satisfaction survey support the Customer Service Management comments above, that customers would rather wait than ring multiple times although further work to determine how long customers are prepared to hold in a queue should be undertaken. This information should be used to inform discussions around any alternative KPI proposals. Customer Services consideration to allow front end personnel to do more processing may have contractual implications and impact on customer wait times. Internal Audit opinion

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9.3	Management should ensure that all staff have an appraisal and complete a learning and development	3 –Medium	Andrea Gough, Service Delivery	30th October 2017	Figures are only available for Customer Services as a whole. However as the highest number of

					The Full Business Case Objective of "no loss of service" and an expected improvement on Capita's Average Speed of Answer (ASA) of 197 seconds has not been achieved. The ASA target remains at 300 seconds. At the time of the follow up audit (June 2018) the ASA was 871 seconds, with a maximum wait time of 3407 seconds. The service are proposing to move to the corporate call centre target of 85% of all calls answered, however it should be noted that the Revenues & Benefits customers are considered to be some of the most vulnerable members of the community which is one of the reasons why the Revenues & Benefits Contact Centre were not automatically given the 85% of all calls answered on service transfer. It is acknowledged that transfer to this target may help contact centre staff integration and morale, which is key to reducing staff turnover and ensuring trained staff are retained by the service. Any changes to the target should be agreed by the Revenues & Benefits Client Team and it is understood that there is currently resistance to such a change. The plan of improvement measures features a number of items which would require additional resource or corporate contract changes. It has, however, been stated that no additional funding is available. In addition, any changes to corporate contracts need to progress through the appropriate channels; which means that improvements will not be seen instantly. **Action ongoing**
9.3	Management should ensure that all staff have an appraisal and complete a learning and development	3 –Medium	Andrea Gough, Service Delivery	30th October 2017	Figures are only available for Customer Services as a whole. However as the highest number of

	plan, as per the corporate requirements.		Manager, Customer Services	Revised implementation date: 31.3.19	employees is within the Contact Centre this should be a reasonable reflection of the Contact Centre figures. In terms of PDRs, up to the end of December 2017, 73% reached either plan or mid-year review stage. The Customer Services Service Plan contains an expectation of a minimum 90% PDR completion rate across all of our services. Internal Audit Opinion Corporately the expectation is that all staff should compete a PDR, therefore a Customer Service target of 90% appears incongruent, and has not been achieved. **Action Ongoing**
9.4	All contact centre staff should complete the mandatory e-learning modules, specifically the information management module.	3 - Medium	Andrea Gough, Service Delivery Manager, Customer Services	31st December 2017 Revised implementation date: 31.3.19	Once again figures are only available for Customer Services as a whole but should be an accurate reflection for the Contact Centre. 86% of Customer Services personnel have completed the Information Management module. Internal Audit Opinion All staff should complete the mandatory core learning e-learning module, Information Management, every 2 years. As the Revenues & Benefits Contact Centre team deal with sensitive data it would be expected that this e-learning module would be given priority to ensure compliance; a rolling programme of learning is in place. **Action Ongoing**

10. 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.

As at July 2018
An Internal Audit follow-up review has been completed and the results are included below.

As at Jan 2019
Internal Audit: An update of progress with the 4 recommendation ongoing in the last report is provided below.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Update provided by Executor Services Managers, SCAS on 8.11.18
10.1	A standardised approach should be introduced for recording details of the payments that are made on client accounts. This does not have to be an onerous task but the schedule (or similar) should record the payments that are made and the decision making that has taken place around the payments. This can then be used for reference if any queries are received on accounts and for continuity purposes should a Client Resource Officer leave the service. Payment schedules should be retained on a client's file. When significant changes are made to payments on a client’s account, management authorisation at an appropriate level should be required. Management should determine the level at which this should be necessary.	3 - Medium	Charles Crowe, SCAS Service Manager Liam Duggan, Head of Business Strategy - Business Planning	December 2017 Revised implementation date 31.1.19	Each client’s daily/weekly spends amounts are logged on a master spreadsheet, any amendments and updates are then stored and a new sheet is saved. Once we move onto Barclays and Trojan (new banking system) this sheet will no longer be needed. As at November, Barclays is now in place. Trojan timescale is now due Dec 18 due to procurement process. **Action ongoing**
10.2	Once the permanent staffing structure has been established and all staff have been recruited in to the posts, all staff should undertake an appropriate Council induction process (where this has not previously taken place) and should sign to say that	2 - High	Charles Crowe, SCAS Service Manager Liam Duggan,	January 2018	All staff are now permanent and have been given access to the Development Hub. Code of Conduct provided to each member of staff in April 2018.

	they have received a copy of the Council's Code of Conduct and have read and understood this. They should also be given the required Corporate training.		Head of Business Strategy - Business Planning		**Action complete**
10.3	Once the permanent staffing structure is in place, management should review the information management training requirements of all staff within the service. Effective training does not have to be an onerous task. Many organisations are now finding that shorter, more targeted training is more effective for staff development with training often lasting only 15 minutes at a time. The information management training requirements of this team could potentially be broken down in to shorter manageable sessions covered in team meetings etc. This could include training on Data Protection Law, handling and sharing information appropriately, dealing with information security breaches and how to deal with these etc. Evidence that training has been undertaken should always be clearly documented. Management should liaise with the Information Governance Team to ensure that they have the means to communicate securely with all third parties outside of the organisation – for example, GCSX email accounts for all staff; including the relevant training in the use of this.	2 - High	Charles Crowe, SCAS Service Manager Liam Duggan, Head of Business Strategy - Business Planning	January 2018 Revised implementation date 31.1.19	Available training has been completed by staff on the Development Hub. E-learning fraud training is still not available. **Action ongoing**
10.4	Client Resource Officers should be involved in any review of potential new banking systems so that they can appraise and feedback on the basis of their operational experience. Management need to clearly assess and assure themselves that the new banking system is as efficient as possible and removes the need for workaround processes wherever possible. They	2 - High	Charles Crowe, SCAS Service Manager	December 2017 Revised implementation date 31.7.18	New Banking process has been procured and we are awaiting a go live date. Staff have been involved in this process throughout and a team of three staff have been chosen to be super users. Audit process is set up and staff are aware of the process – documented procedures have been provided to Internal Audit.

	should also be clear on how the system can support them going forward in the monitoring of client's accounts. A quarterly monitoring process should be established and documented to enable, on a sample basis, the effective review and oversight of client accounts. Payments made to the clients/on behalf of the clients should be reviewed for reasonableness by management. Unusual payments or patterns of payment should be investigated appropriately. Where any issues are identified, these should be fully investigated and appropriate action taken or training put in place etc. Reporting from the banking system, that supports the identification of unusual activity etc. should be fully utilised. All checking undertaken should be clearly recorded.				A monitoring process has been set up and Management will audit all bank accounts fortnightly to begin with. Meetings are carried out fortnightly and no issues have been raised. **Action complete**

11. 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.

As at July 2018
An Internal Audit follow-up review has been completed and the results are included below.

As at Jan 2019
Internal Audit: An update of progress with the 9 recommendations ongoing in the last report is provided below.

The Licensing Service (Place)

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position provided by the Licensing Strategy and Policy Officer 30.11.18.
11.1	Formal arrangements and deadlines should be put	Medium	Head of	31/03/18	The 5 year Business Plan is currently in draft

	in place for the review and refresh of the 5-year Business Plan. Business and Service Plans should be proof-read prior to issue to ensure that all editorial comments, etc have been removed prior to posting in the public domain and that the Plan is complete.		Licensing Service	Revised implementation date: 30/09/18	form. This project has been postponed due to current resources and a new time line will be drafted. The Service plan is current. The Business plan is an addition to the service plan to go over and above - we feel the current service plan is sufficient enough to provide direction of the service. The business plan will be updated in the near future. **Action complete**
11.2	Management should develop a basket of KPIs that reflect the Service's objectives and outcomes and provide a means of measuring and monitoring performance in meeting those requirements. The KPIs should be readily quantifiable and monitored as a minimum on a quarterly basis. Results should be reviewed by the Licencing Management Team and formally reported to SMT. Minutes of those meetings should be sufficient to demonstrate discussion as well as the decisions taken and agreed actions	High	Head of Licensing Service	31/03/18 Revised implementation date: 30/06/18	There are a number of corporate KPIs already in place. A suite of Service Performance KPI's has been established and will commence monitoring 1st December 2017. Monthly Service KPI's are now reported to SMT. **Action complete**
11.3	Deadlines should be set for the prompt development and implementation of the service Business Continuity Plans. Once completed, this should be rolled out to officers as well as members of the Licensing Committee.	Medium	Head of Licensing Service	31/12/17 Revised implementation date: 31/03/19	The Licensing Service BCP document is currently being reviewed. **Action ongoing**
11.4	Formal consideration should be given to the resourcing of the Service in order to implement developmental objectives and strategies set out in its Business and Service Plans.	High	Director of Business Strategy & Regulation	31/12/17 Revised implementation date:	The establishment will be reviewed constantly in line with application fees. This action should be closed as this will be on going and continuous. **Action complete**

	In doing so consideration should be given to the potential impact on the licencing fees levied, as well as the potential risks and impacts on the Service of non-implementation of those objectives.			30/06/18	Business as usual activity.
11.5	Management should develop a cohesive quality assurance framework. This should incorporate effective sampling techniques, such as stratified or focussed sampling, as well as determining responsibility for, and frequency of, the quality checks. The process should be formally documented and the results recorded, particularly where errors are identified or training and development issues highlighted. The application of quality-based KPIs should be considered. The results of the quality assurance programme should be reported periodically to Service Management.	High	Head of Licensing Service	31/03/18 Revised implementation date: 30/09/18	A Quality Assurance process is now in place. The service has a quality assurance framework, a sampling process and quality KPIs. The Stratified sampling (quality Assurance process) results and actions are updated monthly (reviewed in-between) and reported to SMT periodically. **Action complete**
11.6	Following the conclusion of the current investigation in to the officer allegations, a second investigation should be carried out to consider the cultural aspects within the Service that enabled this to go unaddressed until raised by an external organisation. The adoption of a number of recommendations raised in this report will serve to address the cultural issues and to introduce the required levels of internal control and avoid reliance on external bodies for that function. Staff and management should be made aware of the unacceptability of processing personal or related licence applications or of allowing this to take place. Officers have a responsibility under the	Critical	Director of Business Strategy & Regulation	31/03/18 Revised implementation date: 30/06/18	An internal Disclosure of Interest Policy and declaration form has been adopted within the service alongside corporate policies. All forms have been signed and submitted to the Head of Service. An email has also been sent to the service reminding all staff of the terms of their employee code of conduct. Further to discussions with the Director of BS&R as to the carrying out of a further investigation – it is felt that all corrective action has been put in place and further investigation and disciplinary within the service would be counter-productive to the service. No further action will be taken.

	Code of Conduct to report concerns, ensuring that appropriate action is taken.				**Action complete**
11.7	Licencing Service management should take immediate action to review licence records to determine whether the three taxi drivers had provided proof of right to work in the UK. The NFI data base should be updated to reflect the outcome and where necessary licences should be rescinded until right of leave to work has been formally established. Management should further investigate why formally requested deadlines had not been met for the resolution of these cases.	High	Head of Licensing Services	31/10/17 Revised implementation date: 30/06/18	Internal Audit has confirmed that the outstanding NFI queries have been cleared. **Action complete**
11.8	The Head of Licencing should implement formal monitoring of licence processing deadlines.	Medium	Head of Licensing Service	31/03/18 Revised implementation date: 30/06/18	The KPI's, sampling process and front sheet checks will ensure compliance. **Action complete**
11.9	Effective fraud risk management arrangements should be put in place. Full consideration should be given to the identification and evaluation of the Service's fraud risks. These should be set out in a Fraud Risk Management Plan, together with suitable mitigation strategies and then monitored on a quarterly basis to determine whether these are operating effectively and controlling the fraud risks. The Fraud Risk Management Plan should be updated by the responsible officer to reflect the	High	Head of Licencing Service	Revised implementation date: 30.06.2018	The Final fraud risk management plan is now implemented within service - monthly and quarterly checks are being undertaken by LMT. **Action complete**

	quarterly review. Service Management Team minutes should demonstrate the reporting of the periodic reviews and actions taken, or of any fraud risks materialising. In the event of allegations being made or irregularities identified, service management have a responsibility to inform Internal Audit at the earliest opportunity.				

12. 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.

As at July 2018
17 recommendations were either on-going or outstanding at the last update. Progress has been made, with 11 recommendations now complete and 6 ongoing.

As at Jan 2019
Internal Audit: An update of progress with the 6 recommendations ongoing in the last report is provided below.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position provided by the Head of Service Lifelong Learning on 15.11.2018
12.1	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	High	C.Charnley - Operations & Development Manager, CYPF Business Strategy.	30.6.17 **Revised Timescale:** 31.12.17	**Action Completed** The incoming Director commissioned reviews of both Sheaf and Red Tape from Business Strategy which were finalised at the end of May 2018. The recommendations of these reviews have been utilised to develop a three year plan.

	the 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		
12.2	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	**Action Completed** A new timeline for key milestones is available .
12.3	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 documented.	High	C.Charnley - Operations & Development Manager, Business Strategy. Dee Desgranges -	30.6.17 **Revised Timescale:** 31.12.17	**Action Completed**

			Assistant Director for LLSC (retired). Eve Waite - Head of Employment and Skills		
12.4	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	**Action Completed** This is linked to 13.1 and will form part of the new 'Recovery Group' meeting structure. A monthly report is presented to the Director/Asst Directors of LLS/Finance Business Partners as part of Qtier forecasting that shows the outturn for the sites.
12.5	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:** 31.12.18	**Action Ongoing** Monthly report produced as per 13.1 above but 'real time' dashboard linked to replacement data system.
12.6	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:** 31.12.2018	**Action Ongoing** Issue still ongoing with School Deficit Group.

13. 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.

As at July 2018
3 recommendations remained ongoing from the previous update. 1 of these has now been actioned, with 2 being linked to the SCC2020 Records Management Project.

As at Jan 2019
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 provided by Service Manager - Business Support 23.11.18.
13.1	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** 31.12.18	**Action Ongoing** Pauline Hague – Business Manager is now leading the day to day management of SARs. The Business Manager oversees a dedicated team of BSMs who will work on a range of Information Management topics with the SARs backlog being the priority. This team is now in place and working on documenting roles and responsibilities, training and support to applicants. ICO monitoring of progress continues and although progress is being made there continues to be a high level of scrutiny and risk.

13.2	A Portfolio data map should now be produced for responding to subject access requests. This should 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.	2 - High	Elyse Senior-Wadsworth, Service Manager - Business Support	31.10.17 **Revised Timescale** 31.3.19	**Action ongoing** Data map draft is now in place but will be kept under review as Records management work progresses.

14. 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.

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As at July 2018
A progress update on the 2 outstanding recommendations is included below. 1 action has been completed and 1 is now part of the wider SCC2020 programme of work.

As at Jan 2019
Internal Audit: The timescale for implementation of this recommendation is March 2019 and so a further update has not been requested.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position provided by Corporate Programme Management Officer, BCIS 25.5.18.
14.1	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 31.3.19	**Action Ongoing** The strategic plan is to move the Council's ICT infrastructure into a cloud based hosting service, so reducing dependency on the Town Hall Machine Room.

					This activity is now part of the wider SCC2020 programme of work. The Corporate Resilience Group is to feedback requirements around Disaster Recovery.

15. 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.

As at July 2018
Service management confirmed there has been a lot of activity to implement the Internal Audit recommendations as part of the CHC Process Review project (and other higher level organisational work with the CCG) over the past 6 months. This is an ongoing and complex process so much of the narrative update included below remains similar / unchanged.

As at Jan 2019
Internal Audit: An update of progress with the 19 recommendations ongoing in the last report is provided below. The LD service does not exist and CHC processes are integrated into Locality Operating Model. Due to the change in delivery methodology, Internal Audit are proposing to remove this item from the tracker and pick up any issues arising as part of a wider CHC audit, which is currently being undertaken.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position as a result of Internal Audit follow-up work in Oct 2018.
15.1	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	1 - Critical	Karen Mosgrove – Interim Service Manager,	30.6.17 **Revised Timescale** 31.12.18	**Action ongoing** Joint work with the CCG has now finished with regards to a joint Standard Operating Procedure. It includes fully funded and joint

	amendments and changes.		Learning Disabilities Now Robert Broadhead, HoS Localities		packages of care. It is due for sign off in December. Joint work is still ongoing over other aspects of joint working (such as resource allocation). <u>Internal Audit opinion</u> This recommendation will considered to be complete when the SOP is signed off in December.
15.2	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** 31.10.18	**Complete** LD is no longer a separate team within SCC. Many forms used are standard national NHS forms (for example the CHC checklist). The Standard Operating Procedures have formalised their use. ELMA has been updated since the last audit to reflect the forms used by way of '7 Minute Briefings'. These have included 'CHC Checklist 7 minute briefing' and 'Decision Support Tool DST 7 minute briefing' along with other CHC briefings. <u>Internal Audit opinion</u> Action complete
15.3	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, HoS Localities	30.6.17 **Revised Timescale** 31.12.18	**Ongoing** The Standard Operating Procedures contains information about who should be at meetings, and what is expected of them. <u>Internal Audit opinion</u> This recommendation will considered to be complete when the SOP is signed off in December.
15.4	Management to review all policy and procedural documents developed by CCG to ensure they are appropriate. Management to then meet with the CCG	2 - High	Karen Mosgrove – Interim	30.6.17 **Revised**	**Ongoing** The new Standard Operating Procedures are

	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.		Service Manager, LD Now Robert Broadhead, HoS Localities	**Timescale** 31.12.18	due to be signed off next month. SCC has put in place CHC Champions, who have received additional training. They are spread across grades and worksites to ensure an even coverage. In addition, ELMA has been updated with a number of CHC related '7 minute briefings'. Internal Audit opinion This recommendation will considered to be complete when the SOP is signed off in December.
15.5	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** 31.10.18	**Ongoing** A new disputes process has been drafted with the CCG. This is due to be signed off in November. SCC has put CHC Champions in place to help other members of staff. Internal Audit opinion This recommendation will considered to be complete when the SOP is signed off in December.
15.6	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** 31.10.18	**Ongoing** Interim Care and Funding Arrangements are detailed within the Standard Operating Procedure for a dispute. Work will continue on JPOGs (Joint Packages of Care). Internal Audit opinion This recommendation will considered to be complete when the SOP is signed off in December.
15.7	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	30.6.17 **Revised Timescale** 31.10.18	**Completed** CareFirst is no longer a system used at Sheffield City Council. As part of the implementation of the new system (Liquid Logic)

			Now Robert Broadhead, HoS Localities		storage of CHC information has been considered. Internal Audit opinion Action complete
15.8	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** 31.10.18	**Completed** The DST is the standard document to be used during Multidisciplinary Tool to record the decisions made. This has been formalised within the Standard Operating Procedure. Internal Audit opinion Action complete
15.9	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	**Completed** CareFirst is no longer used by SCC. The recording on the new system, Liquid Logic is part of the work with regards to the new system. Internal Audit opinion Action complete
15.10	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.	2 - High	Karen Mosgrove – Interim Service Manager, LD Now Robert Broadhead,	30.6.17 **Revised Timescale** 31.12.18	**Ongoing** The new Standard Operating Procedures formalise who should be present at meetings and what decisions can be made. There is also a new dispute process in place, and an agreement about funding when in dispute. CareFirst no longer a system used by SCC, and

	Management to ensure enforcement by periodic, random checks of information held for clients.		HoS Localities.		the recording of CHC in the new system has formed part of the work undertaken to implement this. <u>Internal Audit opinion</u> This recommendation will considered to be complete when the SOP is signed off in December.
15.11	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	**Complete** The new system, Liquid Logic, has a warning label for when the NHS number has not been completed. <u>Internal Audit opinion</u> Action complete
15.12	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,	2 - High	Karen Mosgrove – Interim Service Manager, LD Now Robert Broadhead, HoS Localities.	30.6.17 **Revised Timescale** 31.10.18	**Complete** CareFirst is no longer used by SCC. This will be part of the implementation of Liquid Logic, the new system. <u>Internal Audit opinion</u> Action complete

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	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.				
15.13	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 Now Robert Broadhead, HoS Localities.	30.9.17 **Revised Timescale** 31.10.18	**Complete** CareFirst is no longer used by SCC. Within the new system, Liquid Logic, there is new 'funding stream' information in which CHC funding information is held. Internal Audit opinion Action complete
15.14	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	**Complete** CareFirst is no longer used by SCC. Storage of documentation formed part of the work for the new system, Liquid Logic. Internal Audit opinion Action complete
15.15	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** 31.12.18	**Ongoing** The new Standard Operating Procedures formalise the process with regards to children reaching the age of 18. This is done by age range (e.g. at 14 years old, at 16-17 years old and at 18 years old). Internal Audit opinion This recommendation will considered to be complete when the SOP is signed off in December.
15.16	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	3 - Medium	Karen Mosgrove – Interim	30.9.17 **Revised**	**Ongoing** The new Standard Operating Procedures

	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.		Service Manager, LD Now Robert Broadhead, HoS Localities.	**Timescale** 31.12.18	formalise the timeframes with regards to cases, and ages in which decisions ought to be taken. However, it should be noted that the 28 day deadline does not apply to young people in transition. Internal Audit opinion This recommendation will considered to be complete when the SOP is signed off in December.
15.18	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** 31.12.18	**Ongoing** The Standard Operating Procedure formalises who should attend panel meetings and how it should be recorded (i.e. a DST, Decision Support Tool). Please note further work is ongoing for resource allocation for JPOC (Joint Packages of Care). The recording of CHC within the new system formed part of the work for the implementation of Liquid Logic. Internal Audit opinion This recommendation will considered to be complete when the SOP is signed off in December.
15.19	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	**Completed** Staff training has recently taken place due to the introduction of GDPR. Because of the changes in legislation, work has been undertaken to ensure that correct privacy documents are in place to reflect the new legislation. This includes ensuring that clients are aware that data sharing takes place. Internal Audit opinion Action complete

Internal Audit proposes to remove this item from the tracker.

16. 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.

As at July 2018
An update of progress with the 3 recommendations ongoing in the last report is provided below. All 3 recommendations remain ongoing – 2 recommendations are being addressed through the introduction of the new Whole Case Family Management system, and 1 item relates to the corporate roll-out of the Fraud e-learning package and so is beyond the control of the Service. This item is being actioned by Internal Audit in consultation with the Learning and Development Service.

As at Jan 2019
Internal Audit: An update of progress with the 3 recommendations ongoing in the last report is provided below.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position provided by Joanne Heald, Executor Services Manager, SCAS 7.11.18.
16.1	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	High	Maxine Stavrianakos - Head of Neighbourhood Intervention and Tenant Support, Communities	31.8.16 **Revised Timescale** 31.1.19	Business case partially signed off. Inclusion of Deputyship under consideration subject to implementation of new IT systems. **Action ongoing**

	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.		Charles Crowe - SCAS Service Manager, People Services		
16.2	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** 31.11.19	The SLA is under review to fit with new business case. The SLA is part of implementation of new business model and is in development. **Action ongoing**
16.3	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** 31.1.19	This remains ongoing, awaiting corporate roll out of revised fraud training. **Action ongoing – due to the corporate roll out of e-learning package.**

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17. 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.

As at July 2018

An update of progress with the 5 recommendations ongoing in the last report is provided below.

As at Jan 2019

Internal Audit: An update of progress with the 3 recommendations ongoing in the last report is provided below.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position - provided Finance Manager, Internal Audit 30.11.18.
17.1	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** 31.1.19	**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.
17.2	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** 31.7.18	**Action complete** The internet pages have been updated and include links to all new policies and procedures.
17.3	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 across the Council.	High	Lynsey Linton, Head of Human Resources Stephen Bower, Finance	31.12.16 **Revised Timescale** 31.1.19	**Action ongoing** As above The e-learning package will be updated to tie in with the new/revised policies.

			Manager, Internal Audit		

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