REPORT TO SHEFFIELD CITY COUNCIL AUDIT COMMITTEE
9th July 2013

Internal Audit Report on Progress Against High Opinion Audit Reports.

Purpose of the Report

1. The purpose of this 'rolling' report is to present and communicate to members of the Audit Committee progress made against recommendations in audit reports that have been given a high opinion.

Introduction

2. An auditable area receiving a 'High Opinion' is considered by Internal Audit to be an area where the risk of the activity not achieving objectives is high and sufficient controls were not present at the time of the review.

3. This report provides an update to the Audit Committee on high opinion audit reports previously reported. Where Internal Audit has yet to undertake follow up work, the relevant Portfolio Directors were contacted and asked to provide Internal Audit with a response. This included indicating whether or not the recommendations agreed therein have been implemented to a satisfactory standard. Internal Audit clearly specified that as part of this response, Directors were to provide specific dates for implementation and that this was required by the Audit Committee.

   This report also details those high opinion audits that Internal Audit plan to remove from future update reports. The Audit Committee is asked to support this.

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 Committee notes the content of the report and approves the removal of reports as indicated.

Laura Pattman
Assistant Director of Finance, Business Partner and Internal Audit

SHEFFIELD CITY COUNCIL
UPDATED POSITION ON HIGH OPINION AUDIT REPORTS AS AT JULY 2013

1. Self Directed Support (Communities). (Issued to the Audit Committee 23 April 2013).

As at May 2013
Internal Audit: This report was issued to management on the 5th April 2013. Therefore an update will be provided in the next high opinion update report.

2. Marketing Sheffield (Place). (Issued to the Audit Committee November 2012).
From the 25 recommendations originally raised, Internal Audit identified 31 distinct, agreed actions for implementation. Internal Audit has undertaken a number of pieces of follow-up work at the request of the Audit Committee. The latest position with regard to the implementation of recommendations is:

- 17 actions had been implemented;
- 5 actions were not implemented, or evidenced;
- 9 actions had not been implemented, but were on-going pending further development.

Update on the 5 outstanding recommendations, as at May 2013:

ref	Recommendation Outstanding	Priority	Original Responsible Officer	Original Implementation Date	Update as at April 2013 following Internal Audit testing
2.1	Management should conduct an investigation as to why Marketing Sheffield incurred net charges of £50,000 on the "contract" for the organisation and staging of the MADE Festival, set at £30,000. The contractor should be required to clarify the nature of the support service costs levied against the sponsorship agreements.	High	Executive Director, Place	31.01.13 Later revised to 31.03.13	Information made available to Internal Audit set out actual income & expenditure incurred by both parties in the staging of the 2012 MADE Festival. Internal Audit was not provided with any report or further information setting out the results of any management investigation or of the contractor's responses. **Internal Audit Opinion** The recommendation was not implemented. Updated Position – June 2013 The Director of Marketing Sheffield presented a report to Internal Audit explaining why the overspend had occurred. **Action Complete**

2.2	The Executive Director of Place should enquire with the main sponsor as to whether the bank was aware of the "support service" charges levied by Seven Hills.	High	Executive Director, Place	31.01.13 Later revised to 31.03.13	The Executive Director subsequently stated that he had spoken to Coutts and that the company was aware of the financial arrangements. <u>Internal Audit Opinion</u> No evidence was provided to support the comments however Internal Audit have accepted the assurances provided by the Executive Director and acknowledge that retrospective evidence will not be obtained. Internal Audit has stressed the importance of clearly documenting sponsorship arrangements for future events in the relevant Business Case. **Action Complete**
2.3	Income and expenditure should be charged to the correct ledger codes.	High	Director of Marketing Sheffield	31.01.13 Now revised to 31.05.13	Internal Audit identified that expenditure continued to be miscoded to ledger and sub-ledger codes by officers within Marketing Sheffield. The Financial Business Partner confirmed Audit findings. <u>Internal Audit Opinion</u> The recommendation was not implemented. The Director provided a revised deadline of 31 May 2013. Update from Executive Director at June 2013. **Action Complete**
2.4	The Service should maintain a detailed and up to date Register of Interests. Staff should be required to declare all relevant interests, relationships and associations.	High	Director of Marketing Sheffield.	30.09.12 Now revised to 31.05.13	Only one Register of Interest was provided. There was no demonstration of 'nil return' declarations from the staff. Gifts and Hospitality were not a standing agenda item on SMT meetings (This appeared only once on the eight monthly minutes reviewed). <u>Internal Audit Opinion</u> The recommendation was not fully

					implemented. Update from Executive Director at June 2013. **Action Complete**
2.5	Orders must be raised in OEO in advance of the request to the supplier. Verbal orders must not be used	High	Director of Marketing Sheffield.	30.09.12 Now revised to 31.05.13	Analysis of OEO confirmed that the raising of verbal orders was still on-going. <u>Internal Audit Opinion</u> The recommendation had not been implemented. Update from Executive Director at June 2013. **Action Complete**

3. Cash Handling Appointeeships in Residential Homes (Communities). (Issued to the Audit Committee February 2012).

Position reported to the Audit Committee in the Jan 2013 update report
Internal Audit: Follow up work was undertaken in September 2012. The follow up work concluded that from the original 12 recommendations, six had been completed and work was either planned or partially completed with a target date of March 2013 for all the remaining actions. Internal Audit has provided management with more detailed feedback to strengthen the Appointeeships Procedural Guidelines in place.

Update on the 6 outstanding recommendations as at May 2013:

ref	Recommendation Outstanding	Priority	Original Responsible Officer	Original Implementation Date	Update provided by Head of Care and Support. May 2013.
3.1	With regards to money held on behalf of people who have died where SCC is not the appointee: • legal advice should be sought on whether it is appropriate for the service to keep hold of this money; • a formal policy or similar should be defined regarding the treatment of monies held under similar circumstances.	High	Head of Care and Support.	31.03.12 Later revised to 31.03.13	Objectives of Service - Appointeeship service definition and procedural guidelines now in place – as per Audit requirement. A quarterly audit is now performed by a team member not directly involved with appointeeships. Monies for appointees are no longer being accepted. **Action Complete**

3.2	A formal policy should be defined that clearly outlines the basis of a service charge or any other reason for Executor Services withdrawing money from the B account. The policy should be endorsed by senior management. Legal advice should be sought with regards to the treatment of deceased clients monies in particular: • the appropriate timescale for retaining money until a next of kin comes forward; • appropriate methods to recoup a service charge; • the legality of making claim to money that should be forwarded to the Crown. A consistent approach for managing deceased client's monies should be formally defined and adhered to.	High	Head of Care and Support.	31.03.13 Later revised to 30.11.12	Bankline withdrawals Arrangements to fund Bank Line service by transferring funds from B Account are no longer in operation. The issue of timescale is addressed in procedural guidelines. No service charge is applied to appointeeships. No claim is made to money which should be forwarded to the Crown **Action Complete**
3.3	Management should ensure that the objectives of providing the appointee service are clearly defined. This should also take account of the staffing resources required to meet those objectives as well as means of monitoring performance.	Medium	Head of Care & Support	29.06.12 Later revised to 31.03.13.	Objectives of Service - Appointeeship service definition and procedural guidelines now in place – as per Audit requirement. A quarterly audit is now performed by a team member not directly involved with appointeeships. A second member of staff has now been trained to supply holiday and sickness cover for the appointeeship work. **Action Complete**

Actions still to be implemented from the 'partially implemented' recommendations identified during the follow-up review. These may not include the full original recommendation and instead captures the element that hasn't been fully implemented.

3.4	Formal policies should be put in place defining: a) the criteria that must be met in order for an appointee service to be provided; b) the standard of service that should be expected; c) arrangements that should be followed regarding deceased clients monies in the event of there being no next of kin; d) how service charges will be collected Formal procedures and process maps should be	Medium	Head of Care & Support	28.06.12 Later revised to 31.03.13	**Audit comment after follow-up review:** Appointeeships Guidelines and procedures document were viewed and recommendations made to further strengthen this. Management acknowledge that this is a 'living document' and needs to be expansive to cover the varied scenarios with regard to appointeeships.

	defined to illustrate the standard practices for providing the appointee service, this would provide transparency and internal control over the whole appointee service and ensure that the service is provided consistently to all service users. These are identified in greater detail in the subsequent audit recommendations. All officers with a role or responsibility in providing the appointee service should be formally made aware of the standard practices and their role within the overall process. Formal business continuity arrangements should be put in place to ensure business as usual if the Client Resource Officer is not available for any period over one week.				Update from Head of Care and Support as at May 2013: **As 3.3 Action Complete**
3.5	Arrangements should also be put in place to periodically review and amend the bank mandate and banking arrangements to ensure that cheque signatories listed are up to date.	Medium	Head of Care & Support	30.03.12 Later revised to 31.3.13	Signatory Sheet Procedural guidelines now confirm signatory list to be reviewed annually. **Action Complete**
3.6	Management should ensure that: • Fraud risk assessments are carried out incorporating appointeeships and deputyships, at least annually; • All irregularities identified are reported and investigated in line with Financial Regulations and corporate guidance on fraud & irregularity; and • The recovery of losses due to fraud or theft is pursued.	Medium	Head of Care &, Support. Senior Contracts Officer. Head of Assessment & Care Management.	29.06.12 Later revised to 31.12.13. Now to be completed 01.11.13	Update as per Head of Care And Support. The agreed and signed off process for checking all new appointeeships will risk assess each one and identify any possible fraud risks. This does not currently include court appointed deputies but given the means of appointment the fraud risk of these should be lower. The fraud risk training is now available to all staff and managers via the Councils e-learning portal. All ACM staff are to complete this e-learning package by 1.11.13 (delayed due to a service restructure this summer). The training will not only support those staff checking new appointeeships for potential fraud it will also enable staff completing

					reviews and safeguarding investigations to be more alert to potential fraud risks. **Action Incomplete**

4. Risk Management (Place). (Issued to the Audit Committee May 2012).

As per Jan 2013 update report
Internal Audit: No further update was requested from the responsible Director as follow up work was undertaken in October 2012. The follow up audit work concluded that of the 12 recommendations agreed, 6 had been fully actioned across all service areas within Place. Of the remaining 6 actions: • 5 had been implemented to service area level but it was acknowledged by the Director of Business Strategy & Regulation that work to further embed risk management procedures in a minority of services was on-going. He further confirmed that as such it was not appropriate to provide a firm end date for this. • 1 action with regard to the review of project risk management arrangements remained outstanding as this was pending the development of corporate risk management arrangements. Comments were provided by the Place Programme Manager acknowledging that there were areas of weakness where implementation was ongoing or needed to begin. These are produced below: There will be further implementation of the Corporate Risk Management Framework in the lower management tiers where this has not already taken place, alongside implementation across all service areas of a robust Quality Assurance process around the identification, description and assessment of risks. There will be ongoing review of the management of risk actions and removal of risks as appropriate in a timely manner.

Update on the 6 outstanding recommendations, as at May 2013:

ref	Recommendation Outstanding	Priority	Original Responsible Officer	Original Implementation Date	Update from Programme Manager, Place. May 2013
4.1	Management should ensure that: • there are formally defined processes in place for the management of risks from business activities up to strategic management; • processes comply with the SCC Risk Management Framework; • processes are endorsed by Portfolio Leadership Team; • all appropriate operational, management and senior management are made formally aware of the	High	Director of Business Strategy & Regulation	02.07.12	Updated position provided from Services to Programme Manager, Place – who subsequently provided information to Internal Audit as follows: Place has been subject to changes at service level since the follow up and this is reflected in the response. Services RM Co-ordinators provided statements and evidence, to show that risk

	processes; • controls are formally defined to ensure adherence to the defined processes and • Non-compliance to the defined processes is promptly and formally reported to the appropriate Director in the first instance and the full Portfolio Leadership Team.				is fully embedded at all levels within the Portfolio. It was noted that a risk management plan was required for Capital & Major Project Service (C&MP) as this was a new service area. No date was provided for this.
4.2	Formal governance arrangements should be defined and implemented to ensure that all PRMG Co-ordinators periodically obtain, review and challenge all service area risk management plans ensuring that: • All service areas do have up to date and reasonable risk management plans in place; and • Risk management plans have been produced in line with the principles and criteria defined within the Corporate Risk Management Framework.	High	Director of Business Strategy & Regulation	02.07.12	This was stated as being fully actioned and in place. **Action Complete**
4.3	In order to appropriately embed and comply with the principles of the Corporate Risk Management Framework, Place Risk Management procedures should require service area and service level Risk Management plans to be compiled. Co-ordinators should ensure that within their respective service areas, formal governance arrangements are in place to ensure: • all managers maintain up to date and reliable risk management plans for the activity/business unit; • all Heads of Service manage and maintain risk management plans/service risk & assurance logs for their service area that clearly demonstrate where risks have been escalated up from activities/business units risk registers; • the above documents are periodically reviewed and challenged by the Co-ordinator and are used as the basis for defining a Portfolio wide risk management plan clearly demonstrating where risks have been escalated up from the service area risk management plans where applicable. • Portfolio risk management plans and service risk & assurance logs are submitted and reported to the Place Risk Management Group for review and are	High	Director of Business Strategy & Regulation	02.07.12 31.05.13	Updated position provided from Services to Denise Turner – who subsequently provided information to Internal Audit as follows: Completed for the majority of services, however, due to changes and movement in services, work has been agreed but has still to be developed in C&MP. Work is still in progress to ensure that sub service areas in Creative Sheffield have risk management plans – this is to be rectified by the end of May 2013. **Action Incomplete**

	used as the basis for that Group to define the Portfolios risk management plan, again clearly demonstrating where risk have been escalated up from the services' risk management plans. As a principle, Portfolio procedures should ensure that risks are being managed at the most appropriate level within the management hierarchy. A clear governance and naming hierarchy for Place should be developed and implemented that ensures a consistent approach to Risk Management plans.				
4.4	Place risk management procedures should require the adoption of the minimum criteria for the risk management plan format. Risk Management Co-ordinators should ensure that all services within their respective Services Areas have up to date risk management plans, minimum criteria (as defined in the CRMF), and adequate description of risks and review of timescales.	Medium	Director of Business Strategy & Regulation	02.07.12	In place for the majority of services, work planned for the new services introduced ie: C&MP, Regeneration and Development Services (RDS). No date given for this. **Action Incomplete**
4.5	The roles and responsibilities for risk management as defined within the Corporate Risk Management Framework should be: • clearly communicated to all staff; • adhered to and clearly demonstrated by the production and maintenance of risk management plans at the different levels of management.	High	Director of Business Strategy & Regulation	02.07.12	Programme Manager confirmed that at Place Resilience Group Meetings the RM Coordinators frequently talk about the responsibilities of themselves and Service Managers with regard to Risk Management – in particular there is acknowledgement at that meeting that the responsibilities of Service Managers is about much more than the production of a Risk Management Plan and that their responsibilities are about managing and mitigating risks. I can also confirm that the same discussion and acknowledgement is made at PLT by Directors when I present the quarterly RM Plan and Report. **Action Complete**
4.6	Project risk management arrangements should be reviewed to ensure that risks to all projects are properly identified and recorded in a risk register/risk management plan.	High	Director of Business Strategy & Regulation	02.07.12	Updated position provided from Services to the Programme Manager, Place – who subsequently provided information to Internal Audit as follows:

	Project managers should be reminded of their responsibilities regarding risk management and further training provided to ensure that project managers: • identify significant risks to a project achieving its objectives; • clearly assess the impact of each risk against the likelihood of the risk occurring to establish the inherent risk; • establish the financial cost to the project, SCC or partners if a risk materialises; & • periodically review project risk registers to ensure that they are up to date and reflect all current risks.				Completed for the majority of services, however, due to changes and movement in services, work has been agreed but has still to be developed in C&MP. Further work is also planned for RDS. **Action Incomplete**

5. Register Office (DCEX) (Issued to the Audit Committee September 2012).

As per Jan 2013 update report
Internal Audit: A follow up review is planned as part of the 2013/14 audit plan.
Director of Legal Services response: "Of the 29 recommendations made by Internal Audit that were agreed or partially agreed 17 have been completed. Eight of the 10 high risks have been completed the 2 that have not are as follows - payment of clergy, which will be virtually complete by the end of November 2012 and guidance on data protection, which will be completed by 31st March 2013. Of the 15 risks categorised as medium 8 have been completed. The 7 outstanding actions identified as medium will be prioritised between December 2012 and March 2013 with a view to completion by 31st March 2013. These include: drawing up the communications plan, under going training on fraud assessment, preparation of a fraud plan and fraud assessment, reviewing fees, reviewing stock control, and providing a key policy. Of the 4 low risks 1 has been completed. The remaining 3 recommendations identified as low, which include ensuring adequate version control and ownership of procedures, noting the date of incoming NCS applications on the form and filing in date order and providing fact sheets at key customer points will be progressed through the year and completed by August 2013".
As at May 2013
The updated position was compiled from regular written, evidenced updates provided to Internal Audit and from a response from the new Director for the

service.

As at April 2013, IA concluded from the evidence received that:
From the original 29 agreed recommendations 26 have been implemented. 1 recommendation given a low priority relating to the Nationality Checking Service is to be completed by August 2013. The remaining 2 actions, both with a medium priority, have been actioned, however will be subject to further work following the transfer to Customer Services on the 1st April 2013.

Director of Customer Services also provided this response:
"The Register Office has now formally transferred to Customer Services as at 1st April 2013. I received an update from the previous service manager on the latest position which is as you have outlined. In addition, I have asked that the follow up audit takes place early in 2013/14 as we have a project team working within the service and we can pick up on any issues that are outstanding or have not been completed in line with your recommendations. This has been agreed with the designated Audit Manager and the audit work has been initiated. The audit and subsequent follow up are really welcomed and support a number of opportunities and improvements that I have already identified for the service going forward".

Update on the 3 outstanding recommendations, as at May 2013:

ref	Recommendation Outstanding	Priority	Original Responsible Officer	Original Implementation Date	Update from Service Manager Business and Registration Service - March 2013.
8.1	Management should develop a communications plan or similar which identifies the key stakeholders of the service. The plan should include as a minimum the various methods, timescales and requirements of each stakeholder.	Medium	Director of Legal Services	11.03.13	Customer Services Communications Plan to be amended when RO transfer to Customer Services. **Action Incomplete**
8.2	Management should ensure that a policy is written and implemented regarding the key holding procedures for all keys within the Service. This policy should be subject to an annual review to ensure it remains fit for purpose.	Medium	Director of Legal Services	11.03.13	This has been actioned, however will be subject to further work following the transfer to Customer Services on the 1st April 2013. **Action Complete**
8.3	To improve tracking, the Nationality Checking Service (NCS) team should note the date the NCS applications are posted on the copy checklist, the client care sheets held and the form detailing the applications posted each day. Applications should be filed and maintained in date order.	Low	Director of Legal Services	12.08.13 Revised to 31.08.13	This will be completed by August 2013. **Action Incomplete**

6. Critical Incident Planning (CYPF).

Please note: this high opinion report was issued prior to the revised reporting arrangements to the Audit Committee – hence not issued in full to the Committee. Therefore an overview paragraph has been included:

The audit covered schools and other external locations in additional to all central CYPF service areas. The audit concentrated on the policy and associated procedures in place ensuring that incidents were appropriately identified and dealt with. 13 recommendations were made - 9 of which were agreed.

As per Jan 2013 update report

Internal Audit: No further update was requested from the responsible Director as follow up work was undertaken in September 2012. From the information provided Internal Audit is satisfied that progress has been made against the 9 original recommendations made and agreed;

- 7 had been implemented and documentary evidence provided to support this;
- 2 had written management assurance of implementation provided. These actions were due to be undertaken/completed by the end of the financial year.

Additionally, follow-up testing has demonstrated that action has also been taken against the 4 recommendations that were not agreed at the time of the original report:

- 3 had been fully implemented;
- 1 had written management assurance provided of implementation.

Update on the 2 outstanding recommendations, as at May 2013:

ref	Recommendation Outstanding	Priority	Original Responsible Officer	Original Implementation Date	Update provided by Contingency Planning Manager May 2013.
6.1	There should be regular checks and verification that Critical Incident Plans are in place in all schools. Non-school sites should be part of the circulation list for the updated Critical Incident Policy/Plans and checks should be conducted to ensure that plans are developed	High	Contingency Planning Manager	30.9.11 Revised implementation date 31.03.13	The actions identified in the November 2012 comments have all taken place including – • There is a joint approach to the management of health and safety, risk management and contingency planning and the CIP was approved by the schools health and safety committee prior to publication. • CYPF have developed, published and promoted via schoolpoint a CIP with guidance and supporting documentation for all schools and

					educational settings. • A contingency planning traded service offer to schools is in place. Schools not signing up to the traded service are informed that they should have plans in place and directed to the templates. **Action Complete**
6.2	Where applicable, recommendations should be made and implemented to ensure any 'lessons learnt' are integrated into future policies and communicated across the service.	Medium	Contingency Planning Manager	31.10.11 Revised implementation date 31.03.13	• Critical Incidents are recorded on a CYPF contact log (owned by Inclusion and Learning Service) • The Contingency Planning Manager or the School inclusion team follow up on incidents, recording this on the contact log. • Schools are encouraged to inform us of incidents which enables us to develop knowledge of trends and to consider the lessons learned and future mitigation strategies together with the Joint Emergency Planning Shared Service. • The CIP provides full guidance notes and supporting documentation for schools. • Partnership working with other internal services including inclusion and learning, Emergency Planning, Risk Management, Educational Psychology and Health and Safety. **Action Complete**

Internal Audit proposes to remove this audit from future update reports.

7. Carbon Reduction Commitment (CRC) (Place). (Issued to the Audit Committee March 2012).

Position reported to the Audit Committee in the Jan 2013 update report
Internal Audit: Follow-up work was undertaken in September 2012. The follow up review found that 7 out of the 11 agreed recommendations had been actioned, with progress being made on the remaining 4 actions. A target date of 31.03.13 was in place for these 4.

Update on the 4 remaining actions as at May 2013:

ref	Recommendation Outstanding	Priority	Original Responsible Officer	Original Implementation Date	Update as at May 2013, from Energy Team Leader, Place.
7.1	A robust, documented accountability framework, or similar, should be put in place that outlines ownership, accountability and responsibility for all Executive Directors, Directors, senior managers and officers throughout the Council. This accountability document should be signed up to by EMT and should align with programme management documentation produced.	High	Head of Service, Design & Project Management, Place.	31.12.11 Later revised to 31.03.13 To be implemented by August 2013.	Following restructure this now falls under the responsibility of the Director of C&MP. Governance and reporting will be clarified and defined through the review of Energy Management which has been recently commissioned and is due to be completed by August 2013. **Action Incomplete**
7.2	A risk register or similar process should be put in place and used to record and monitor the risks for the CRC scheme. This must be updated on a regular basis and a process for risk escalation applied. The Councils Corporate Risk Management Procedures should be followed.	Medium	Principal Engineer.	31.12.11 Later revised to 31.03.13	High Level Risks are now identified on Capital Delivery Service's (CDS) risk register. **Action Complete**
7.3	Management should consider whether a specific BCP for the CRC scheme within the Council should be created or whether the BCP risks for the scheme can be documented, formalised and put in place as part of the Energy Team's overarching BCP arrangements. Management should ensure that staff/services are aware and that there is a system in place to keep it updated and reported to senior management if required.	Medium	Head of Business Planning & Performance, Resources	31.12.11 Later revised to 31.03.13	CRC is now included in CDS Business Continuity Plan (BCP). **Action Complete**

7.4	Linked to BCP and a risk register, in order to mitigate the risk of staff losses/budget cuts on the delivery of the CRC scheme, management should develop a succession plan that is reviewed on a regular basis.	Medium	Director Property and Facilities Management	31.03.12 Later revised to 31.03.13	This is now referred to in CDS's BCP, and will also be picked up as part of the energy management review work that is now in progress. **Action Complete**

Internal Audit proposes to remove this audit from future update reports.

8. Youth Commissioning – Sheffield Futures (CYPF). (Issued to the Audit Committee February 2012).

As per Jan 2013 update report
Internal Audit: A follow up audit is to be undertaken in quarter 4 of the 2012/13 plan**.**
As at May 2013:
Internal Audit: The follow up found that of the 15 recommendations agreed in the original report, evidence was provided and reviewed for 11 of these. For the remaining 4, verbal assurance was provided and these are noted below.

Update on the 4 outstanding recommendations, as at May 2013:

ref	Recommendation Outstanding	Priority	Original Responsible Officer	Original Implementation Date	Update May 2013 following Internal Audit testing
8.1	A requirement for SF to maintain a risk register and to produce/discuss this document at periodic contract monitoring meetings should be included within the specification in order to assist the monitoring/assurance work undertaken by SCC	Medium	Assistant Director – Youth, CYPF	31.03.12	Internal Audit received verbal assurance from the Assistant Director (Youth and Head of Strategic Development and Support) that this action had been completed. Internal Audit plan to verify these actions as part of a planned audit on contract management as part of the 2013/14 plan.
8.2	The contract specification should contain a requirement for SF to periodically provide evidence to SCC that there are sufficient business continuity plans in place and that periodic testing/review of these plans has been undertaken internally. There should also be a clause that SCC have the right to perform additional scrutiny/review if considered	Medium	Assistant Director – Youth, CYPF	31.03.12	Internal Audit received verbal assurance from the Assistant Director (Youth and Head of Strategic Development and Support) that this action had been completed. Internal Audit plan to verify these actions as part of a planned audit on contract management as part of the

	necessary. The contract should also require SF to notify SCC of any risks/issues encountered that could potentially affect their ability to operate, such as cash flow difficulties or legal claims etc.				2013/14 plan.
8.3	The costs of all SCC staff resource that is involved with the SF contract needs to be calculated and documented, so that long term decisions can be made as to what support SF should be given going forward, and whether/how this cost is to be recovered from SF.	Medium	Director, Lifelong Learning, Skills and Communities	30.06.12	Internal Audit received verbal assurance from the Assistant Director (Youth and Head of Strategic Development and Support) that this action had been completed. Internal Audit plan to verify these actions as part of a planned audit on contract management as part of the 2013/14 plan.
8.4	The contract with Sheffield Futures should contain a named SCC officer who has responsibility for contract liaison. Any changes to this contact should also be documented and formally notified to SF.	Medium	Assistant Director – Youth, CYPF	31.03.12 Now revised to 31.05.13	Internal Audit received verbal assurance from the Assistant Director (Youth and Head of Strategic Development and Support) that this action had been completed. Internal Audit plan to verify these actions as part of a planned audit on contract management as part of the 2013/14 plan.

Internal Audit proposes to remove this audit from future update reports.

9. Performance Monitoring Process (Deputy Chief Executives).

Please note: this high opinion report was issued prior to the revised reporting arrangements to the Audit Committee – hence not issued in full to the Committee. Therefore an overview paragraph has been included:

An audit was undertaken on the performance monitoring process which is in place to monitor the performance of the Council and report to a number of internal and external bodies. Five recommendations were made and subsequently agreed. The audit was given a high opinion due to the high priority given to all the recommendations. The report was issued to management and the Executive Director on 13/07/2011.

As per Jan 2013 update report
Internal Audit: No further update was requested from the responsible Director as follow up work was undertaken in June 2012. The follow up work undertaken in June 2012 concluded that 2 out of the 5 agreed recommendations had been actioned; with the remaining actions to be completed by July 2012.

As at May 2013
Internal Audit note: No further update was requested from the responsible Director as assurance with regard to performance monitoring has been gained by undertaking the programme of Performance Management Framework audits in portfolios throughout the year. To date all audits carried out have been issued with a Low or Medium to Low opinion and therefore controls are operating effectively.

Internal Audit proposes to remove this audit from future update reports.

10. Establishment Control (Resources). (Issued to the Audit Committee July 2012).

As per Jan 2013 update report
Internal Audit: A follow up review is planned as part of the 2013/14 audit plan.
Director of Human Resources response: "The following actions have been taken to ensure that the establishment information is correct and changes made in a timely manner, as required by the Audit report. **System Issues -** The Council and Capita now have a programme of improvement in place to improve the HR system capability and fundamental to this is to ensure that the Council has accurate establishment information. A discrepancy report has been run which highlighted discrepancies between post to post and hierarchy. Where there are issues these are being addressed. In addition there have been a number of meetings between the Director of HR, Directors of Business Strategy and HR Business Partners to ensure that Portfolios update their hierarchies and cleanse inaccurate data. In November the biannual workforce census takes place; this will ensure that all individual data is checked and amended in the system. **Ongoing Changes to Establishment -** Capita have amended the forms and processes which are used to change and update the establishment. The Managers' Guide to Establishment Control is updated and on the Intranet. **KPIs -** The use of KPIs to measure establishment control has been investigated and it has been decided that this is not the best way to manage this issue. Org Plus will be rolled out to all managers in January 2013; this will enable HR Business Partners and managers to better understand, check and amend their establishment. Establishment information is reported in the quarterly HR report to both Executive Management Team and to Portfolio Leadership Teams. **Risks & Issues Register -** The risks and issues log is regularly reviewed and is updated on a monthly basis as the HR/Capita Service Operations Board".
As at May 2013
Internal Audit: HR has incorporated the required controls within the on-going development of their processes. IA has an audit programmed for quarter 4 which will examine the HR processes including establishment controls.

Internal Audit proposes to remove this audit from future update reports.

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