REPORT TO SHEFFIELD CITY COUNCIL AUDIT AND STANDARDS COMMITTEE
20th January 2022

Internal Audit Tracker Report on Progress with Recommendation Implementation

Purpose of the Report

1. The purpose of this 'rolling' report is to present to members of the Audit and Standards Committee progress made against recommendations in audit reports that have been given a high opinion (using the old system), a no assurance opinion, or a limited assurance with high organisational impact opinion (using the new system).

2. As the report tracks recommendations until they have been fully implemented, there will be a period when reports are included that use both the old and new style of internal audit opinion.

Introduction

3. An auditable area receiving one of the above opinions 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. All reports will have been issued in full to members of the Audit and Standards Committee at their time of issue.

4. Where Internal Audit has yet to undertake follow up work, the relevant Portfolio managers 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, managers were required to provide specific dates for implementation, and that this information was required by the Audit and Standards Committee.

5. This report also details reviews 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 report from the tracker:

    - Enforcement Agent Review
    - Appointeeship Service
    - Council Processes for Management Investigations
    - Controls in Town Hall Machine room
    - Data Security and Protection (DSP) Toolkit

Executive Summary

Reports received in full by the Committee

As agreed, the Audit and Standards Committee members will receive, in full, reports with no assurance (regardless of the organisational impact) and limited assurance with a high organisational impact. In addition, limited assurance, medium impact opinion reviews would be reported on a discretionary basis.

One review was added to the Recommendation Tracker report in April 21. This was not followed-up for the last report due to longer than usual implementation dates, and so are included in this report.

This report is:

- Data Security and Protection (DSP) Toolkit

New reports added to this Tracker

For this period, 1 new report has been added.

Title	Assurance	Impact
Assurance Reviews		
Adult Safeguarding	Limited Assurance	High Organisational Impact

Recommendation implementation

In total, updates have been provided on 34 out of 34 recommendations that are due for implementation. Of these, 23 (68%) have been implemented and 11 (32%) are ongoing, indicating work has been started but not yet fully completed.

Items to note
There is only one critical recommendation ongoing in this report.

This is contained within the OHMS (Housing Management System) application review and relates to upgrading the system. OHMS has now been upgraded to the latest version, however there has been limited functionality improvements that have offered any benefits to the service. As part of the Place Systems Review they will start to test and build the new system in April 22 and the implementation phase is due to start in April 23. It will however take some time to implement all the functions in the new system and therefore a revised implementation date of December 2023 has been proposed. (Executive Recommendation Lead – Mick Crofts).

This report has a RAG rating to easily identify the extent of the delays implementing agreed recommendations. A RAG rating key is provided at the end of the report.

Report to the Performance and Delivery Board
The tracker report was circulated to the Performance and Delivery Board on the 30th November 2021.

The Performance and Delivery Board are committed to ensuring audit recommendations are actioned promptly and effectively within the agreed timeframe and take full responsibility and ownership in managing and controlling the process. They acknowledge the increased risks if audit recommendations are not progressed promptly and will seek clarity and confirmation of mitigating controls in place whilst appropriate action is being taken in service areas. The Performance and Delivery Board will reflect on how this can be communicated throughout the Portfolios. The People Portfolio have now successfully launched a SharePoint recommendation tracker that was first established in the Place Portfolio. This has provided a consistent and effective approach across the People and Place Portfolio.

The Performance and Delivery Board discussed the outstanding critical recommendation relating to OHMS and this area is being discussed at another group committee meeting and a ‘deep dive’ exercise undertaken. This will include investment, change management and lessons learnt.

The Board also discussed assurance that the outstanding actions are being fed through to the Directors Annual Governance Statement (AGS) and Risk Registers.

The overall message is that service recommendation leads need to be proactive and address the agreed audit recommendations and risks in a timely manner.

The Performance and Delivery Board fully support and encourage the service recommendation leads to attend any future Audit and Standards Committee meetings to explain in more detail recommendation progress, issues and revised timeframes.

UPDATED POSITION ON TRACKED AUDIT REPORTS AS AT DECEMBER 2021

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**
Data Security Protection Toolkit	2	3	1		2	3	1							
Information Security Incidents		2	1							2	1			
Software Licensing	1	3			1	2				1				
Hardware Asset Management		2				1				1				
Enforcement Agent Review		1				1								
OHMS Application Review	1								1					
Controls in Town Hall Machine Room		1				1								
Appointeeship Service		1				1								
Council Processes for Management Investigations		2				2								
Direct Payments		6	7			3	5			3	2			
Total	**4**	**21**	**9**		**3**	**14**	**6**		**1**	**7**	**3**			

Shaded items to be removed from the tracker

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1. Safeguarding (People) (issued to Audit and Standards Committees 4.10.21)

As at December 2021
Internal Audit: This report was issued to management on the 17.9.21 with the latest agreed implementation date of 31.12.22. This report will be followed up and included in the next tracker.

2. Data Security and Protection Toolkit (Resources) (issued to Audit and Standards Committees 24.3.21)

As at April 2021
Internal Audit: This report was issued to management on the 22.9.20 with the latest agreed implementation date of 30.11.20. This report will be followed up and included in the next tracker.
As at December 2021
Internal Audit: An update on progress with the recommendations is included below.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position provided by Andrea Brown Oct 2021
1.1	Establish, at pace, a task and finish group or dedicated resource with responsibility for completing the Data Security & Protection Toolkit. In the first instance, the mandatory evidence items required should be reviewed and updated for the current submission year 2019/20 prioritising the work required to submit the evidence by 30th September 2020. The assertions should be signed off wherever possible.	**Critical**	Mark Gannon/Roger Norton/Elyse Senior-Wadsworth	End August/Early September 2020	**Action completed** This group has been established and meets weekly, an agenda is set and minutes taken.

1.2	A Dedicated Officer is required to clearly establish any evidence items (including those detailed) that will be challenging to deliver, discussing and evaluating the consequences of this with Senior Management in relation to non-compliance with the toolkit (a Standards not Met submission). A clear action plan needs to be developed for delivery of the outstanding mandatory items.	**Critical**	Dedicated Officer in consultation with Roger Norton and Elyse Senior-Wadsworth	September 2020	**Action completed** Dedicated Role sits in the Information Management Department is currently on a contract basis due to finish end of October 2021.
2.1	Responsibility for completion of the Data Security and Protection Toolkit to be included within the job description/person specification for the post of Senior Information Management Officer/DPO.	**Medium**	Mark Gannon	October 2020	**Action completed**
2.2	A working group (possibly similar in design to the PCI DSS working group) should be set up (with roles and responsibilities clearly defined) to ensure that the Council can meet the standards set by the Data Security & Protection Toolkit. The working group should have the authority to programme the work necessary to meet the evidence requirements.	**High**	Dedicated Officer in Consultation with Roger Norton/Elyse Senior-Wadsworth	October/ November 2020	**Action completed** Refer to 1.1 above.
3.1	All key stakeholders should be identified as part of the setting up of the working group that will drive compliance with the Data Security and Protection Toolkit. Once the working group has been set up, a terms of reference should be prepared that details the roles and responsibilities of the group.	**High**	Dedicated Officer in consultation with Roger Norton/Elyse Senior-Wadsworth	October/ November 2020	**Action completed** Terms of Reference established.

4.1	All risks associated with the Data Security and Protection Toolkit to be documented. These should be escalated via the Council's risk management processes as appropriate. Risks in relation to the toolkit to continue to be captured, reviewed and updated throughout the year.	**High**	Roger Norton/Elyse Senior-Wadsworth	September 2020	**Action completed** Data Security and Protection Toolkit Risk Report captures risks and provides an update. Last report produced 12.7.21.

3. Information Security Incidents (Corporate) (issued to Audit and Standards Committees 21.1.20)

As at Sept 2020
Internal Audit: This report was issued to management on the 12.9.19 with the latest agreed implementation date of 31.12.19. An update on progress with the recommendations is included below.
As at April 2021
Internal Audit: An update on progress with the recommendations is included below.
As at December 2021
Internal Audit: An update on progress with the recommendations is included below.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position provided by Sarah Green Senior Information Management Officer / Data Protection Officer on 3.11.21
4.1	Incident management reports to be completed for all incidents regardless of risk. Where risk is lower, reports can be tailored to reflect this - with only key details recorded. The report to be sent to the relevant Head of Service/Information Asset Owner for sign off and agreement to actions.	**High**	Mark Jones, Senior Information Management Officer	December 2019 **Revised Implementation Timeframe: 31.12.21**	**Action ongoing** Once security incidents are moved to ServiceNow, we will be in a better position to track and report on security incidents. The risk analysis programming in ServiceNow should commence in the new year. It is

	The report to be retained within the relevant G Drive folder.				proposed that when security incidents are logged on the ticketing system, the risk analysis is completed off tool. The security incidents are logged with the relevant Head of Service/Information Asset Owner.
5.1	Information management team to establish programme of checking on agreed actions (in conjunction with the Information Governance Working Group). Priority to be given to high risk incidents.	**Medium**	Mark Jones, Senior Information Management Officer	December 2019 **Revised Implementation Timeframe: 31.12.21**	**Action ongoing** Please see action status above. Once the IM Team are reshaped to start to fulfil their audit and governance function, we will be in a stronger position to mobilise this recommendation. Programme of checking on actions to focus initially on high risk incidents. We now have a full team, however, they continue to be trained, as new in post. We are waiting to move security incidents across to Service Now which will provide the analysis tools.
5.2	Once incident management reports have been produced, review how the information gathered can be presented to the IGB as part of quarterly reporting on information security incidents (this can be undertaken in conjunction with the Information Governance Working Group). The reports should be used to support greater trend analysis in reporting to the Board so that support and training can be targeted where appropriate.	**High**	Mark Jones, Senior Information Management Officer	December 2019 **Revised Implementation Timeframe: 31.12.21**	**Action ongoing** We are moving security incident reporting to ServiceNow and this should be completed by December 2021. ServiceNow will provide better analysis of data, for example, types of incidents, services impacted etc so that trends can be picked up and specialised training devised, if needed. It has been agreed at IGB that the reports created should be the same as those prepared for IGWG so that all parties are aware of trends and actions.

4. Direct Payments (People) (issued to Audit and Standards Committees 2.3.20)

As at Sept 2020
Internal Audit: This report was issued to management on the 15.1.20 with the latest agreed implementation date of 30.6.20. This report will be followed up and included in the next tracker.
As at April 2021
Internal Audit: An update on progress with the recommendations is included below.
As at December 2021
Internal Audit: An update on progress with the recommendations is included below.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position provided by Becky Towle and Mary Gardner 18.11.21
1.1	It is recommended that the Operational Plan and Service Plan is updated showing a clear link to corporate objectives, building in a process to identify legal responsibilities and demonstrate clear roles and responsibilities within the direct payment process. SMART targets should be identified and implemented covering service delivery, performance and monitoring arrangements. A 'fit for purpose' business continuity plan should be established, regularly reviewed and communicated to all staff. A Service RMP should be established and maintained in accordance with Corporate guidelines. All the key documents identified above should be reviewed on a yearly basis with a responsible officer/role overseeing this action.	**High**	Becky Towle Assistant Director of Provider Services	30.4.2020 **Revised implementation date: Ongoing as a 3 year transformation plan**	**Action ongoing** 3 year transformation plan, improvements in year 1 and then transformed in years 2 and 3. This continues to be the plan and there is now in the DP plan a clear connectivity between the direct payments and objectives. The new direct payments team will be able to offer advice and support to both the LA and families using DP.

1.2	It is recommended that a written agreement is implemented between CDT and SCAS in relation to the direct payments audit team. Clear expectations including tasks, roles and realistic timescales for delivery should be recorded. It should include achievable performance targets that can aid with the monitoring of the direct payment process.	**Medium**	Becky Towle Assistant Director of Provider Services Fiona Orr and John Stott	31.7.2020	**Action completed** Direct Payment audit team moved out of SCAS into commissioning led by Mary Gardner. This transition has enabled clear roles and agreements between teams.
2.1	It is recommended that clear process notes/guidance are produced and made available for delivering all aspects of the direct payment process. This guidance should include a checklist of tasks. A clear timetable of actions is required which outlines achievable and realistic timescales. A clear monitoring process should be implemented to ensure that the direct payment process is delivered efficiently and effectively.	**High**	Becky Towle Assistant Director of Provider Services	30.4.2020 **Revised implementation date: April 2022**	**Action ongoing** As above, undergoing transformation over the next 3 years. This continues to be on progress. A new leaflet for families has been produced so that they have a better understanding of this area.
2.3	The Employing a Personal Assistant Handbook - Direct Payment guidance requires a review. Information should be concise, relevant and up to date. Clear wording detailing expectations of SCC and those of the recipient should be spelt out to avoid confusion and misinterpretation Wherever possible this document should be provided electronically so that it can be updated on an annual basis to allow for legislation or process changes. To aid management with this process, examples of guidance should be obtained from other Local Authorities to assist with producing a comprehensive document.	**Medium**	Becky Towle Assistant Director of Provider Services	31.7.2020	**Action completed** The handbook has been updated and covers adults and children's Direct Payments.

2.6	Internal Audit are aware of ongoing work in this area and recommend expediting the decision to allow joint ways of working, centralised information and to merge processes and staff knowledge and experience.	**Medium**	Becky Towle Assistant Director of Provider Services	31.7.2020	**Action completed** The DP team are ensuring that there is a much better understanding for the process.
3.3	It is recommended that all client accounts managed by payroll companies are reviewed and updated. Any outstanding issues regarding unpaid minimum wage uplifts, outstanding management fees and surplus balances should be resolved promptly. Internal Audit consider the current issues with one account to be more about multiple client accounts unresolved rather than one payroll company account not being managed correctly and as a result, urgent work is required to get these service user accounts up to date and correct. A joint working approach with DP Audit Team and CDT is required to ensure clarity around account management and the monitoring of payroll company accounts.	**Medium**	Becky Towle Assistant Director of Provider Services Fiona Orr and John Stott	30.6.2020 **Revised implementation date: April 2022**	**Action ongoing** As part of the review of direct payments, a full project on our use of managed accounts will be conducted across adults and children's. This will include how we manage our relationship with the external providers and monitor performance.
3.4	It is recommended that if the current financial year uplift issues have not been resolved, then work should be undertaken to rectify underpayments as soon as possible. Management should seek a resolution for system updates, to ensure that all direct payment wage uplifts can be system generated at the correct time with minimal manual interventions which may increase error rates and delays.	**High**	Becky Towle Assistant Director of Provider Services	30.4.2020	**Action completed** Work was undertaken looking at how we record direct payments and how the system can be used to minimise the work require in annual uplifts.
4.1	Internal Audit acknowledges that changes will have taken place since the audit fieldwork ended. Future work is to be conducted by Internal audit surrounding the Transitions process.	**High**	Becky Towle Assistant Director of Provider Services	30.4.2020 **Revised implementation date: 30.1.2022**	**Action ongoing** Achieving change is happening in the PAT team.

4.2	It is recommended that a transfer document is completed and retained for the transition process to allow monitoring of the service users movement between service areas. This document can be used to monitor the transfer time for clients, confirmation of the handover process and provide assurance that they have been passed to the appropriate panels in Adults and act as the final transfer document between LCS and LAS record.	**Medium**	Becky Towle Assistant Director of Provider Services	31.7.2020	**Action completed** As part of the new PAT team we have now met with LL and the IT system will now ensure a better transfer. There are also a monthly transition panel where we are looking at all cases to transfer. Both adults and children are at this meeting.
5.1	It is recommended that the DP audit team alert CDT of non-compliant service users earlier. This will allow service users to be better supported in the submission of audit information and allow for alternative arrangements to be made if a different method of support is required.	**Medium**	Becky Towle Assistant Director of Provider Services John Stott	31.7.2020	**Action completed** A review of how alerts are passed to CDT has been undertaken.
5.2	It is recommended that direct payment audit documents are stored electronically using a consistent naming convention including the period of the audit and document type. Housekeeping should be conducted regularly on open forms to close/remove duplicates or add explanations of part completed documents. The DP audit team should allow for a number of in-depth audits per quarter, randomly selecting service users to return more detailed evidence to support the direct payment. This will allow enhanced assurance that monies are being spent appropriately.	**High**	Fiona Orr and John Stott	30.4.2020	**Action completed** Refer to 5.1 above
7.2	Management should ensure that monitoring of the CCG direct payment packages is completed within CDT. It is recommended that CDT complete financial monitoring for direct payments, especially where funding is to be recovered from another source, in this case CCG.	**Medium**	Becky Towle Assistant Director of Provider Services	30.4.2020 **Revised implementation date: Ongoing as a 3 year**	**Action ongoing** Regular meetings now in place between CDT, CCG and finance to discuss.

	It is recommended that system reports are checked as part of the monthly monitoring process to ensure correct payments and recovery of CCG funding and ensure queries can be resolved at source.			**transformation plan**	
7.3	It is recommended that a process is implemented whereby all panel decisions are recoded and communicated to the relevant teams promptly to ensure that CCG payments are made and stopped in a timely manner. This will help reduce instances of overpayments to clients and aid subsequent recovery of CCG funding.	**High**	Becky Towle Assistant Director of Provider Services	30.4.2020	**Action completed** Panel decisions are now recorded and communicated promptly.

5. Software Licensing (Asset Management) (Resources) (issued to Audit and Standards Committee 1.5.19)

As at July 2019
Internal Audit: This report was issued to management on the 18.3.19 with the latest agreed implementation date of 1.4.20. The recommendations will be implemented post the current contract and hence the longer than usual implementation timescale. Internal Audit will maintain a watching brief of this area.
As at Sept 2020
Internal Audit: An update on progress with the recommendations is included below.
As at April 2021
Internal Audit: An update on progress with the recommendations is included below.
As at December 2021
Internal Audit: An update on progress with the recommendations is included below.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position provided by Jon Rayner – ICT Service Delivery Manager on 22.10.21
2.1	Appropriate due diligence should now be undertaken and a true up of all software assets, to ensure that the Council has in place the required volume of software licences to cover the operational activity of the Council. This should be completed prior to the end of the Council's contract with the IT supplier. Any costs associated with this should be dealt with within the contract.	**Critical**	Mike Weston, Assistant Director - ICT Service Delivery	1.04.2020	**Action completed** MECM has been deployed and we can now manage devices with Intune and MECM. We are able to produce reports on software installed on devices.
2.2	Roles and responsibilities for software licensing management to be clearly defined and documented. This links to the recommendation above on the Council having in place a clear statement of policy on Software Licensing. Management to seek the relevant assurance that staff/suppliers employed to manage the Council's software licensing requirements have the necessary skills and expertise to undertake the work. Management to seek assurance that periodic reviews will be undertaken to ensure compliance with the terms and conditions of licences. Management to seek assurance that staff/suppliers are skilled in delivering efficiencies within the licensing processes and to clarify and document how this will work in practice.	**High**	Gary Sweet, ICT Client Service Delivery Officer Mike Weston, Assistant Director - ICT Service Delivery	01.04.2020 **Revised Implementation Timescale** 31.12.21	**Action ongoing** Roles & Responsibilities are understood. Formal training cancelled due to Covid and will be rearranged as soon as the vendor starts training again Formally assigned roles to be reviewed under MER with an estimated completion date in Q3. Although MER dates have been pushed back.
3.1	Assurance to be sought on the use of an appropriate discovery tool to track and monitor software assets.	**High**	Gary Sweet, ICT Client Service Delivery Officer Mike Weston, Assistant Director - ICT Service Delivery	01.04.2020	**Action completed** MECM has been deployed and we can now manage devices with Intune and MECM. We are able to produce reports on software installed on devices. PowerBI training has been completed and PowerBI reports being created.

3.3	BCIS management to seek assurance that a full baseline of the Council's software assets has been established. Results of this to be agreed with the appointed supplier/s.	**High**	Gary Sweet, ICT Client Service Delivery Officer Mike Weston, Assistant Director - ICT Service Delivery	01.04.2020	**Action completed** MECM has been deployed and we can now manage devices with Intune and MECM. We are able to produce reports on software installed on devices.

6. Hardware Asset Management (Resources) (issued to Audit and Standards Committee 1.5.19)

As at July 2019
This report was issued to management on the 18.3.19 with the latest agreed implementation date of 1.4.20. The recommendations will be implemented post the current contract and hence the longer than usual the longer than usual implementation timescale. Internal Audit will maintain a watching brief of this area.
As at Sept 2020
Internal Audit: An update on progress with the recommendations is included below.
As at April 2021
Internal Audit: An update on progress with the recommendations is included below.
As at December 2021
Internal Audit: An update on progress with the recommendations is included below.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position provided by Jon Rayner – ICT Service Delivery Manager on 22.10.21
2.2	Asset extracts received from the IT supplier should be sample checked for accuracy over the coming weeks. Identified issues to be addressed directly with the IT supplier. The new supplier, SCC, will need to establish an asset baseline once the contract commences. This	**High**	Gary Sweet, ICT Client Service Delivery Officer Mike Weston, Assistant	01.04.2020	**Action completed** MECM has been deployed and we can now manage devices with Intune and MECM. We are able to produce reports on software installed on devices.

	will be achieved by the use of an appropriate discovery tool that should deliver a clear and accurate view of hardware devices deployed across the multi-platform/multi-site networks of the Council. This should be used in conjunction with the asset information sample checked by BCIS and inform the end of contract negotiations with the IT supplier. The use of a discovery tool will only identify assets connected to the network. A process will need to be in place for standalone assets etc. Assurance to be sought from the new supplier on how the discovery tool will be utilised on an on-going basis and how this will be used to update the CMDB.		Director - ICT Service Delivery		PowerBI training has been completed and PowerBI reports being created.
2.4	Assurance to be sought on how the new CMDB operated by the Council's supplier SCC, will be integrated with requisition, change, discovery and audit processes. Once this has been fully agreed between all parties, the processes should be fully defined and documented with all roles and responsibilities clearly specified. Any process should report on users with more than one laptop/asset. Review of these users will ensure that the issue of assets not being disposed of correctly is addressed. A comprehensive starters and leavers process will also aid the process.	**High**	Gary Sweet, ICT Client Service Delivery Officer Mike Weston, Assistant Director - ICT Service Delivery	01.04.2020 **Revised Implementation Timescale** 31.12.21	**Action ongoing** Processes now in place to ensure CMDB is up to date and disposals are accurately accounted for. Formally assigned roles to be reviewed under MER with an estimated completion date in Q3. Although should be noted MER dates have been pushed back.

7. Enforcement Agent Review (Resources) (issued to Audit and Standards Committee 1.5.19)

As at July 2019
This report was issued to management on the 15.3.19 with the latest agreed implementation date of 31.8.19. An update on progress with recommendation implementation will be included in the next tracker report.
As at Sept 2020
Internal Audit: A follow up review was undertaken in March 2020, from the information provided Internal Audit is satisfied that progress has been made against the original recommendations. All 13 recommendations were accepted following the original review; all but one of these have been satisfactorily implemented. The only recommendation outstanding relates to fraud training which is not yet available to the service (refer to the table below for full details).

As at April 2021
Internal Audit: An update on progress with the recommendations is included below.
As at December 2021
Internal Audit: An update on progress with the recommendations is included below.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position on 5.11.21
2.4	Management should be aware of fraud indicators and escalate concerns regarding employee performance to ensure appropriate action is taken to protect both the Council and the employee.	**High**	Len Rubie, Finance Manager Income Collection and Management Team	30.6.2019	**Action completed** The fraud e-learning is now available on the Development hub for all staff and members to complete.

8. 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.
As at Jul 2019
Internal Audit: An update on progress with two recommendations ongoing in the last report is included below.
As at Jan 2020
Internal Audit: one of the remaining two recommendations was due to for implementation within the timescales for completion of this report.

As at Sept 2020
Internal Audit: An update on progress with two recommendations ongoing in the last report.
As at April 2021
Internal Audit: An update on progress with the recommendations is included below.
As at December 2021
Internal Audit: An update on progress with the recommendations is included below.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position provided by Head of Neighbourhood Services 6.10.21
1.2	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.	Critical	Beverley Mullooly, Head of Neighbourhood Services	April 2018 **Revised Implementation Timeframe:** 31.12.23	**Action ongoing** OHMS has now been upgraded to the latest version, however there has been limited (if any) functionality improvements that have offered any benefits to the service. As part of the Place Systems Review we will start to test and build the new system in April 22 and the implementation phase is due to start in April 23 (this could move to Sept 23). It will however take some time to implement all the functions in the new system.

9. 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.
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.
As at Jul 2019
Internal Audit: An update on progress with final recommendation ongoing in the last report is provided below.
As at Jan 2020
Internal Audit: The revised implementation date for the final recommendation has not been reached however an IT update is on the agenda for the January Audit and Standards Committee meeting and this will cover the work being undertaken on ICT business continuity.
As at Sept 2020
Internal Audit: An update on the final recommendation is provided below.
As at April 2021
Internal Audit: An update on the final recommendation is provided below.
As at December 2021
Internal Audit: An update on progress with the recommendations is included below.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position provided by Assistant Director ICT Service Delivery and Senior Information Risk Owner 6.10.21
6.1	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.	High	Mike Weston, Assistant Director ICT Service Delivery	31.12.17	**Action completed** Resilient internet service has been implemented with a dark fibre connecting the Town Hall with Moorfoot. No applications are left in the Town Hall with only core infrastructure items such as domain controllers, print servicers, DNS servers and MECM distribution servicers replicated in the Town Hall, Moorfoot, Howden House and Manor Lane

10. 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.

As at Jul 2019
Internal Audit: An update on progress with 3 recommendations ongoing in the last report is provided below.
As at Jan 2020
Internal Audit: An update on progress with the final recommendation remaining is included below.
As at Sept 2020
Internal Audit: An update on progress with the final recommendation remaining is included below.
As at April 2021
Internal Audit: An update on progress with the recommendations is included below.
As at December 2021
Internal Audit: An update on progress with the recommendations is included below.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position on 5.11.21
7.1	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	**Action completed** The fraud e-learning is now available on the Development hub for all staff and members to complete.

11. 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.
As at Jul 2019
Internal Audit: An update on progress with 2 recommendations ongoing in the last report is provided below.
As at Jan 2020
Internal Audit: An update on progress with the two remaining recommendations is included below.
As at Sept 2020
Internal Audit: An update on progress with the two remaining recommendations is included below.
As at April 2021
Internal Audit: An update on progress with the recommendations is included below.
As at December 2021
Internal Audit: An update on progress with the recommendations is included below.

Ref	Recommendation	Priority	Original Responsible Officer	Original Implementation Date	Updated position on 5.11.21
8.1	Internal Audit should review and update the counter fraud training course online. 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	**Action completed** The fraud e-learning is now available on the Development hub for all staff and members to complete.
8.2	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 Manager, Internal Audit	31.12.16	**Action completed** As above

RATING KEY

- Red highlights recommendations outstanding for over 12 months from the originally agreed implementation date.
- Amber highlights recommendations outstanding between 6 to 12 months.
- Yellow highlights recommendations outstanding up to 6 months from the original agreed implementation date.
- Green highlights recommendations that have been completed.

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