Public Document Pack

Audit and Standards Committee

Thursday 16 December 2021 at 5.00 pm

Town Hall, Sheffield, S1 2HH

The Press and Public are Welcome to Attend

Membership

Councillors Sioned-Mair Richards (Chair), Simon Clement-Jones (Deputy Chair), Angela Argenzio, Mohammed Mahroof, Josie Paszek, Ben Curran and David Barker.

Independent Co-opted Members

Alison Howard.

Sheffield City Council

PUBLIC ACCESS TO THE MEETING

The Audit and Standards Committee oversees and assesses the Council's risk management, control and corporate governance arrangements and advises the Council on the adequacy and effectiveness of these arrangements. The Committee has delegated powers to approve the Council's Statement of Accounts and consider the Annual Letter from the External Auditor.

The Committee is also responsible for promoting high standards of conduct by Councillors and co-opted members.

A copy of the agenda and reports is available on the Council's website at http://democracy.sheffield.gov.uk. You can also see the reports to be discussed at the meeting if you call at the First Point Reception, Town Hall, Pinstone Street entrance. The Reception is open between 9.00 am and 5.00 pm, Monday to Thursday and between 9.00 am and 4.45 pm. on Friday. You may not be allowed to see some reports because they contain confidential information.

Recording is allowed at meetings of the Committee under the direction of the Chair of the meeting. Please see the website or contact Democratic Services for details of the Council's protocol on audio/visual recording and photography at council meetings.

If you require any further information please contact Sarah Cottam in Democratic Services on 0114 273 5033 or email sarah.cottam@sheffield.gov.uk.

FACILITIES

There are public toilets available, with wheelchair access, on the ground floor of the Town Hall. Induction loop facilities are available in meeting rooms.

Access for people with mobility difficulties can be obtained through the ramp on the side to the main Town Hall entrance.

AUDIT AND STANDARDS COMMITTEE AGENDA
16 DECEMBER 2021

Order of Business

1. Welcome and Housekeeping Arrangements

2. Apologies for Absence

3. Exclusion of the Press and Public
To identify items where resolutions may be moved to exclude the press and public.

4. Declarations of Interest (Pages 5 - 8)
Members to declare any interests they have in the business to be considered at the meeting.

5. Minutes of Previous Meeting (Pages 9 - 18)
To approve the minutes of the meeting of the Committee held 21 October 2021.

6. Education Healthcare Plan Update (Pages 19 - 24)
Report of the Director of Education and Skills.

7. Whistleblowing Policy Review (Pages 25 - 32)
Report of the Director of Legal and Governance.

8. Information Governance Annual Report
Report of the Director of Business Change and Information Solutions to follow.

9. Verbal Update on the Progress of the External Audit
To receive a verbal update.

10. Progress on High Opinion Audit Reports (Pages 33 - 58)
Report of the Senior Finance Manager, Internal Audit.

11. PSIAS - External Quality Assessment Peer Review (Pages 59 - 80)
Report of the Senior Finance Manager, Internal Audit.

12. Work Programme (Pages 81 - 88)
Report of the Director of Legal and Governance.

13. Dates of Future Meetings
To note that meetings of the Committee will be held at 5.00 p.m. on:-

20th January 2022
24th February 2022 (Additional Meeting if required)
24th March 2022

16th June 2022
21st July 2022

ADVICE TO MEMBERS ON DECLARING INTERESTS AT MEETINGS

If you are present at a meeting of the Council, of its executive or any committee of the executive, or of any committee, sub-committee, joint committee, or joint sub-committee of the authority, and you have a **Disclosable Pecuniary Interest** (DPI) relating to any business that will be considered at the meeting, you must not:

- participate in any discussion of the business at the meeting, or if you become aware of your Disclosable Pecuniary Interest during the meeting, participate further in any discussion of the business, or
- participate in any vote or further vote taken on the matter at the meeting.

These prohibitions apply to any form of participation, including speaking as a member of the public.

You **must**:

- leave the room (in accordance with the Members' Code of Conduct)
- make a verbal declaration of the existence and nature of any DPI at any meeting at which you are present at which an item of business which affects or relates to the subject matter of that interest is under consideration, at or before the consideration of the item of business or as soon as the interest becomes apparent.
- declare it to the meeting and notify the Council's Monitoring Officer within 28 days, if the DPI is not already registered.

If you have any of the following pecuniary interests, they are your **disclosable pecuniary interests** under the new national rules. You have a pecuniary interest if you, or your spouse or civil partner, have a pecuniary interest.

- Any employment, office, trade, profession or vocation carried on for profit or gain, which you, or your spouse or civil partner undertakes.

- Any payment or provision of any other financial benefit (other than from your council or authority) made or provided within the relevant period* in respect of any expenses incurred by you in carrying out duties as a member, or towards your election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.

  *The relevant period is the 12 months ending on the day when you tell the Monitoring Officer about your disclosable pecuniary interests.

- Any contract which is made between you, or your spouse or your civil partner (or a body in which you, or your spouse or your civil partner, has a beneficial interest) and your council or authority –

  - under which goods or services are to be provided or works are to be executed; and
  - which has not been fully discharged.

- Any beneficial interest in land which you, or your spouse or your civil partner, have and which is within the area of your council or authority.

- Any licence (alone or jointly with others) which you, or your spouse or your civil partner, holds to occupy land in the area of your council or authority for a month or longer.

- Any tenancy where (to your knowledge) –
  - the landlord is your council or authority; and
  - the tenant is a body in which you, or your spouse or your civil partner, has a beneficial interest.

- Any beneficial interest which you, or your spouse or your civil partner has in securities of a body where -

  (a) that body (to your knowledge) has a place of business or land in the area of your council or authority; and

  (b) either -
    - the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or
    - if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you, or your spouse or your civil partner, has a beneficial interest exceeds one hundredth of the total issued share capital of that class.

If you attend a meeting at which any item of business is to be considered and you are aware that you have a **personal interest** in the matter which does not amount to a DPI, you must make verbal declaration of the existence and nature of that interest at or before the consideration of the item of business or as soon as the interest becomes apparent. You should leave the room if your continued presence is incompatible with the 7 Principles of Public Life (selflessness; integrity; objectivity; accountability; openness; honesty; and leadership).

You have a personal interest where –

- a decision in relation to that business might reasonably be regarded as affecting the well-being or financial standing (including interests in land and easements over land) of you or a member of your family or a person or an organisation with whom you have a close association to a greater extent than it would affect the majority of the Council Tax payers, ratepayers or inhabitants of the ward or electoral area for which you have been elected or otherwise of the Authority's administrative area, or

- it relates to or is likely to affect any of the interests that are defined as DPIs but are in respect of a member of your family (other than a partner) or a person with whom you have a close association.

Guidance on declarations of interest, incorporating regulations published by the Government in relation to Disclosable Pecuniary Interests, has been circulated to you previously.

You should identify any potential interest you may have relating to business to be considered at the meeting. This will help you and anyone that you ask for advice to fully consider all the circumstances before deciding what action you should take.

In certain circumstances the Council may grant a **dispensation** to permit a Member to take part in the business of the Authority even if the member has a Disclosable Pecuniary Interest relating to that business.

To obtain a dispensation, you must write to the Monitoring Officer at least 48 hours before the meeting in question, explaining why a dispensation is sought and desirable, and specifying the period of time for which it is sought. The Monitoring Officer may consult with the Independent Person or the Council's Audit and Standards Committee in relation to a request for dispensation.

Further advice can be obtained from Gillian Duckworth, Director of Legal and Governance on 0114 2734018 or email gillian.duckworth@sheffield.gov.uk.

This page is intentionally left blank

SHEFFIELD CITY COUNCIL

Audit and Standards Committee

Meeting held 21 October 2021

PRESENT: Councillors Sioned-Mair Richards (Chair), Simon Clement-Jones (Deputy Chair), Angela Argenzio, Mohammed Mahroof, Josie Paszek and Alison Howard (Independent Co-opted Member)

.....

1. APOLOGIES FOR ABSENCE

1.1 Apologies for absence were received from Councillors David Barker and Ben Curran.

2. EXCLUSION OF THE PRESS AND PUBLIC

2.1 No items were identified where resolutions may be moved to exclude the press and public.

3. DECLARATIONS OF INTEREST

3.1 There were no declarations of interest made at the meeting.

4. MINUTES OF PREVIOUS MEETING

4.1 **RESOLVED:** That the minutes of the meeting held on the 23 September 2021 were approved as a correct record.

5. FINAL ACCOUNTS AUDIT PROGRESS

5.1 The external auditors, Janet Dawson and Hayley Clarke, from Ernst & Young were in attendance to give an update to members of the Committee on the progress of the audit of the 2020/21 Statement of Accounts.

5.2 Janet Dawson mentioned that due to staff absences, the external auditors were unable to carry out their audit procedures in September as originally planned. The audit would now take place in October and the external auditors aimed to update the Committee at the 16 December 2021 meeting.

5.3 Hayley Clarke mentioned that the risk assessment process, which was presented at a previous meeting, identified two potential risks of

significant weakness and that those risks remained. The risks related to financial sustainability and regeneration programmes.

5.4 Members of the Committee asked questions and the key points to note were-

5.5 The Chair asked if information related to the two sub-risks had been shared with other areas within the Council. The Head of Strategic Finance, Dave Phillips, informed the Committee that the information had been communicated within the Audit Plan. The information had also been discussed with a range of Council officers including the Director of Resources and the Chief Executive.

5.6 Councillor Simon-Clement Jones asked what the external auditors had done to mitigate the two potential risks of significant weakness. Hayley Clarke explained that they had looked at the decisions made by the Council since the beginning of the financial year and what governance arrangements the Council had put in place since then.

5.7 Concerns were raised that West Bar and the Heart of the City programmes were appearing as risks in the report. Councillor Mohammed Mahroof referred to the Council's agreement to lease office space in the city and mentioned how that could negatively impact the Council's budget. The Director of Resources mentioned that reports on the two programmes were taken to the Co-operative Executive, which highlighted the Council's decision making for those proposals. It was mentioned that information on the programmes were in the public domain.

5.8 The Head of Strategic Finance mentioned that it was good practice for the Committee to have an opportunity to meet in private with the external auditors, without officers being present, and invited the Committee to consider whether they wished to do so periodically. The Committee indicated that they would like to do so.

5.9 The Chair thanked the external auditors for attending the meeting and presenting their report.

5.10 **RESOLVED:** That **(1)** the Committee noted the audit progress update report and **(2)** a closed meeting be arranged.

6. ANNUAL OMBUDSMAN REPORT

6.1 Jenny Callaghan highlighted that the report provided an overview of the complaints received, formally referred and determined by the three Ombudsman (Local Government & Social Care Ombudsman, Parliamentary & Health Service Ombudsman and Housing Ombudsman) during the twelve months from 1 April 2020 to 31 March 2021.

6.2 Jenny Callaghan mentioned that the Housing Ombudsman's annual report had been delayed until January 2022 due to resourcing issues.

6.3 The Committee received a presentation about the Annual Ombudsman Enquires and Investigations for 2021/22. The presentation covered;

- Departments within the Council that had received the highest number of complaints for 2021/22.
- The average response times for the complaints identified.
- The outcomes for the complaints identified.
- Examples of training and learning provided across the service.
- What had been introduced to improve the service and any other future developments.

6.4 Members of the Committee asked questions and the keys points to note were-

6.5 Councillor Josie Paszek asked if the timescales when issuing an apology could be reduced. Jenny Callaghan mentioned that payments and apologies in most cases were dealt with in a matter of weeks, it was the wider learning actions that were given a longer time period for a response.

6.6 Councillor Angela Argenzio asked if the number of complaints for 2020/21 had reduced due to the impact of COVID-19. Jenny Callaghan confirmed that COVID-19 had impacted the number of complaints. It was also mentioned that the Local Government and Social Care Ombudsman had effectively closed the door to receiving complaints for a period at the beginning of the pandemic, this also contributed to the reduction in complaints.

6.7 Councillor Angela Argenzio stated how difficult it was to log a complaint, therefore that could have impacted how many people went through the process. Corleen Bygraves-Paul advised that the new CRM (Customer Relationship Management) system should address the issues around logging a complaint.

6.8 Councillor Angela Argenzio raised doubts around the sincerity of the apology from the Council, given to people involved and affected by the tree incident that took place in 2016. The Chair commented that she was unhappy to hear this and therefore expressed a sincere apology on behalf of the Council. Jenny Callaghan informed the Committee that her role was to oversee how the Council complied with the Ombudsman recommendations when issuing the public apology. It was added that the Ombudsman was satisfied with how the apology was carried out.

6.9 The Committee highlighted the benefit for members to take part in the next phase of the complaints project (customer panel) and observe live cases. Corleen Bygraves-Paul confirmed she would ask the relevant Executive Member if that was a possibility.

6.10 Councillor Simon-Clement Jones asked if the Committee could have an indication of figures from the Housing Ombudsman annual report. Jenny Callaghan advised that once the report from the Housing Ombudsman was received in January 2022, it could be shared with the Audit & Standards Committee.

6.11 The Chair expressed concerns around late/incomplete service comments leading to response delays and mentioned that Customer Services had the full support from the Committee to obtain information in a timely manner. Jenny Callaghan thanked the Chair for the support and acknowledged how difficult it could be to respond however, responding to Ombudsman enquiries should be seen as a priority.

6.12 The Director of Legal and Governance mentioned that the new complaints system would improve processes around how staff interacted with customers. It was important that customers had an input on how the current system could be improved.

6.13 The Chair thanked Jenny Callaghan and Corleen Bygraves-Paul for attending the meeting and presenting the report.

6.14 **RESOLVED:** That the Committee considered the Annual Ombudsman report and provided its view on the performance of Ombudsman complaints and the issues raised.

7. CUSTOMER SERVICES CONTACT CENTRE PERFORMANCE

7.1 The Director of HR and Customer Services, Mark Bennett, informed the Committee that the report gave an overview of the 2021/22 to date performance of the Customer Services Contact Centre.

7.2 It was mentioned that the report identified issues that affected performance, future developments and areas for improvement.

7.3 The Committee was advised that the Contact Centre had experienced issues on recruitment. It was also mentioned that inductions for new starters had been affected due to the pandemic.

7.4 New ways of working and how the Contact Centre could improve its performance were set out in the report for the Committee to review. Short-term issues and how to reduce immediate pressures along with long-term potential developments were highlighted.

7.5 Members of the Committee asked questions and the key points to note were-

7.6 Councillor Angela Argenzio referred to the Revenue and Benefits table which reported the longest waiting and handling times across all the departments outlined in the report. Councillor Argenzio asked why it was difficult to contact the Revenue and Benefits department. The Director of HR and Customer Services acknowledged that the waiting and handling times were unacceptable although it was mentioned that the nature of the calls directed to Revenue and Benefits, were usually more complex and required specialist responses.

7.7 Councillor Angela Argenzio asked what the Customer Services Contact Centre had done to improve their performance. The Director of HR and Customer Services informed the Committee that the Storm telephony system along with a new CRM (Customer Records Management) system had been introduced. The Director of HR and Customer Services outlined the ambition to improve the Council's Contact Centre webpage, adding that the aim was to make it the primary point of receiving adequate information, which would lead to the reduction of call volume. It was mentioned that approximately 60% of customers had tried to resolve their issues initially on the Councils webpage before calling the Contact Centre.

7.8 The Director of HR and Customer Services stated that approximately 30% of customers had previously called the Contact Centre and the purpose of their call was to follow up on existing enquiries. Therefore, it was noted that issues needed to be dealt with first time round, which

would also lead to the reduction of call volume.

7.9 Councillor Angela Argenzio asked if there was a timeframe on updating the Contact Centres webpage. The Director of HR and Customer Services advised that developing the webpage would not be a quick process and would require contribution from multiple services, therefore a deadline would not be confirmed.

7.10 Councillor Angela Argenzio asked if there was anything in place to encourage staff to remain in the Contact Centre. The Director of HR and Customer Services explained that Team Leaders, Supervisors and Managers were excellent at providing support to staff. Corleen Bygraves-Paul stated that regular one to ones and team meetings were scheduled. It was added that one reason why staff leave the Contact Centre was due to development opportunities as the Contact Centre is known for developing staff knowledge in various services which gave staff the ability to progress their careers, within the Council.

7.11 Councillor Josie Paszek expressed sympathy for the staff within the Contact Centre. Councillor Paszek asked if the Contact Centre was adequately staffed and how many posts required recruitment. Corleen Bygraves-Paul explained the difficulty around recruiting when the requirement is only for short-term contracts although active recruitment was taking place. Part-time staff had been asked to extend their working hours and the recruitment process had been adapted to attract quality staff. The training time for new starters had been reduced from 6 weeks to 3 weeks.

7.12 It was mentioned that 7 experienced Customer Service staff had moved to the Council's Test, Track and Isolate Team and that they would return to Customer Services in the future.

7.13 Councillor Mohammed Mahroof stated that some customers could become anxious when trying to resolve an immediate issue, and that long waiting times could worsen the customers' anxiety.

7.14 Alison Howard (Independent Co-opted Member) suggested that future reports should include benchmarking against other authorities and the private sector, this would assist the Committee understand the position of the Council compared to other organisations. There was also a suggestion to incorporate an action plan so the Committee could see the progress made at a future meeting.

7.15 The Chair thanked the Director of HR and Customer Services and

Corleen Bygraves-Paul for their detailed responses and requested that the Executive Member for Finance and Resources be made aware of the discussion that had taken place.

7.16 **RESOLVED:** That **(1)** the Committee considered the report in order to provide its view on the future performance of service, the improvements proposed, and the issues raised and **(2)** the minutes be circulated to the Executive Member for Finance and Resources.

8. PROGRESS REPORT OF MEMBER DEVELOPMENT

8.1 The Director of Legal and Governance described the progress that had taken place with Member Development at the Council and outlined the plans for its future development.

8.2 The Committee were advised that the LGA (Local Government Association) had offered one years' worth of training and development to the Council and that the programme would run until May 2022.

8.3 Training for Members and Officers had also been provided on the introduction of Local Area Committees and the Transition to a Committee System.

8.4 Members of the Committee asked questions and the key points to note were-

8.5 The Chair suggested training on Personal Safety and Conflict Resolution for elected members be added to the programme. The Director of Legal and Governance referred to 3.6.1 in the report which highlighted that Personal Safety and Conflict Resolution along with other topics requested to be included in the programme.

8.6 The Director of Legal and Governance mentioned that Personal Safety sessions were held previously, with the help of the Police, and that this training would be looked at being brought forward. It was added that immediate advice and guidance on Personal Safety was accessible on the LGA website.

8.7 Councillor Angela Argenzio recommended the LGA safety training session to other Members.

8.8 Councillor Angela Argenzio raised concerns as the induction for new members had low attendance and asked if this was rolled out once. The Director of Legal and Governance advised that inductions for new member were scheduled once a year, usually a week after the

election, and that the session was carried out over a two-day period. If a member was not able to attend the induction, they would have to complete all the elements separately. It was mentioned that the low attendance could be a result of Councillors being re-elected, although it was advised that every Councillor should attend the induction whether they are new or returning Councillors.

8.9 Councillor Angela Argenzio asked whether training sessions could be recorded and provided to members who were not able to attend a training session. The Director of Legal and Governance stated that recording training sessions was a good principle and would be looked at where possible.

8.10 The Chair requested that Equality, Diversity, and Inclusion training be made mandatory for members. The Director of Legal and Governance agreed to raise mandatory training with the Whips.

8.11 The Chair thanked the Director of Legal and Governance for the report on Member Development.

8.12 **RESOLVED:** that the Committee note the progress of Member Development.

9. WORK PROGRAMME

9.1 The Committee considered a report of the Director of Legal and Governance that outlined the work programme for the remainder of the municipal year. Members were asked to identify any further items for inclusion.

9.2 The Chair suggested that an Annual Housing Ombudsman Report be brought to the Committee on 20 January 2022 if the review was complete.

9.3 The next meeting of the Audit & Standards Committee would consider; -

- Statement of Accounts 2020/21
- Educational Healthcare Plan Update
- Report of those Charged with Governance (ISA 260)
- Whistleblowing Policy Review
- Progress on High Opinion Audit Reports

It was mentioned that the decision made by the Committee, to opt-in to using PSAA for appointing the Council's external auditors, would need to be agreed by Full Council. Full Council would receive a report of The Chair, Councillor Sioned-Mair Richards seconded by Vice Chair, Councillor Simon Clement-Jones in January 2022.

9.4 **RESOLVED:** that **(1)** the work programme be noted; and **(2)** that the report mentioned be included to the work programme; and **(3)** that the Committee agreed a report of The Chair/Vice Chair be taken to Full Council to agree using PSAA for appointing the Council's external auditors.

10. DATES OF FUTURE MEETINGS

10.1 Future Meetings of the Audit and Standards Committee would be held on Thursdays at 5pm on:

16th December 2021
20th January 2022
24th February 2022 (Additional Meeting if required)
24th March 2022
16th June 2022
21st July 2022

This page is intentionally left blank

Audit and Standards Committee Report

Report of: **Andrew Jones Director of Education and Skills**

Date: **16th December 2021**

Subject: **SEND Statutory Services and Compliance**

Author of Report: **Rose Ward**

Recommendations:

That the Audit & Standards Committee:

- Note the information set out in the report and appendices.
- Request any further information or briefing on SEND
- Support and challenge regarding SEND development

Background Papers: None

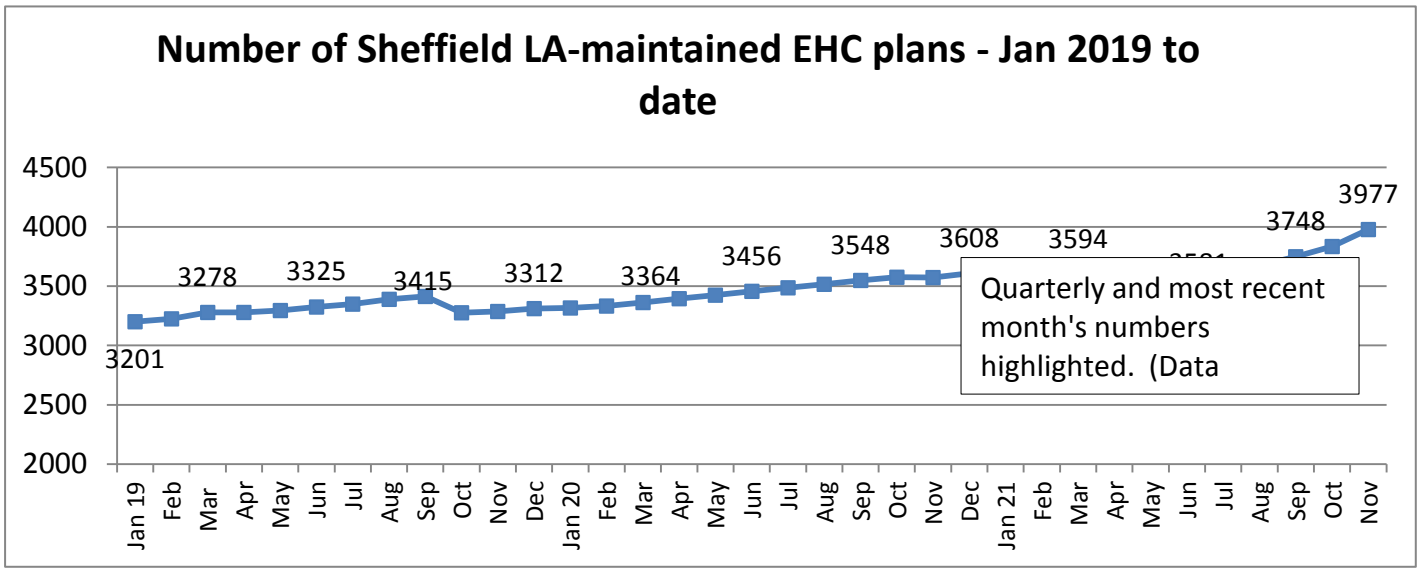
Category of Report: OPEN

Statutory and Council Policy Checklist

Financial Implications
NO
Legal Implications
NO
Equality of Opportunity Implications
NO
Tackling Health Inequalities Implications
NO
Human rights Implications
NO:
Environmental and Sustainability implications
NO
Economic impact
NO
Community safety implications
NO
Human resources implications
NO
Property implications
NO
Area(s) affected
None
Relevant Cabinet Portfolio Member
Councillor Terry Fox, Cabinet Member for Finance
Is the item a matter which is reserved for approval by the City Council?
NO
Press release
NO

Summary:

- In Sheffield there are 3977 Children and Young People with Education Health and Care Plans (EHCPs) (just under 5% of the child population)
- A third of EHCPs are held by Young People who are post 16
- The west of the city (Localities E, F & G) has the highest number of children



(under 16) with EHCPs, Locality F has the highest overall.

SEND in Sheffield is subject to a Written Statement of Action from the Ofsted Joint Area Inspection, SEND and CQC, conducted in November 2018.
7 areas or weakness were identified, and an action plan developed to address each of the 7 areas: (in brief)

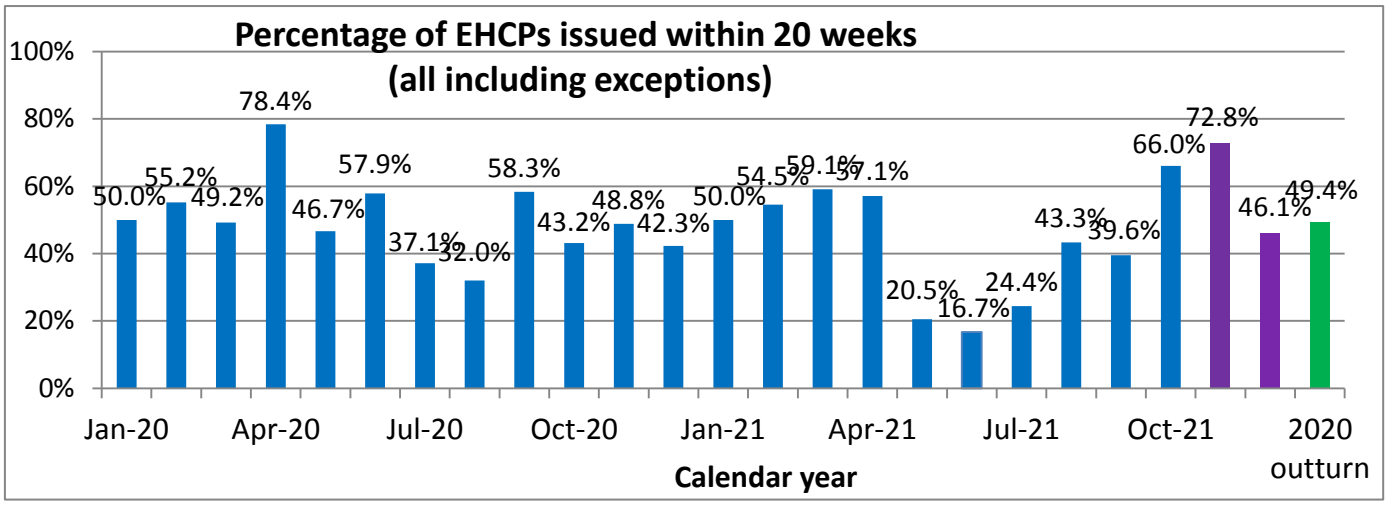
1. To develop an Inclusion Strategy and Implementation Plan
2. Improve communication – children, families and partners
3. Improvements in CCG – waiting times, joint commissioning
4. Improve joint commissioning and commissioning arrangements for SEND
5. EHCNA / P compliance, quality, and oversight
6. Mainstream education – identification, assessment, and response to needs
7. Multi Agency Transition arrangements

Progress has been made in all areas, areas where progress began to decelerate or become significantly worse were identified in May 2021, these areas were number 5 and 7 of the WSOA.

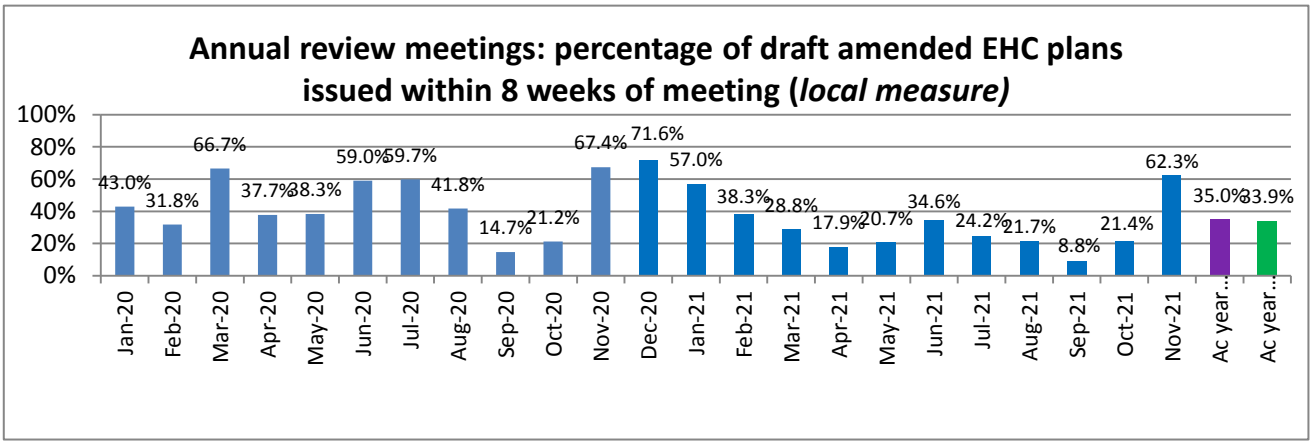
In May – July 2021, the compliance within the 20 weeks EHCNA process dipped from 32-18% with 102 plans exceeding the statutory 20 weeks. (National average compliance for plan completion is between 55-65%)
An interim Head of SEND was put in post from June 2021, since this time work has been undertaken, the outcomes are:

Compliance:

- Compliance within the 20 weeks process has risen to 72.8 % (as of the end of November)



- Professional Advice from Education, Health and Care providers show no over timescale advice
- Proposed Amended plans following Annual Review has risen from 8.8% to 62.3% within 8 weeks of the review.



Staffing:

- A commitment to ensure establishment remains at the right level for the number of plans (not exceeding 200 per worker)
- Increase from 16 -22 FTE Inclusion Officers
- Recruited to vacant management posts = x 3 Locality Managers (5 now in post)
- Additional resource for the EP service to allow for advice to be completed - Locum and Agency Support (backlog is now cleared and agency / locum arrangements are coming to an end)
- Service Manager vacancy being recruited to.
- Recruitment to new leaders for the Autism Team and HI/VI services
- A new Principal EP will begin in post from January 2022.
- Recruited to a Service Manager for specific work on Post 16 and PFA pathways alongside Education, Health and Care colleagues.

Audit:

- A new approach to audit has been devised, online platforms have been utilised for immediate response to compliance in all sections
- Quality Assurance Multi-Agency group audits advice and 2 EHCPs per term
- Quality Audit has been used, but no reporting in place, new audit cycle with feedback has been agreed
- Development of child and family voice being included in the audit process.

Funding:

- Locality Model of funding is under review
- An increase of funding for children with EHCPs has been submitted to Schools Forum
- Comparatively our High Needs funding agreement for our mainstream schools is low, as a result the LA has overspent in the Exceptional Needs and Growth funding pots.

Sufficiency:

- We do not have sufficient specialist places for children who need them, despite ongoing work with commissioners.
- Shortages are apparent within ASD specialist provision at both Primary and Secondary phases.
- Further IR places are planned from September 2022
- The new Discovery School will open from September 2022.

Performance:

To ensure performance does not dip in the service again and that compliance remains high there have been several new performance management structures put into place:

- Fortnightly compliance meetings and Performance Clinics alternating
- Risk Meetings to consider children who are causing concern and actions agreed
- Direction to schools where we have high risk placement breakdowns
- Introduction of practice standards and supervision expectations.
- Audit tools developed to ensure plans are always compliant
- Steering groups for the WSOA have been developed to move forward at pace with continued areas of weakness
- Work with the Inclusion Board to unblock any barriers to progress and support to create a Young People Council
- Development of the Local Offer and agreement for a commitment officer to develop this further
- Reporting weekly to SLT and monthly to Director Performance Clinic

This page is intentionally left blank

Audit and Standards Committee Report

Report of: **Gillian Duckworth, Monitoring Officer**

Date: **7 December 2021**

Subject: **Whistleblowing**

Author of Report: **Claire Corneille, Head of HR**

Summary:

This report

- Provides the Audit and Standards Committee with information on activity under the Whistleblowing Policy from April 2018 (when last reported) to the present date in accordance with the requirements of the Constitution (Appendix A)
- Provides details of the plans to publicise the Whistleblowing Policy, as part of the planned approach to this and associated ways for staff to raise concerns.
- Informs the Committee on the planned recruitment, support, training and development to equip a refocused group of Contact Advisors, as part of the promotion of ways to raise concerns.

Recommendations:

It is recommended that the Audit and Standards Committee:

- Note the information on the activity under the Whistleblowing Policy since April 2018.
- Note the plans for publicising the Whistleblowing Policy and associated ways in which staff can raise concerns.
- Note the plans for Contact Advisors

Background Papers:	**None**

Category of Report:	OPEN

* Delete as appropriate

Statutory and Council Policy Checklist

Financial Implications
YES/NO - Cleared by:
Legal Implications
YES/NO - Cleared by:
Equality of Opportunity Implications
YES/NO - Cleared by:
Tackling Health Inequalities Implications
NO
Human rights Implications
NO:
Environmental and Sustainability implications
NO
Economic impact
NO
Community safety implications
NO
Human resources implications
NO
Property implications
NO
Area(s) affected
None
Relevant Cabinet Portfolio Member
Councillor Cate McDonald, Executive Member for Finance and Resources
Is the item a matter which is reserved for approval by the City Council?
NO
Press release
NO

WHISTLEBLOWING POLICY

1. Introduction

Sheffield City Council is committed to the highest standards of ethics, transparency, integrity and accountability. It seeks to conduct its affairs in a responsible manner taking into account the requirements of the proper use of public funds and the standards required in public life. If employees feel that this is not happening then the Council encourages them to tell us. This is called Whistleblowing.

The Council has a Whistleblowing Policy to enable employees to raise matters of concern that are in the public interest so that they may be investigated and where appropriate acted upon. There are additional ways in which colleagues can raise wider concerns, such as through Contact Advisors.

2. Current position

The Councils current arrangements have been in place since 2016 and were last reported to this Committee in April 2018.

The number of concerns raised under the Whistleblowing Policy remains very low, although this is against a context of having a range of ways to raise concerns at all levels and an active Audit function, who work in partnership with HR to review allegations of inappropriate behaviours including fraud and criminal activities when identified / reported.

The allegations reported since April 2018 are detailed in Appendix 1.

The Director of Legal and Governance (Monitoring Officer), Finance Manager (Internal Audit) and the Head of HR meet on a quarterly basis to review both the Whistleblowing and Financial Irregularities monitoring report, as part of the Councils governance arrangements.

3. Plans to publicise Whistleblowing, and associated ways to raise concerns

Whilst monitoring and communications were put in place in 2018, since March 2020 the opportunity to continue to publicise the process for raising concerns, including whistleblowing, has reduced.
The varied way in which have worked throughout the pandemic has minimised promotional opportunities. As we start to transition back into all

workplaces from February 2022, we have an opportunity to refocus our approach and publicise the various ways in which staff can raise concerns.

A targeted campaign, using a range of mediums including direct emails, narrative in bulletins, posters etc. will be used from April 2022.

4. Contact Advisors

Contact Advisors were originally introduced, as part of the Dignity and Respect at Work Policy and Procedure, to enable employees to access relevant advice and information and to help them to explore and understand various routes to raising concerns and resolving issues.

The role of the Contact Advisor was broadened to include support for people using this procedure or people who are subject to Whistleblowing investigations.

The number of Contact Advisors has reduced significantly in recent years, and we have a immediate issue in terms of staff being able to access support in this way.

Plans are being developed to refocus the Contact Advisor role, learning lessons from previous approaches and other organisations who have successfully provided similar opportunities (e.g., the Freedom to Speak Up Guardians within the NHS).

This will result in a targeted campaign, in January 2022, to recruit more Contact Advisors, who will be provided with specific training and ongoing development to support them in their role.

It is vital that we have these individuals in place prior to the promotion of whistleblowing and associated ways to raise concerns, hence the plans to promote these approaches from April 2022.

5. Recommendations

It is recommended that the Audit and Standards Committee:

- Note the information on the activity under the Whistleblowing Policy since April 2018.
- Note the plans for publicising the Whistleblowing Policy and associated ways in which staff can raise concerns.
- Note the plans for Contact Advisors.

This page is intentionally left blank

Appendix 1 – Whistleblowing cases (April 2018 – November 2021)

Portfolio	Date reported	Substantive issues	Findings	Outcome	Status of case
People	04/01/2019	Recruitment Practice	No evidence to support allegations	Correspondent made aware	Closed
People	27/03/2019	Bad atmosphere in the team due to the way a manager behaviour (belittles staff and makes them feel awkward and tense) – raised anonymously	Investigated and evidence found to substantiate concerns	Final Written warning for the employee	Closed
People	25/07/2019	During an OFSTED inspection it came to the attention of the HMI that a Senior Manager was not a qualified or registered social worker. Concerns raised about ability to carry out role without the correct training or qualifications – raised anonymously	Senior Manager post does not require the post holder to be a qualified social worker.	No further action required	Closed
People	06/03/2020	Support worker accused, by colleague, of looking through a service users bedside cabinet. (No requirement to be in service users bedroom)	Insufficient evidence to proceed with the case	No further action required	Closed
People	01/08/2021	Alleged improper payments for annual leave	Investigation ongoing	TBC	Open

This page is intentionally left blank

Audit and Standards Committee Report

Report of: Senior Finance Manager, Internal Audit

Date: 16th December 2021

Subject: Progress on No Assurance/Limited Assurance (High organisational impact) Opinion Audit Reports

Author of Report: Linda Hunter, Senior Finance Manager, Internal Audit

Summary: The attached is the report of the Senior Finance Manager, Internal Audit providing an updated position on implementation of recommendations contained in audit reports issued with a high opinion or a limited/no assurance opinion and high organisational impact assessment.

Recommendations:
Members are asked to:
To note the contents of the report.
That the Audit and Standards Committee agrees to the removal of the following reports 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

Background Papers:

Category of Report: **Open**

* Delete as appropriate
If closed, the report/appendix is not for publication because it contains exempt information under Paragraph (insert relevant paragraph number) of Schedule 12A of the Local Government Act 1972 (as amended).'

Statutory and Council Policy Checklist

Financial implications
~~YES~~/NO Cleared by: Linda Hunter
Legal implications
~~YES~~/NO
Equality of Opportunity implications
~~YES~~/NO
Tackling Health Inequalities implications
~~YES~~/NO
Human rights implications
~~YES~~/NO
Environmental and Sustainability implications
~~YES~~/NO
Economic impact
~~YES~~/NO
Community safety implications
~~YES~~/NO
Human resources implications
~~YES~~/NO
Property implications
~~YES~~/NO
Area(s) affected
Relevant Scrutiny Committee if decision called in
Not applicable
Is the item a matter which is reserved for approval by the City Council? ~~YES~~/NO
Press release
~~YES~~/NO

REPORT TO SHEFFIELD CITY COUNCIL AUDIT AND STANDARDS COMMITTEE
16th December 2021

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

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.

This page is intentionally left blank

Audit and Standards Committee Report

Report of: Senior Finance Manager, Internal Audit

Date: 16th December 2021

Subject: Public Sector Internal Audit Standards – External Quality Assessment Peer Review

Author of Report: Linda Hunter, Senior Finance Manager, Internal Audit

Summary: The attached is the report from Birmingham City Council providing feedback on the recent independent review and External Quality Assessment Peer Review.

Recommendation:
Members are asked to:

To note the contents of the report and the highest possible rating of 'conforms'.

Background Papers:

Category of Report: **Open**

* Delete as appropriate

If Closed, the report/appendix is not for publication because it contains exempt information under Paragraph (insert relevant paragraph number) of Schedule 12A of the Local Government Act 1972 (as amended).'

Statutory and Council Policy Checklist

Financial implications
~~YES~~/NO Cleared by: Linda Hunter
Legal implications
~~YES~~/NO
Equality of Opportunity implications
~~YES~~/NO
Tackling Health Inequalities implications
~~YES~~/NO
Human rights implications
~~YES~~/NO
Environmental and Sustainability implications
~~YES~~/NO
Economic impact
~~YES~~/NO
Community safety implications
~~YES~~/NO
Human resources implications
~~YES~~/NO
Property implications
~~YES~~/NO
Area(s) affected
Relevant Scrutiny Committee if decision called in
Not applicable
Is the item a matter which is reserved for approval by the City Council? ~~YES~~/NO
Press release
~~YES~~/NO

Birmingham Audit

Final Report

Public Sector Internal Audit Standards – External Quality Assessment Peer Review

Sheffield City Council

17th November 2021

Sarah Dunlavey
Assistant Director Audit and Risk Management
Sarah.Dunlavey@birmingham.gov.uk
07927 665715

Contents

Distribution List	
For acceptance:	Head of Strategic Finance (Deputy Section 151 Officer)
For action:	Senior Finance Manager (Internal Audit)
To be presented to Audit and Standards Committee on 16/12/21	

1. Executive Summary

Top Issues for Management

1	Our independent review and sample testing have confirmed that Sheffield City Council's Internal Audit Function 'conforms' with the requirements of the Public Sector Internal Audit Standards in line with the Local Government Application Note.
2	The function is seen as independent and objective; trusted; highly regarded by stakeholders; making a positive contribution to the systems of governance, risk management and internal control.

Summary of findings

1.1 Sheffield's Internal Audit Service provides a range of assurance, investigation, and Business Partner advisory services to the Council. The 2021/22 audit plan contains 1739 days of planned activity.

1.2 The Public Sector Internal Audit Standards (PSIAS) apply to Internal Audit in all parts of the public sector in the UK and are mandatory. The Standards introduced a requirement for an external assessment of an organisation's internal audit function, which must be conducted at least once every five years by a qualified, independent reviewer from outside of the organisation.

1.3 Sheffield's first external assessment against the PSIAS took place in March 2017. In line with the agreed terms of reference a further independent 'peer-review' has been completed by Birmingham City Council to validate current compliance.

1.4 The self-assessment against the standards was completed by the Senior Finance Manager (Internal Audit) using the 'Checklist for Assessing Conformance with the PSIAS and Local Government Application Note' published by the Chartered Institute of Public Finance and Accountancy (CIPFA).

1.5 Our review of this self-assessment and evidence provided confirmed that Sheffield's Internal Audit Service 'conforms' with the standards. Interviews with key stakeholders, together with the survey responses, indicate that Sheffield's Internal Audit Service is valued; and makes a positive contribution to the systems of governance, risk management and internal control.

2. Background and Scope

2.1 In April 2013, a new set of PSIAS became effective. PSIAS encompass the mandatory elements of the Institute of Internal Auditors (IIA) International Professional Practices Framework (IPPF). The standards apply to Internal Audit in all parts of the public sector in the UK and are mandatory. They seek to secure 'a professional, independent and objective internal audit' that makes an effective contribution to governance arrangements. Guidance on the interpretation of the Standards is set out by the Chartered Institute of Public Finance and Accountancy (CIPFA) in its Local Government Application Note (LAGN) 2019.

2.2 The PSIAS sets out the Mission and definition of Internal Auditing; the core principles for professional practice; together with a Code of Ethics. These seek to capture the characteristics of effective internal audit functions. Whilst specific attribute and performance standards provide guidance on how internal auditing should be carried out and the function managed. The Standards also introduced a requirement for an external assessment of an organisation's internal audit function, which must be conducted at least once every five years by a qualified, independent reviewer from outside of the organisation.

2.3 The Core Cities Chief Internal Auditors group has established a 'peer-review' process. This process addresses the requirement of external assessment by 'self-assessment with independent external validation'. The self-assessment of Sheffield City Council's Internal Audit function against the requirements of the Standards and Application Note was completed by the Senior Finance Manager (Internal Audit), using the checklist contained within the LAGN.

2.4 In line with the agreed Terms of Reference, Appendix One, the external review was undertaken by the Assistant Director of Audit and Risk Management, and Principal Group Auditor, from Birmingham City Council. Both are senior members of staff; qualified members of CIPFA; hold appropriate experience of internal audit within the public sector; and have an in-depth knowledge of the Definition, Code of Ethics, and the International Standards for Internal Audit. No conflict of interests, that would limit the independence of the review, have been identified.

2.5 The self- assessment checklist was independently validated by reviewing a sample of supporting documentation; interviewing key stakeholders, Appendix Two; viewing recordings of Audit and Standards Committee meetings; and examining the result of the recent Internal Audit director survey in order to capture an organisational perspective on the delivery and value of internal audit services.

2.6 Due to COVID restrictions, the review was undertaken remotely.

3. Findings

3.1 An effective internal audit service should:

- understand the whole organisation, its needs and objective;
- understand its position with respect to the organisation's other sources of assurance and plan its work accordingly;
- be seen as a catalyst for improvement at the heart of the organisation;
- add value and assist the organisation in achieving its objectives; and
- be forward-looking, knowing where the organisation wishes to be and aware of the national agenda and its impact.

3.2 Compliance with the PSIAS and LGAN provides the foundations for an effective internal audit service.

3.3 It is clear from the review and stakeholder / survey feedback that Sheffield's Internal Audit Service aspires to accomplish the mission of Internal Audit set out by the International Professional Practices Framework (IPPF) and adopted by PSIAS. The role of Internal Audit is understood across the senior management team and the assurance and advice provided is trusted.

3.4 A proportion of the audit plan is set aside to support business partnering activities. This has enabled Internal Audit to provide insight and value over and above its assurance and fraud related service by offering pro-active advice and guidance and assisting services with change projects, system and process reviews, and value for money exercises.

3.5 PSIAS consists of nineteen attribute standards, that address the organisational characteristics of internal audit services and thirty-three performance standards, that describe the nature of internal audit services and the criteria against which performance should be measured. From the 115 questions contained within the self-assessment checklist completed by the Senior Finance Manager (Internal Audit); 89 were assessed as 'conforms', 14 as 'partial conforms', and 12 as 'not applicable'. Based on our review of the self-assessment checklist; the documentation evidence; explanations provided; and interviews with key staeholders, we consider that overall the service 'conforms' with the standards setout. Whilst the self-assessment did identify a number of 'partial conforms' these were considered to have arisen due to the need to align audit practices with the organisation or not sufficiently significant to prevent achievement of the overriding standard.

3.6 The Senior Finance Manager (Internal Audit) is the designated Chief Audit Executive under the standards reporting through to the Head of Strategic Finance (deputy Section 151 officer). The Senior Finance Manager (Internal Audit) does not report on an administration basis at an organisation level equal or higher to the corporate management team as required under standard 1110 Organisational Independence. However, the Senior Finance Manager (Internal Audit) has unfettered access to, and is able to report in her own name, to the Chief Executive, Executive Director of Resources, and Audit and Standards Committee. We therefore consider the objective of the standard, i.e. sufficient status and independence, to be satisfied.

3.7 Quality review processes are well established and embedded into opeartional procedures. An established risk-based planning process is in place. This planning process will be linked to corporate plans as they are developed.

3.9 The stakeholder interviews / results of the recent director survey conducted by Internal Audit confirmed that:

- the advice and guidance provided is trusted and valued;
- strong and effective professional relationships have been established;
- the function is seen as independent and objective;
- Internal Audit respond to change and emerging risks;
- recommendations are discussed, are practical and support improvement;
- senior managers are consulted and able to feed into the annual audit plan; and
- internal Audit have a positive impact on the systems of governance, risk and internal control.

3.10 We have identified a number of minor recommendations for consideration that seek to further strengthen the positive position of Internal Audit and help it to continue to drive forward, these include:

- reviewing the Audit Charter and considering incorporating within it the Mission for Internal Audit;
- reviewing the definition of consultancy services;
- reviewing and updating the declaration of endorsements;
- developing a training strategy;
- consolidating and reporting the results from the Quality Assurance and Improvement Programme (QAIP) to the Board;
- reviewing and finalising the External Audit joint working protocol;
- developing a governance and ethics audit universe; and
- reviewing Terms of Reference (TOR) template and considering the inclusion of auditor's responsibilities in relation to fraud and value for money;

3.11 We would like to thank all colleagues from Sheffield City Council involved in the review for their co-operation and assistance.

4. Recommendations

01. PSIAS 1000 Purpose, Authority and Responsibility

PSIAS Requirement
The Chief Audit Executive (CAE) to produce and periodically review the internal audit charter and present it to senior management and the board for approval**.**

Matters Arising
Sheffield's Internal Audit Services Audit Charter is dated March 2019 and covers the key criteria laid out within the Standards.

Action Plan	
Recommendation 01: Review the Audit Charter and present it to the Audit and Standards Committee for approval. Consider including the Mission of Internal Audit, as defined by the Standards, within the Charter.	**Management Response:** **Agreed – to review the Audit Charter and include the Mission of Internal Audit. The Audit Charter will then be appended to the 21/22 Annual Audit Opinion Report and presented to the September 2022 Audit and Standards Committee.** **Officer Responsible: Senior Finance Manager (Internal Audit)** **Agreed Implementation date: Sept 22**

4. Recommendations

02. PSIAS 1000 Purpose, Authority and Responsibility

PSIAS Requirement
The Internal Audit Charter sets out the scope and nature of internal audit activity.

Matters Arising
The Audit Charter implies that consultancy activity is provided through earmarked resources for business partnering activity.

Action Plan	
Recommendation 02: Review and agree a definition of consultancy services, update the Audit Charter and PSIAS self-assessment checklist in line with the agreed definition.	**Management Response:** **Agreed – Business Partnering activity is and will be defined as consultancy services (as per the Audit Charter) and the PSIAS self-assessment checklist will be amended to reflect this.** **Officer Responsible: Senior Finance Manager (Internal Audit)** **Agreed Implementation date: 31.12.21**

4. Recommendations

03. PSIAS 1110 Organisational Independence

PSIAS Requirement
The CAE reports to an organisational level equal or higher to the corporate management team.

Matters Arising
The CAE does not report on an organisational level equal or higher to the corporate management team. However, the CAE has unfettered access to the Chief Executive, Executive Director of Resources, and Audit and Standards Committee and reports in her own name. A Declaration of Endorsement is in place to confirm that key stakeholders are satisfied that adequate arrangements are in place to protect the independence of the CAE.

Action Plan	
Recommendation 03: Review and update the Declaration of Endorsement. Once reviewed the Declaration should be signed by the new Chief Executive and re-signed by the Executive Director of Resources.	**Management Response:** **Agreed – to review and update the Declaration of Endorsement and then get the Chief Executive and Executive Director of Resources certification.** **Officer Responsible: Senior Finance Manager (Internal Audit)** **Agreed Implementation date: 31.12.21**

4. Recommendations

04. PSIAS 1200 Proficiency and Due Professional Care

PSIAS Requirement
The CAE to define the skills and competencies for each level of auditor and periodically assess individual auditors against these.

Matters Arising
Whilst formal job descriptions and person specifications are in place that define key competency areas for each grade, an overall training strategy, that identifies future skill requirements, has not been developed.

Action Plan	
Recommendation 04: Consider developing a training strategy that sets out the current and future skills; together with delivery options; required to fulfil the Mission of Internal Audit and support the Council in delivering its strategic objectives and priorities.	**Management Response:** **Agreed – this is a positive approach to map out and identify current and future skills along with staff competencies. A Training Strategy will be developed.** **Officer Responsible: Senior Finance Manager (Internal Audit)** **Agreed Implementation date: 31.3.22**

4. Recommendations

05. PSIAS 1320 Quality Assurance and Improvement Programme

PSIAS Requirement
The CAE communicates the results of the Quality Assurance Improvement Programme (QAIP) to senior management and the Board.

Matters Arising
A QAIP is established and embedded into operational processes. The structure of the programme, together with achievements against performance targets, is reported to the Board. A summary of the overall results from the QAIP, or quality improvement initiatives, are not reported.

Action Plan	
Recommendation 05: Consolidate and report the wider results from the QAIP to the Board together with any improvement actions plans.	**Management Response:** **Agreed – the results from the QAIP will be reported in the 21/22 Annual Audit Opinion Report and presented to the September 2022 Audit and Standards Committee.** **Officer Responsible: Senior Finance Manager (Internal Audit)** **Agreed Implementation date: Sept 22**

4. Recommendations

06. PSIAS 2050 Coordination

PSIAS Requirement
The CAE to make arrangements to share information and coordinate activities with other internal and external providers of assurance.

Matters Arising
A protocol, dated 2015, for liaison between the Council's Internal and External Auditors is in place

Action Plan	
Recommendation 06: Review, update, and finalise the joint working protocol for liaison between Internal and External Audit.	**Management Response:** **Agreed – this protocol is out of date and will be reviewed and updated.** **Officer Responsible: Senior Finance Manager (Internal Audit)** **Agreed Implementation date: 31.3.22**

4. Recommendations

07. PSIAS 2110 Governance

PSIAS Requirement
Internal audit should evaluate the design, implementation and effectiveness of the organisation's ethics related objectives, programmes and activities.

Matters Arising
Elements of ethics have been subject to review.

Action Plan	
Recommendation 07: Consideration be given to the development of an governance and ethics audit universe. Available sources of assurance could be mapped to this universe to inform the Internal Audit planning process.	**Management Response:** **Agreed – we need to further consider how Internal Audit can assess appropriate ethics and values within the organisation. Elements of ethics have been subject to audit review in the past few years (for example, review of the officer and members constitution and code of conduct ensuring they meet the Nolan principles, audit review of the declaration of interests, gifts and hospitality and health and safety reviews) and it is accepted the audit universe for this area should be reviewed and updated as part of the 22/23 audit planning process. We will also consult with Core Cities about ethics audits.** **Officer Responsible: Senior Finance Manager (Internal Audit)** **Agreed Implementation date: 31.3.22**

4. Recommendations

08. PSIAS 2200 Engagement Planning

PSIAS Requirement
Internal auditors to have regard to resource requirements, fraud and value for money concerns when planning engagements.

Matters Arising
Guidance on producing Terms of Reference (TOR) and standard templates are in place; these seek to ensure that a standard approach is adopted, and key areas are addressed.

Action Plan	
Recommendation 08: Consider reviewing the standard TOR template to include internal auditors' responsibilities in relation to fraud and value for money.	**Management Response:** **Agreed – a standard paragraph will be included in the TOR template.** **Officer Responsible: Senior Finance Manager (Internal Audit)** **Agreed Implementation date: 31.12.21**

Appendix One

Core Cities Peer Review Terms of Reference

Core Cities Chief Internal Auditor Group

External Assessment – Peer Review

Terms of Reference

Background Information

External Assessments:

The Public Sector Internal Audit Standard (PSIAS) introduced a requirement for an external assessment to be conducted at least once every five years by a qualified, independent reviewer from outside of the organisation as part of an ongoing quality assurance and improvement programme.

There are two possible approaches to external assessments outlined in the standard: a full external assessment; or an internal self-assessment which is validated by an external reviewer.

External reviewers should:

- possess a recognised professional qualification;
- have appropriate experience of internal audit within the public sector / local government;
- have detailed knowledge of leading practices in internal audit; and
- have current, in-depth knowledge of the Definition, the Code of Ethics and the International Standards.

The Head of Internal Audit should discuss the proposed form of the external assessment with their line manager (where relevant) or Section 151 Officer (or equivalent) or Chief Executive prior to making recommendations to the Audit Committee regarding the nature of the assessment. The scope of the external assessment should have an appropriate sponsor, such as the Chair of the Audit Committee or Section 151 Officer.

The Head of Internal Audit should report the results of their quality assurance improvement programme (ongoing activity, internal and external assessments) to stakeholders. Such stakeholders should monitor the implementation of actions arising from internal and external assessments.

Purpose of the Review

The purpose of the external assessment is to help improve delivery of the audit service and establish whether governance requirements relating to the provision of service are embedded. The assessment should be a supportive process that identifies opportunities for development and enhances the value of the audit service to the authority.

Proposed Approach

Members of the Core Cities group have elected to adopt the internal self-assessment approach validated by an external peer reviewer. The key benefit to this approach is cost. The Chartered Institute of Public Finance (CIPFA) offer a service to provide external assessments and can undertake a full quality assessment at an approximate cost of £30K. The Chartered Institute of Internal Auditors (CIIA) also offer a similar service at an approximate cost of £14k. They also provide a validated assessment, similar to the approach agreed by the core cities group, which takes around 5 working days and costs approximately £12.5k (costs based on quotes obtained for PSIAS reviews at Birmingham City Council).

There are clear financial savings to members of the Core Cities group by adopting a peer review approach. In addition, the approach is in keeping with the promotion of collaborative working arrangements.

Each authority will determine an appropriate member of their team to conduct the external assessment, taking into account qualifications and relevant experience.

Upon conclusion of the external assessment, the reviewer will offer a 'true and fair' judgement and it is proposed that each authority will be appraised as **Conforms**, **Partially Conforms** or **Does Not Conform** to the PSIAS.

Independence and Objectivity

Prior to the assessments taking place all parties will agree the programme of peer reviews and an appropriate timetable, including the number of days required to undertake the reviews. It is important to ensure the independence of the auditor undertaking the peer assessment. Any known or perceived conflicts of interest should be disclosed. It should be acknowledged at the outset that all Core City Internal Audit services have some knowledge of each other.

The Assessment Process and Indicative Timescales

Completion of the Checklist:

Each Head of Internal Audit must complete the Checklist for Conformance with the PSIAS which is attached to the Local Government Application Note in advance of the external assessment. It is essential that the basis of the assessment is documented.

Pre Assessment Phase (2 days):

- Confirm the terms of reference for the review, timescales and dates for the review – this should include any specific issues that the authority may want to be considered as part of their quality assessment.
- Obtain:
    - relevant background information to gain an understanding of the service. This should include the Internal Audit Charter / Strategy or Terms of Reference (independence, scope authority, purpose and the relationship with the Audit Committee and senior executives);
    - details of responsibilities, resources, structure and activities;
    - details of any external client organisations e.g. Joint Authorities and consider whether such organisations may have different outcomes in terms of compliance with the PSIAS and whether separate assessments may be required;
    - the completed self-assessment and supporting evidence; and
    - evidence of how quality is maintained, and performance measured and reported.
- Issue a questionnaire to key stakeholders at the Council to obtain feedback on the internal audit procedures and process.
- Evaluate all documentation supporting the self-assessment prior to the on-site visit.

Assessment Phase (on-site visit) (1day):

- Raise and resolve any queries arising from the review of the self-assessment.
- Examine a sample of audit engagements to verify compliance to the PSIAS and procedures.
- Interview key staff and stakeholders to confirm audit procedures and process.
- Undertake an exit meeting with the Head of Internal Audit.

Post Assessment Phase (1 day):

The review should conclude with a detailed report providing an evaluation of the team's conformance with the Definition of Internal Auditing, the Code of Ethics, and the Standards. The report should highlight areas of partial conformance / non-conformance and include suggested actions for improvement, as appropriate.

Reporting Phase (1 day):

- Discussion of the draft report with the Head of Internal Audit.
- Issue of draft final report and agreed actions to the Head of Internal Audit to confirm accuracy.
- Issue final report to the Head of Internal Audit and Sponsor.
- Head of Internal Audit / Sponsor to report outcomes to their Audit Committee, together with an action plan and proposed implementation date(s).

It is envisaged that the assessment process should approximately 5 days in total.

Proposed schedule

Manchester review Birmingham
Bristol review Liverpool
Birmingham review Sheffield
Glasgow review Leeds
Leeds review Manchester
Sheffield review Nottingham
Nottingham review Bristol
Birmingham review Glasgow

Appendix Two

Stakeholders Interviewed / Surveyed

Stakeholders Interviewed

- Chief Executive
- Executive Director for Resources
- Chair of Audit Committee

Survey

Reliance placed on results from the director survey which had recently been undertaken by the Senior Finance Manager (Internal Audit)

This page is intentionally left blank

Audit and Standards Committee Report

Report of:	Director of Legal and Governance
Date:	16 December 2021
Subject:	Work Programme
Author of Report:	Sarah Hyde, Democratic Services

Summary:

The report provides details of an outline work programme for the Committee.

Recommendations:

That the Committee:-

(a) considers the Work Programme and identifies any further items for inclusion; and

(b) approves the work programme.

.

Background Papers: None

Category of Report: OPEN

Statutory and Council Policy Checklist

Financial Implications
NO Cleared by:
Legal Implications
NO Cleared by:
Equality of Opportunity Implications
NO Cleared by:
Tackling Health Inequalities Implications
NO
Human rights Implications
NO:
Environmental and Sustainability implications
NO
Economic impact
NO
Community safety implications
NO
Human resources implications
NO
Property implications
NO
Area(s) affected
NONE
Is the item a matter which is reserved for approval by the City Council?
NO
Press release
NO

REPORT OF THE DIRECTOR OF LEGAL AND GOVERNANCE

AUDIT AND STANDARDS COMMITTEE
****DATE****

WORK PROGRAMME

1. **Purpose of Report**

1.1 To consider an outline work programme for the Committee.

2. **Work Programme**

2.1 It is intended that there will be at least five meetings of the Committee during the year with three additional meetings arranged if required. The work programme includes some items which are dealt with at certain times of the year to meet statutory deadlines, such as the Annual Governance Report and Statement of Accounts, and other items requested by the Committee. In addition, it also includes standards related matters, including an annual review of the Members Code of Conduct and Complaints Procedure and an Annual Report on the complaints received.

2.2 An outline programme is attached and Members are asked to identify any further items for inclusion.

3. **Recommendation**

3.1 That the Committee:-

(a) considers the Work Programme and identifies any further items for inclusion; and

(b) approves the work programme.

Gillian Duckworth
Director of Legal and Governance

This page is intentionally left blank

Date	Item	Author
20 January 2022	Statement of Accounts 20/21	Dave Phillips (Head of Strategic Finance)
	Report of those Charged with Governance (ISA 260)	(External Auditor) Ernst & Young
	Annual Audit Letter 2020/21	Ernst and Young (External Auditor
	Annual Housing Ombudsman	Jenny Callaghan (Customer Services Operational Manager)
	Review of Members' Code of Conduct	Gillian Duckworth (Director of Legal and Governance)
	Review of Standards Complaints Procedure	Gillian Duckworth (Director of Legal and Governance)
	Annual Standards Report	Gillian Duckworth (Director of Legal and Governance)
	Work Programme	Gillian Duckworth (Director of Legal and Governance)
24 February 2022	(Additional meeting if required)	
24 March 2022	Compliance with International Auditing Standards	Dave Phillips (Head of Strategic Finance)
	Formal Response to Audit (ISA 260) Recommendations	Dave Phillips (Head of Strategic Finance)
	Certification of Claims and Returns Annual Report 2020/21	External Auditor (EY)
	External Audit Plan 2021/22	External Auditor (EY)
	Annual Audit Fee Letter 2021/22	External Auditor (EY)

	Work Programme	Gillian Duckworth (Director of Legal and Governance)
June 2022	Audit Training	External Facilitator (Gary Bandy)
16 June 2022	Internal Audit Annual Fraud Report	Linda Hunter (Senior Finance Manager)
	Internal Audit Plan 2022/23	Linda Hunter (Senior Finance Manager)
	Progress in High Opinion Reports	Linda Hunter (Senior Finance Manager)
	Strategic Risk Reporting	Helen Molteno (Corporate Risk Manager)
	Work Programme	Gillian Duckworth (Director of Legal and Governance)
	Summary of Statement of Accounts	Dave Phillips (Head of Strategic Finance)
	Work Programme	Gillian Duckworth (Director of Legal and Governance)

IMPORTANT INFORMATION FOR REPORT WRITERS

The Audit and Standards Committee provides an independent and high-level focus on the audit, assurance and reporting arrangements that underpin good governance and financial standards.

The purpose of the Committee is to provide independent assurance to the Council of the adequacy of the risk management framework and the internal control environment. It provides independent review of Sheffield City Council's governance, risk management and control frameworks and oversees the financial reporting and annual governance processes. It oversees internal audit and external audit, helping to ensure efficient and effective assurance arrangements are in place.

The Committee also cover Standards and is primarily responsible for promoting and maintaining high standards of conduct by councillors, independent members,

and co-opted members. It is responsible for advising and arranging relevant training for members relating to the requirements of the code of

conduct for councillors. The Committee also monitor the Council's complaints process and the Council's response to complaints to the Ombudsman.

The Committee is not an operational committee, so is not focussed on the day to day running of your service. However, its focus is on risk management and governance, so it will want to understand how you manage your key risks, and how you are responding to new challenges and developments. In particular the Committee will be interested in the progress on implementing agreed recommendations from inspection and audit reports, and will want to review your services' outputs and actions in response. You can expect some challenge if deadlines for implementing agreed actions have been missed. Please ensure breakdowns of information are included in your report, as the Committee is interested in the key facts and figures behind areas.

Most Audit and Standards papers are public documents, so use everyday language, and use plain English, don't use acronyms, or jargon and explain any technical terms. Assume the reader knows little about your subject.

Think about how the paper will be interpreted by those who read it including the media.

Use standard format - don't subvert it.

Ensure – You convey the key message in the first paragraph not the last.

The report should include –

- ***Summary***
- ***Recommendation (s)***
- ***Introduction***
- ***Background***
- ***Main body of the report (in. legal, financial and all other relevant implications)***

(report templates are available from Democratic Services)

This page is intentionally left blank