REPORT TO SHEFFIELD CITY COUNCIL AUDIT AND STANDARDS COMMITTEE
16th June 2022

Internal Audit Tracker Report on Progress with Recommendation Implementation

Purpose of the Report

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

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

Introduction

3. An auditable area receiving one of the above opinions is considered by Internal Audit to be an area where the risk of the activity not achieving objectives is high and sufficient controls were not present at the time of the review. All reports will have been issued in full to members of the Audit and Standards Committee at their time of issue.

4. Where Internal Audit has yet to undertake follow up work, the relevant Portfolio managers were contacted and asked to provide Internal Audit with a response. This work included indicating whether or not the recommendations agreed therein have been implemented to a satisfactory standard. Internal Audit clearly specified that as part of this response, managers were required to provide specific dates for implementation, and that this information was required by the Audit and Standards Committee.

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

FINANCIAL IMPLICATIONS

There are no direct financial implications arising from the report.

EQUAL OPPORTUNITIES IMPLICATIONS

There are no equal opportunities implications arising from the report.

RECOMMENDATIONS

1. That the Audit and Standards Committee notes the content of the report.

2. That the Audit and Standards Committee agrees to the removal of the following report from the tracker:

    - Information Security Incidents

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 December 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:

- Adult Safeguarding

New reports added to this Tracker

For this period, 2 new reports have been added.

Title	Assurance	Impact
Assurance Reviews		
Disposal of IT Assets	Limited Assurance	High Organisational Impact
Creditors Audit Review of Non-Standard Payments	Limited Assurance	High Organisational Impact

Recommendation implementation

In total, updates have been provided on 29 out of 29 recommendations that are due for implementation. Of these, 16 (55%) have been implemented and 13 (45%) are ongoing, indicating work has been started but not yet fully completed.

Items to note

There are two critical recommendations ongoing in this report.

One is contained within the OHMS (Housing Management System) application review and relates to upgrading the system/new housing system. The process is at the preferred supplier stage and then awarding the contract. The test and build of the new system will start May/June 2022 and the dates for implementation of phase 1 set for Sept 2023. This process forms part of

the Place Systems Review. 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 – Ajman Ali will be attending the June 2022 Audit and Standards meeting to provide an update on this project.

The other ongoing critical recommendations is contained within the Adult Safeguarding report. It relates to working with Mental Health to identify ways the referral timeframe can be bought in line with other adults, and to mitigate any risks with the use of fast track or similar approaches. Executive Recommendation Lead – John Macilwraith.

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 17th May 2022.

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 Performance and Delivery Board discussed the outstanding critical recommendation relating to OHMS and fully support the Executive Lead attending the June 2022 Audit and Standards Committee meeting to discuss this outstanding recommendation.

The Performance and Delivery Board discussed the Direct Payments outstanding ‘red’ recommendations and agreed that the recommendation lead should attend a future meeting to provide and update on the progress with these recommendations. It was further agreed that the Performance and Delivery Board will encourage and provide opportunity for recommendation leads to attend the Performance and Delivery Board to discuss outstanding ‘red’ rated recommendations and proposed timelines. This will be opportunity to provide support and also gain a clear understanding of the outstanding recommendation and challenge where necessary.

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 JUNE 2022

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**
Adult Safeguarding	5	6	6	1	4	3	3	1	1	3	3			
Information Security Incidents		2	1			2	1							
Software Licensing		1								1				
Hardware Asset Management		1								1				
OHMS Application Review	1								1					
Direct Payments		3	2			1	1			2	1			
Total	**6**	**13**	**9**	**1**	**4**	**6**	**5**	**1**	**2**	**7**	**4**			

Shaded items to be removed from the tracker

1. Disposal of IT assets (Resources) (issued to Audit and Standards Committee 3.2.22)

As at June 2022
Internal Audit: This report was issued to management on the 17.12.21. This report will be followed up and included in the next tracker.

2. Creditors Audit Review of Non-Standards Payments (Resources) (issued to Audit and Standards Committee 10.2.22)

As at June 2022
Internal Audit: This report was issued to management on the 27.1.22 with the latest agreed implementation date of 30.9.22. This report will be followed up and included in the next tracker.

3. Safeguarding (People) (issued to Audit and Standards Committee 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.
As at June 2022
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 Service Quality and Safeguarding 4.5.22
1.1	The Performance and Audit Group that has recently been re-established should review the performance reporting to ensure there are clear targets, monitoring of trends, identification of action and monitoring of the effectiveness of action(s).	**Medium**	Simon Richards	1.4.22 **Revised implementation date: 31.9.22**	**Action ongoing** Sheffield Adult Partnership Board agreed to review performance measures and better define what good looks like. Performance and Audit Board will progress in Q2.

1.2	The Commissioning team are currently working with the Trust to clarify responsibilities and agree an assurance framework. It is recommended that the Head of Adult Safeguarding liaise with the Commissioning team to ensure the requirements of the Adult Safeguarding Partnership Board (ASPB) to effectively monitor Safeguarding performance is adequately reflected in that discussion, and regular reporting arrangements are put in place, and agreed by the ASPB.	**High**	Simon Richards	1.4.22 **Revised implementation date: 31.9.22**	**Action ongoing** Sheffield Health and Social Care providing data on a quarterly basis. Cessation of this was attributable to Covid pressures. Approach to focus on core data on a regular basis which will add value. Sheffield Health and Social Care Trust (SHSCT) performance data included in Performance Report to Sheffield Adult Safeguarding Partnership Exec Board. Work continuing to bring SHSCT reporting into line with SCC reporting. Options agreed as part of Multi Agency Safeguarding Hub (MASH) development.
1.3	That an appropriate representative from SCC Adult Social Care attends the Mental Health (ASCMH) Safeguarding Assurance Committee.	**High**	Sam Martin	31.12.22	**Actioned** Head of Safeguarding and Practice Development attended. Further attendance under review as Adult Social Care Mental Health Safeguarding to be integrated with mainstream Adult Social Care.
1.4	That the Practice Development Team should establish a risk register and a process to regularly review this register.	**High**	Simon Richards	31.12.22	**Actioned** Risk log discussed at Team Meeting and established. Identified risks to date. All risks to be reviewed at subsequent monthly team meetings.
2.1	In liaison with the Business Information and Liquid Logic teams, a review of the Liquid Logic system process should be carried out. Fields to record the relevant data, or other mechanisms, should be identified. Developments should be formally requested and implemented as soon as possible.	**Critical**	Janet Kerr	31.10.21	**Actioned** The performance is now monitored on the performance hub - currently 94.9% of initial responses completed within one day, however performance low of S42(1) - 16.2% New Safeguarding pathway has been created to combine the first two stages, this is to be implemented this month with the goal of aligning performance through best use of staff time. The timescale measures are incorporated into First Contact and Localities performance dashboards

					which go to management team meetings monthly. The overview of this performance then goes monthly to the Adult Social Care Leadership Team (ASCLT) Performance Clinic and also to PLT.
2.2	Relevant data and possible system developments should be reviewed to identify how performance can be improved, and an implementation plan put in place.	**Critical**	Janet Kerr	31.12.21	**Actioned** Links to 2.03. Amended auto reply to explain how to proceed outside of office hours. Business Support only 'screening' initial screen if abuse or neglect evident, ensuring this doesn't now trigger a Safeguarding episode.
2.3	The level of risk presented by referrals not being reviewed outside of working hours should be evaluated. A review of the process should be carried out to identify and implement appropriate mitigations.	**Critical**	Janet Kerr	31.12.21	**Actioned** As outlined above 2.2
2.4	Once recommendation 2.1 has been implemented and 48-hour performance is recorded then appropriate performance reports should be developed. These should be included in the Safeguarding Data Hub, Service Performance measures and regular performance reports to the Adult Safeguarding Partnership Board.	**High**	Simon Richards	1.4.22	**Actioned** Safeguarding performance measures, including those relating to timescales now embedded within ASCLT, Localities and First Contact performance dashboards.
2.5	To work with Mental Health to identify ways this timeframe can be bought in line with other adults, and to mitigate any risks with the use of fast track or similar approaches. To ensure allocations to Mental Health are consistently reported which potentially could help fast track clients previously referred.	**Critical**	Janet Kerr	31.12.21 **Revised implementation date: 31.9.22**	**Action ongoing** The target for all cases is 72 hours or 3 working days from the point of a referral which will screen and decide on the safeguarding/action necessary. Regardless of whether the decision is made by the Local Authority or Mental Health this timescale will be consistent for all referrals. The timescale for transferring referrals to Mental Health will be within a 24-hour period or 1 working day. A record is made on Liquid logic of each referral that is made to Mental Health. A record of the emails (current method to refer) are retained.

					This arrangement will continue until the necessary system and practice changes are made within the wider project and MASH work with Sheffield Health and Social Care Trust.
2.6	That an exception report or regular review is introduced to identify Abuse and Neglect contacts that have not had a safeguarding case opened within a reasonable time. A process for prioritising and resourcing these should be agreed.	**Critical**	Simon Richards	31.12.21	**Actioned** Regular reporting of performance against agreed PIs via Safeguarding Dashboard. Performance reviewed at ASCLT on monthly basis. The First Contact team continues to manage new Safeguarding referrals, the number of referrals remain high, however since the support offered in the summer of this year this is now in a positive position. Response times have improved and Median number of days to complete S42 (1) has gone down. New work-flow design 'Test for Change' combined with positive impact of Agency reviewing team has reduced cases to normal levels. Backlog not anticipated to recur provided demand remains constant. In medium to longer term improvements implemented as part of the MASH options initiative will further strengthen resilience and improve performance. Cleared the initial backlog and there is regular monitoring in the ASCLT dashboard, this is being added to the First Contact dashboard and other service dashboards.
2.7	That the process should be clarified to consider the best approach and be fully documented.	**Medium**	Janet Kerr	31.12.21 **Revised implementation date: 31.9.22**	**Action ongoing** The Hospital First Contact Team process for referrals and handoffs has now been documented. In most cases it will be appropriate for the Hospital Team to hand off the case to another team that already knows or has a relationship

					with the person. There will always be decisions that require professional judgment to assist with these decisions. A protocol or set of principles will be written to support hand over decisions.
2.8	The list of social workers invited to training should be reconciled to Human Resources (HR)/Payroll and updated for new starters and changes on a regular basis. Any exemptions for attendance should be authorised by the relevant Head of Service on an individual or group basis.	**Medium**	Simon Richards and Andrew Drummond	31.10.21	**Actioned** HR have produced a report of all Care Managers, Social Workers and Team Managers. This report is cross checked against training attendance records to provide up to date and accurate log of who has and hasn't attended training
2.9	That the Service establish a routine process to quality assess performance using a risk-based approach as to the volume and specific cases to be reviewed.	**High**	Simon Richards	1.4.22 **Revised implementation date: 31.9.22**	**Action ongoing** Work progressing via wider work ASC Change Programme Governance Workstream Quality Practice and Performance Frameworks. Safeguarding practice and systems support in Localities will support this going forward.
2.10	The message to signpost to other parties where there is a risk to others should be reiterated to staff. Training on this topic should be targeted at the same audience as wider safeguarding training and monitored.	**Medium**	Simon Richards	31.10.21 **Revised implementation date: 31.9.22**	**Action ongoing** Training is available on PiPoT. (Persons in Position of Trust) This will be promoted, and staff will be encouraged to book onto it. A quick tip guide for practitioners on how to manage and record the PiPoT process was available December 2021. For PiPoT concerns that are managed as part of a Section 42 enquiry it will be made clear that referrals to professional bodies must be recorded, on the LAS recording system as part of the enquiry action. PiPoT concerns that are referred and connected to issues that arise in the persons private life (not S42) are scheduled for improvements as part of the MASH project.

3.1	It is recommended that representatives from the voluntary sector and independent providers are sought to be part of Adult Safeguarding Partnership Board. To find suitable representatives by potentially contacting Voluntary Action Sheffield, and the Care Provider Alliance or National Care Association and also seeking advice from Commissioning with regard to provider involvement.	**Medium**	Simon Richards and Tina Gilbert	1.4.22	**Actioned** Representative from Carers Centre has joined the ASPB and endorsed by VAS
3.2	The Terms of Reference should be updated and should review the diversity of the membership to represent all groups impacted by safeguarding risks. Ways to identify hard to reach groups should be considered and liaison with relevant 3rd sector organisations may provide suitable nominations.	**Medium**	Simon Richards and Dawn Shearwood	1.4.22	**Actioned** Workshop held with Customer Forum, the Terms of Reference have been reviewed an updated and are now signed off.
3.3	The introduction of an action tracker is recommended to ensure all actions are followed through. Responses to formal questions raised with other Boards should be documented in writing in subsequent Forum agendas.	**Efficiency/ Effectiveness**	Simon Richards and Dawn Shearwood	31.10.21	**Actioned** Tracking system in place now for actions for the Customer Forum, Tracker system in place for questions to City Wide Best Practice group. These are in place and being used.
3.4	That work is carried out in liaison with Mental Health to provide the same evaluation of outcomes and satisfaction as other adults, and an implementation plan and timetable is put in place.	**High**	Simon Richards	1.4.22 **Revised implementation date: 31.9.22**	**Action ongoing** SHSC providing data on Quarterly basis. Cessation of this was attributable to Covid pressures. Approach to focus on core data on a regular basis which will add value. SHSCT performance data included in Performance Report to SASP Exec Board. on Work continuing to bring SHSCT reporting into line with SCC reporting. Options agreed as part of MASH development.

4. Information Security Incidents (Corporate) (issued to Audit and Standards Committee 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.
As at June 2022
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 6.5.22
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. The report to be retained within the relevant G Drive folder.	**High**	Mark Jones, Senior Information Management Officer	December 2019	**Actioned** Security incidents are reported to the relevant Head of Service/Information Asset Owner. The report included synopsis, mitigations, outcome and 'learning outcomes and actions'. The report is retained within the security incident.

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	**Actioned** High risk incident reports to be shared at IGWG. The IGWG members will review outstanding actions and support the progress of these.
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 - IGWG). 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	**Actioned** ServiceNow provides analysis of data, for example, types of incidents, services impacted etc so that trends can be picked up and specialised training devised, if needed.

5. Direct Payments (People) (issued to Audit and Standards Committee 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.
As at June 2022
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 Mary Gardner 14.4.22
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** The programme plan covers all these requirements with clear milestones and outcomes set. The Policy work stream covers all these actions. A Direct Payment strategy will be drafted for the Health & Social Care Committee by July.
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	**Actioned** The process workstream covers these activities/requirements. Process notes are drafted for all Direct Payment activity. The Direct Payment audit process workstream is underway and reviewing /updating all Direct Payment processes.

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 Direct Payment Audit Team and Children with Disabilities Team 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	**Actioned** There is an on-going programme of work to audit all Direct Payments including money management companies. A new Recognised Provider List Framework for money management companies has been delivered with new standards/requirements. Quality Monitoring visits are complete for all provers on the list. All pay rate annual increases have been undertaken for the 2nd year running and there are no fee issues outstanding. Recovering unused Direct Payment is core business and is a continual process as part of the Direct Payment audit process. Joint ways of working between Direct Payment audits and CDT exist. These are being formalised as part of the audit process review. Regular meetings occur between CYPF and Direct Payment service every 6 weeks and senior colleagues from CDT are members of the Direct Payment Steering Group (the programme board).
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: 31.7.2022**	**Action ongoing** Project work underway.
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. 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.	**Medium**	Becky Towle Assistant Director of Provider Services	30.4.2020 **Revised implementation date: Ongoing as a 3-year transformation plan**	**Action ongoing** The Process and Audit workstreams are reviewing and updating these processes.

6. 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.
As at June 2022
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 6.5.22
2.2	Roles and responsibilities for software licensing management to be clearly defined and documented. This links to the recommendation 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.	**High**	Gary Sweet, ICT Client Service Delivery Officer Mike Weston, Assistant Director - ICT Service Delivery	01.04.2020 **Revised Implementation Timescale** Autumn 2022	**Action ongoing** Formally assigned roles to be reviewed under MER with an estimated completion date in Q3. Although MER dates have been pushed back.

	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.				

7. 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.
As at June 2022
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 6.5.22
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** Autumn 2022	**Action ongoing** Formally assigned roles to be reviewed under MER with an estimated completion date in Q3. Although MER dates have been pushed back.

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.
As at June 2022
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 and Programme Manager 13.4.22
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** We are in the process of deciding who the preferred supplier is and awarding the contract. Therefore, test and build of the new system has been delayed and will start in May/June – the dates for the implementation for phase 1 is Sept 2023. This all forms part of the Place Systems Review. It will however take some time to implement all the functions in the new system. Progress is reported to Our Sheffield Board.

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.