REPORT TO SHEFFIELD CITY COUNCIL AUDIT AND STANDARDS COMMITTEE
19th January 2023

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 no assurance opinion, or a limited assurance with high organisational impact opinion.

Introduction

2. 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.

3. 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.

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.

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

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 (June 2022) 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, 4 new reports have been added.

Title	Assurance	Impact
Assurance Reviews		
Montgomery Residential Home	Limited Assurance	High Organisational Impact
Heritage Park Community School	Limited Assurance	Medium Organisational Impact
Holgate Meadows Community School	Limited Assurance	Medium Organisational Impact
Freedom of Information (FOI)/ Subject Access Requests (SAR)	Limited Assurance	High Organisational Impact

Recommendation implementation

In total, updates have been provided on 30 out of 30 recommendations that are due for implementation. Of these, 17 (57%) have been implemented and 13 (43%) are ongoing, indicating work has been started but not yet fully completed.

Items to note

There are no critical recommendations ongoing in this report.

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 presented to the Performance and Delivery Board on the 29th November 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 and ensure appropriate action is being taken in service areas.

The Performance and Delivery Board discussed the outstanding ‘red’ recommendations and confirmed that the recommendation leads for these areas have already attended a previous Performance and Delivery Board meeting. The meeting provided an opportunity for recommendation leads to explain in detail the outstanding recommendations and proposed timelines for implementation. This process will continue for all ‘red’ recommendations and will be an opportunity to provide support and 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 DECEMBER 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**
Creditors – Non standard payments		10	2	1		6	2			4		1		
Disposal of IT assets	1	4			1	1				3				
Adult Safeguarding	1	3	3		1	1	3			2				
Software Licensing		1								1				
Hardware Asset Management		1								1				
Direct Payments		2	1			1	1			1				
Total	**2**	**21**	**6**	**1**	**2**	**9**	**6**			**12**		**1**		

1. Montgomery Residential Home (People) (issued to Audit and Standards Committee 29.7.22)

As at December 2022
Internal Audit: This report was issued to management on the 13.7.22. This report will be followed up and included in the next tracker.

2. Heritage Park Community School (People) (issued to Audit and Standards Committee 8.9.22)

As at December 2022
Internal Audit: This report was issued to management on the 14.7.22. This report will be followed up and included in the next tracker.

3. Holgate Meadows Community School (People) (issued to Audit and Standards Committee 8.9.22)

As at December 2022
Internal Audit: This report was issued to management on the 14.7.22. This report will be followed up and included in the next tracker.

4. Freedom of Information /Subject Access Requests (Resources) (issued to Audit and Standards Committee 8.12.22)

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

5. 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.
As at December 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 22.11.22
1.1	An asset disposal champion should be nominated (who has a suitable level of authority). A section should be added to the Council's IT Security Policy or a separate policy document	**High**	Mike Weston/Andy Pearson	April 2022 **Revised Implementation**	**Action ongoing** Formally assigned roles to be reviewed under MER with an estimated completion date in Q4. Although MER dates have been pushed back.

	produced that addresses the process of IT asset disposal and personal data deletion. It should clearly state what will happen with devices that are no longer needed - will they be available for re-use or will they be recycled or destroyed? It should detail the whole process and describe how the assets will be removed from the organisation and who will be involved in the process.			**Timescale** Spring 2023	We are now awaiting the outcome of the Executive Management structure to align the Head of IT to subsequently initiate the ICT MERs.
2.1	It is important that a member of staff is assigned the responsibility of managing the asset disposal process and a realistic timescale should be set for this to be achieved. Once staffing is in place, the process to be followed with the key controls required should be mapped out and documented (once a process has been designed by the Service, Internal Audit can support by reviewing the proposed process and suggesting improvements etc). The expectations of the contractor in this process should also be discussed and agreed with the company. A review of the stock holding facilities should also take place to ensure that the storage is secure and all assets are protected until collection takes place. All storage media should be fully traceable through the system.	**High**	Mike Weston/Andy Pearson	April 2022 **Revised Implementation Timescale** Spring 2023	**Action ongoing** Reefer to point 1.1 above
2.2	Management to seek assurance that the processes as they understand them in relation to what happens to the Council's assets when they are collected by the contractor, are in place. A site visit should be undertaken where deemed appropriate.	**High**	Andy Pearson	Ongoing **Revised Implementation Timescale** Spring 2023	**Action ongoing** Process in place and understood. Site visit to be arranged once appropriate resource in post.
3.1	The contract agreement should be drawn up by Procurement as soon as possible and signed by both parties.	**Critical**	Andy Pearson	January 2022	**Actioned** Contract has been drafted and signed.

3.3	A number of weaknesses in the disposal process have already been identified and as desktops pose more risk due to the lack of hard disk encryption, it is important that management can account for all desktops, including those sent for disposal. Where desktops have been sent for disposal, management should verify that there is evidence that these have disposed of appropriately. A formal reconciliation should be undertaken when the discovery system is fully functional to ensure that all equipment not currently in use can be accounted for. All assets disposed of should be removed from the configured management database (CMDB). Consideration should be given to the encryption hard disk drives on the remaining desktops.	**High**	Andy Pearson	Ongoing	**Actioned** Also note Windows 10 desktops that have now been deployed have Bitlocker/ encryption configured.

6. 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.
As at December 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 Stephen Bottomley 18.11.22 and follow up review December 2022
1.1	Financial Regulations should be updated to cover every type of Non-Standard Payment (NSP) within F&CS, and state that they will be processed in accordance with the NSP Policy.	**High**	Peter Carr	May – Sept 2022	**Actioned** This recommendation and additional advice were included in the update and refresh of the Financial Regulation that went to the AGM 18th May. Also incorporated elements from the Non-Standard P2P Policy too.
1.2	Financial Regulations should be amended to place the overall responsibility for approval of all Non-Standard Payment Types in one place to ensure a complete oversight, consistent approach, and common controls.	**High**	Peter Carr	May – Sept 2022	**Actioned** Refer to 1.1 above
1.3	A F&CS Policy or Framework should be developed and implemented covering the governance, standards, and controls for all Non-Standard Payments. This should be regularly reviewed.	**High**	Jane Wilby Chair of Financial Design Assurance (FDA) Group	March 2022 **Revised implementation date: February 2023**	**Action ongoing** Policy drafted and discussed at FDA Standards and Policy Group 13/12/22. This will be operationalised by uploading to Finance Sharepoint by January 2023 and updating the 2023/24 Financial Regulations in the February 2023 update.
1.4	The NSP Policy recommended in 1.3 should clarify the key responsibilities and outline any delegations or limitations.	**Medium**	Jane Wilby Chair of Financial Design Assurance Group	March 2022	**Actioned** Included in the Policy mentioned at 1.3 above.
2.1	Each Non-Standard Payment Type should have a current Approval Form completed and agreed to bring records up to date. These should be regularly reviewed and be a requirement of the NSP Policy.	**High**	Jane Wilby Chair of Financial Design Assurance Group	September 22 Prioritising recurring larger value payment types	**Action ongoing** Approval form included in Policy mentioned at 1.3 above. Renewal of approval forms for existing NSPs outstanding.

				Revised implementation date: March 2023	
2.3	A summary of Non-Standard Payment Types should be created and links to recommendation 2.1 The requirement for regular management information with values, trends etc should be considered in preparation of the NSP Policy considering the benefits it could bring against the time and complexity in maintaining the data.	**Medium**	Jane Wilby Chair of Financial Design Assurance Group	March 2022	**Actioned** This is included in the Policy. An annual review of transactions will be timetabled at FDA each March.
2.5	The individual Non-Standard Payment Type Approval Form recommended in 2.1 should have a section asking about the number and value of commercial invoices to be processed and any mitigations in place to monitor performance in a different way. This information should be assessed and either Payment Types rejected, or separate monitoring made a condition of the arrangement.	**High**	Siam Holmes/Richard Hallam	September 2022 **Revised implementation date: March 2023**	**Action ongoing** Referral of the review of Controcc payment process to FDA to ensure a governed task and finish group to include all areas of finance are involved in reviewing this process. Separate monitoring arrangements are needed as it is difficult to legislate for. Systems and Training Team have new monitoring process for One Time Payment, MPA (multiple payment) and interface payments. Creditors provide NSP listing each month. Need to add to Standards and Policy future agenda to review payments but the Policy proposes that this is an annual process.
2.6	The individual Non-Standard Payment Type Approval Form recommended in 2.1, and the One Time Payment (OTP) pre-approval form should have a section asking whether any payments are subject to the Transparency Code guidance. If so, the Payment Type should be rejected, or other mitigation identified.	**High**	Jane Wilby Chair of Financial Design Assurance Group	September 2022	**Actioned** The pre-approval form agreed at FDA Standards & Policy Group has a separate field to request information on this.

2.7	Given the value and payments of public interest involved, Internal Audit recommend that all Transparency reports from April 2020 to date are reviewed and amendments published where necessary. This should include any relevant Treasury payments.	**High**	Sian Holmes	June 2022 **Revised implementation date: March 2023**	**Action ongoing** All relevant Treasury payments, inclusive of Covid grants, dating back to April 2020, published in September 2022. Finance and Procurement and Supply Chain collaborated to implement necessary amendment within Integra to ensure all relevant payments are included within the report from this point forward. Treasury payments for April – September 2022 have been uploaded and there are plans to add 2021-22 data.
2.8	Internal Audit recommend that an amended or revised Qtier report is considered for development that would remove or significantly reduce the manual process and risk of errors.	**Efficiency/ Effectiveness**	Sian Holmes/ Stephen Bottomley	June 2022 **Revised implementation date: March 2023**	**Action ongoing** Full review of our statutory requirements under the transparency is underway and this requirement will be picked up by Chris Boyle as part of that review. Some changes to Qtier transparency report have been made to make it easier to identify counterparty for NSPs via OTP.
3.2	The Non-Standard Payment Framework should outline a consistent approach to approval levels and values including escalation of unusual/high transactions. Internal Audit recognise this will need to consider the subsidiary approvals that take place within other systems.	**High**	Jane Wilby Chair Finance Design Assurance Group	March 2022	**Actioned** Refer to 1.3 above - this is included in the Policy.
3.4	The key stakeholders using this payment method (payroll, Fleetmaster and VAT only) should be contacted to nominate separate requistioners and approvers and any necessary changes made to the system and processes.	**High**	Sean Torpey	March 2022	**Actioned** Payroll have confirmed that they have a separation of duty and that the persons approving any payment are not the ones sending the request to my team.

					VAT only invoices would come direct from suppliers. The Fleetmaster team have confirmed that a supervisor raises and completes the order in Fleetmaster and a member of Business Support forwards the invoices to our automated processing centre for loading to Integra. 4 people are set up on Integra to approve these invoices.
3.6	Stakeholders should be advised that control totals of both value and number of transactions should be provided. Any requests without these, or where the approver has not agreed those values should be returned for confirmation.	**High**	Stephen Bottomley	March 2022	**Actioned** NSP providers reminded of need to provide control totals (value & volume) when submitting files to process.

7. 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.
As at December 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 management on 11.11.22
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**	Janet Kerr and Tim Gollins	1.4.22	**Actioned** A meeting was held with all partners on 7.11.22 and a set of 9 quantitative and qualitative measures were agreed upon that would refine the current performance dashboard. The short-

					listed 9 measures have targets and trends identified. Some of these 9 priority measures will require some changes to data collection and technical data gathering, but with that caveat collectable for Q4. Performance and Quality group, meets quarterly where the performance measures in place are analysed. Discussions in this group do include decisions about the data we are currently collecting and whether or not it is useful to determine what good looks like. This is not a one-off piece of work but is constantly reviewed.
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**	Janet Kerr and Tim Gollins	1.4.22 **Revised implementation date: 31.3.23**	**Action ongoing** The Multi-agency Safeguarding Hub (MASH) is being developed, for Q4 2022. A final model has been identified, and partners will now be consulted on resources needed. As part of this process new performance measures have been identified (see above 1.1). Organisational abuse monitoring will be conducted alongside the new systems and processes in the MASH.
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 and Tim Gollins	31.12.21	**Actioned** This has been actioned in that all alerts we are made aware of are recorded on LAS. While the delegated powers still remain there will be some alerts that are screened out we are not aware of, but the development of the MASH is taking this into account.

2.7	That the process should be clarified to consider the best approach and be fully documented.	**Medium**	Janet Kerr and Tim Gollins	31.12.21	**Actioned** There is a written protocol in place.
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**	Janet Kerr and Tim Gollins	1.4.22	**Actioned** Quality Practice and Performance Frameworks. Including file audits have been developed.
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**	Janet Kerr and Tim Gollins	31.10.21	**Actioned** Guidance has been produced and the training is in place. We reiterate on training about the recording of referrals to professional bodies. PiPoT (Persons in Position of Trust) will move to MASH eventually but regardless our duties are still being carried out.
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**	Janet Kerr and Tim Gollins	1.4.22 **Revised implementation date: 31.3.23**	**Action ongoing** Refer to 1.1 and 1.2 above.

8. 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.
As at December 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 22.11.22
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	**Actioned** Service/Operational and Business Continuity Plans are completed.
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: 31.12.22**	**Action ongoing** The whole of transitions from children to adults and for children with additional needs now has a clear action plan with regular weekly meetings. The re-designed PAT team is now working with the new adults transitions team. We are meeting on the 8th Dec to complete the performance indicators to ensure that ALL assessments are completed in a timely way, visits are undertaken and all support plans including the financial assessments are completed in a timely way.

7.2	Management should ensure that monitoring of the CCG direct payment packages is completed within Children with Disabilities Team (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	**Actioned** Audits for CDT have been underway for the last 2 months, this includes CCG health budgets. The project brief for the review of how audits are undertaken has been approved by the Steering Group, again including CCG health budgets.

9. 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.
As at December 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 22.11.22
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. 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** Spring 2023	**Action ongoing** Formally assigned roles to be reviewed under MER with an estimated completion date in Q4. Although MER dates have been pushed back. We are now awaiting the outcome of the Executive Management structure to align the Head of IT to subsequently initiate the ICT MERs.

10. 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.
As at December 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 22.11.22
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** Spring 2023	**Action ongoing** Formally assigned roles to be reviewed under MER with an estimated completion date in Q4. Although MER dates have been pushed back. We are now awaiting the outcome of the Executive Management structure to align the Head of IT to subsequently initiate the ICT MERs.

RATING KEY

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

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