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MANCHESTER CITY COUNCIL

Audit Committee

Date: Tuesday, 15 September 2020
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This is a **supplementary agenda** and contains information that was not available when the agenda was first published.

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Membership of the Audit Committee

Councillors - Ahmed Ali (Chair), Clay, Lanchbury, Russell, Stanton and Watson

Independent Co-opted Members – Dr S Downs and Dr D Barker

Agenda

Further Information

For help, advice and information about this meeting please contact the Committee Officer:

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This agenda was issued on **Thursday, 10 September 2020** by the Governance and Scrutiny Support Unit, Manchester City Council, Level 3, Town Hall Extension (Lloyd Street Elevation), Manchester M60 2LA.

Manchester City Council
Report for Information

Report to: Audit Committee - 15 September 2020

Subject: Internal Audit Assurance Report 2020/21

Report of: Deputy Chief Executive and City Treasurer / Head of Internal Audit and Risk Management

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Summary

The Internal Audit Section delivers an annual programme of audit work designed to raise standards of governance, risk management and internal control across the Council. This work culminates in the Annual Head of Internal Audit Opinion and an Annual Assurance Report. This report provides copies of the opinions issued in the period February to July 2020 as there was no assurance report issued in April and it outlines progress on the agreed 2020/21 audit plan.

Recommendations

Audit Committee is requested to consider and comment on the Internal Audit Assurance Progress Report.

Wards Affected: All

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Background documents (available for public inspection): The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of the background documents are available up to four years after the date of the meeting and can be accessed on the Council website:

- Internal Audit Plan 2020/21 (Audit Committee meeting July 2020)
- Outstanding Audit Recommendations Report (11 February / 15 September 2020)
- Head of Audit Annual Opinion 2019/20 (July 2020)
- Internal Audit Assurance Report April to July 2020

1 Introduction

1.1 This report provides a summary of the work of the Internal Audit Section since April 2020. Publication of quarter four 2019/20 executive summaries was delayed due to the impact of Covid19 and cancellation of Audit Committee meetings in April and June so the report also includes copies of executive summaries and assurance opinions from completed audits finalised between February 2020 and July 2020.

1.2 Appended to this report are:

- Appendix One: Delivery status of the annual audit plan 2020/21
- Appendix Two: Executive summaries February to July 2020
- Appendix Three: Basis of Audit Assessments (Opinion/Priority/Impact)

2. Audit Programme Delivery

2.1 The following is a summary of progress against the 2020/21 audit plan.

Audit Status	**2019/20** **Brought Forward**	**2020/21** **Audit Plan Status At July 2020**
Final Report	25	3
Draft Report	1	1
Fieldwork Completed	1	0
Fieldwork Started	-	1
Planning	-	7
Not started	-	36
Totals	**27**	**48**
Cancelled / Deferred / Re-scoped	-	0

2.2 Outputs include audits and briefing notes, as well as advice, guidance and support to management where captured in formal reports. It includes counter fraud investigations where there is a formal was report issued but does not include all casework outcomes.

2.3 The annual audit plan currently assumes 48 individual or block outputs in the year and this was agreed at Audit Committee 28 July 2020. The total number of individual audits and assurance activities will increase as blocks of time assigned to areas of risk are scoped and drawn down as required. Work is now underway to consider scope and timing of priority audit work.

2.4 In quarter one there were four areas of focus for audit resources specifically:

- audit advice and guidance to support managers in the response to risks emerging from Covid19 including changes in systems of internal control.
- administration of urgent business rates relief, grants and discretionary support, where auditors have supported design of the schemes; checked and validated applications and payment runs; and investigated issues of potential fraud and error;
- development and delivery of arrangements for the Manchester and Trafford PPE Hub; and
- completion of audit work from the 2019/20 audit plan.

2.5 An overall annual assurance opinion in relation to 2019/20 and an overview of quarter one activities was reported to Audit Committee on 28 July 2020. This report and the 2020/21 Internal Audit Plan confirmed that there will continue to be resource support required for both the PPE hub and business grants through quarter two. Actions are being progressed to confirm the proposed audit structure and to progress recruitment to support plan delivery.

2.6 The sections below describe the progress against the agreed annual audit plan 2020/21 and finalised work from the 2019/20 plan where appropriate.

3 Children's Services

3.1 **Early Help Delivery ES1 (Appendix 2 Executive Summary 1)**. Reasonable assurance was provided over the Early Help offer as key elements of the service such as whole family assessments, regular progress monitoring, co-ordination of support from partner agencies and a robust case closure process were in place and consistently discharged. There were some specific instances of non-compliance with procedures identified in testing, particularly in respect of consent, timeliness, chronologies, and post intervention reviews for which recommendations have been made and management actions agreed.

3.2 **Adoptions Policy and Procedure ES2** An assessment of the processes supporting family finding through to adoption placement determined that arrangements were efficient and effective. A substantial opinion was provided as there were strong systems and processes in place, including effective communication between the Adoption Counts Service hosted by Stockport Council and Manchester City Council staff to support delivery of timely and effective adoption arrangements. One significant priority recommendation was made to improve the quality of Child Performance Reports used in decision making as this was a potential cause of delay.

3.3 **Free Early Education Entitlement (FEEE) Compliance ES3**. There had been a positive improvement in compliance since the last audit in 2014 when concerns had been raised. The audit concluded there was reasonable assurance that providers were generally complying with the requirements of the Manchester Early Education Provider Agreement and statutory requirements in relation to FEEE funding received. A positive development was an audit process with linked risk assessment to ensure providers were held accountable for compliance and we recommended this positive

development be further developed into a full assurance framework to support clarity and consistency of process

3.4 Children's Services continued to embed significant service changes as designed in year to strengthen service provision. There were some areas of concern generated by the introduction of new systems LiquidLogic and ContrOCC, for social care management and financial payments which had been a key focus of the service in 2019/20 and where some challenges in embedding systems and new ways of working remained. Childrens Services have taken positive steps to address backlogs and to support this work Internal Audit have provided some initial support and will deliver a high level assurance review by the end of September.

4 Education and Schools

4.1 **Schools' Financial Health Checks ES4–ES13.** Ten of the 14 schools financial health checks were finalised from the 2019/20 audit programme. The audits provided a range of assurances, with four limited opinions and the rest being reasonable or substantial. These were reported to Governors and Head Teachers to consider and agree actions to address governance and control issues. The outcomes of this work is assessed and support options explored as part of the schools risk and assurance process within the Council and follow up reviews will be carried out on all four limited opinions in the autumn term to establish what improvements have been made. Key themes from the audits and lessons learned will be shared with all schools and their governors through the new schools portal.

5 Health and Care (Adult Services)

5.1 **Mental Health Casework Compliance Follow Up ES14** Actions have been taken in relation to improved transparency of the system; annual review of care packages; and control over protection plan reviews; This had partially addressed issues around timeliness of manager approvals and conclusion of safeguarding referrals. However there is work still to do in ensure timescales are met in line with policy and the delegated statutory social care functions discharged through Greater Manchester Mental Health Trust. To assess progress an audit has been agreed for later in the year to assess the impact of a range of actions underway within the Trust.

5.2 **Safeguarding Casework Management ES15**. The audit confirmed that whilst there was no evidence that any citizen's safety had been compromised there was limited assurance over consistency and quality of case records to evidence timely actions and management review of safeguarding referrals. Actions have been agreed to improve recording of the initial screening of reported incidents and ensure records show a consistent, contemporaneous record of action, timeliness of actions taken and the rationale for and timing of closure of cases. It was clear that limitations in understanding of and experience in using the new Liquidlogic System had also had an impact on the effectiveness of recording of safeguarding activities.

5.3 **Financial Sustainability Plan ES16.** Audit work provided reasonable assurance that the arrangements in place to monitor the delivery of the Financial Sustainability Plan (FSP) were effective. Internal Audit confirmed that the processes in place provided a basis for effective monitoring and that finance officers from Manchester Clinical Commissioning Group and the Council worked in partnership providing comprehensive and up to date financial information for key stakeholders. In our opinion there were some gaps in the reporting framework and there were challenges experienced in ensuring that the savings targets and timescales were realistic and achievable.

5.4 **Deprivation of Liberty Safeguards (DoLS) ES17.** A follow up review of DoLS concluded there had been significant progress made to address risks identified in the original audit regarding DoLS Urgent and Standard Authorisations. Actions have now been taken as agreed however the system of control will be impacted on by a change in legislation in the coming year with a new system put in place and as a result challenges will remain in ensuring that timescales for approval can be met.

5.5 **Disability Supported Accommodation Services (DSAS**) **ES18**. A review was carried out to explore the significant budget pressures in the in-house DSAS and there was limited assurance over procedures and the authorisation of decisions to provide additional care hours to meet citizen needs. While services were provided and citizens were not at risk there were limited records to demonstrate control over provision. As the budget had remained static for a number of years and there was a heavy reliance on agency workers for the additional care it was inevitable that there was a gap between budget and spend. There were risks of error and omission in budgets and we support the ongoing work to review and validate each care package and the costs involved as a way to address these issues.

6 Corporate Core and Information Governance

6.1 **Core Systems: Payroll Continuous Auditing.** We finalised the regular quarterly review of payroll data and provided a summary report for management with a substantial audit opinion in regard to the payroll process. We identified a small number of errors in processing during the year which were standalone issues and were rectified by payroll officers and there were no significant issues arising from the work which provides assurance that the underlying system is operating as intended.

6.2 **Core Financial Systems.** Assurance mapping will carried out to assess the assurance over the core financial systems and that this will be used to scope audit activity to year end, minimise duplication of effort and focus on areas of concern where audit can add most value.

6.3 **MS365 and ICT.** The programme for implementation of Microsoft 365 has progressed well. This is underpinned by a number of workstreams that have focused on the technical, policy, compliance and user adoption requirements to ensure an effective migration to the new platform. These are well

advanced and the decision has been taken to proceed with the programme as planned and will be a key focus for ICT and services across the Council. ICT continue to progress the projects for data centre provision, end user devices, telephony and wide area network with clear project management arrangements in place to support the delivery of these complex projects by March 2021. Internal Audit remain sighted on progress and engaged in work streams so this will be an area of ongoing audit focus in the second half of the year.

6.4 **Grant Certifications.** URBACT C-Change and Interreg ABCities grant certifications were completed to plan with no issues raised during testing.

7 Neighbourhoods; Growth and Strategic Development

7.1 **Trading Standards ES19.** There was substantial assurance provided over arrangements reduce the supply of unsafe products/services through advice and enforcement action. There was an appropriately designed system and team structure to support risk based activities and there was a high level of positive compliance with referrals being actioned and appropriate up to date supporting case records maintained. Management information supported decision making and work was undertaken to improve written guidance during the audit to provide for consistency and continuity.

7.2 **Planning Application Process Compliance ES20**. The Council's planning application process was examined to assess compliance and was given substantial assurance. Staff demonstrated a clear understanding of the processes and timelines required and the system had been mapped to ensure that key actions and controls were understood and discharged. The case management system provided sufficient functionality and fees were collected in line with expectations.

7.3 **Civic Quarter Heat Network (CQHN).** An initial risk assessment and evaluation review was held with officers engaged in the CQHN that is being finalised and will be used to inform options for further audit and assurance work in the year.

8 Procurement, Contracts and Commissioning (PCC)

8.1 **Leisure Service Contract Performance Framework ES21.** A reasonable level of assurance was provided over the design and operation of the leisure services contract performance framework. Performance monitoring activity was wide ranging, produced on a regular basis and was supported by an established and well embedded governance structure. This enabled robust review and challenge over performance and there was evidence of plans and action tracking arrangements being developed to address areas for improvement. We made one significant recommendation support a central record of actions taken and two moderate recommendations for wider service improvements.

8.2 **Contract Governance Framework Agreements: Follow up ES22.** The

follow up audit confirmed that positive action had been taken to implement the five significant recommendations and that the risk had reduced as a result.

8.3 **Capital Frameworks Contract Selection and Award ES23.** Reasonable assurance was provided over the contractor selection and award process. While responsibility for call-off contracts from the North West Construction Hub (NWCH) was split between the NWCH framework team and the client there was clarity over responsibilities and evidence that these were being correctly discharged. There was some ambiguity noted around the completion of insurance checks and this was an area that the team immediately actioned following the audit. There was also a recommendation to review fee processes to ensure they reflected the work completed by Council officers.

9 Counter-Fraud and Investigations

Proactive

9.1 As a result of Covid19 resources from the Counter Fraud and Core audit teams were assigned to support business grant payments in quarter one. This has involved support in the design of the validation and payment processes and pre and post payment checks. For the period to the end of July this work has prevented at least £650k in payments that would have otherwise been made in error. The teams remain involved in the coordination of monthly reports to be submitted to Government, post payment assurance and fraud and error investigations and this work will continue in some form up to year-end.

Reactive

9.2 Reactive case work was mainly paused in the period because of resources being directed to Business Grant Payment support activities with triage and assessment carried out on all incoming referrals to ensure that actions could be taken by relevant service areas where appropriate. Plans to restart work on business rates, housing tenancy and council tax fraud cases have been developed although activity this area will need to be regularly reviewed and prioritised with the current focus on business grants cases.

Corporate Cases

9.3 Internal Audit has received 21 referrals of potential corporate fraud, theft or other irregularity in the year to date of which three are being handled under the principles of the Council's Whistleblowing Policy and Procedure. These allegations made either anonymously or from a named source and have been risk assessed and public interest tests applied as necessary. Work has begun to restart on paused investigations and outcomes of cases to date and the work being progressed in respect of Council Tax Reduction Scheme, Housing Tenancy, Right to Buy and Non-Domestic Rates are provided in the Annual Counter Fraud report.

10 Recommendation Implementation

10.1 Internal Audit continued to monitor implementation of recommendations but the focus on Covid19 has meant loss of momentum in some areas who have been understandably focused on critical and urgent priority work. There was limited information provided to Internal Audit on progress and we are now re-engaging with managers to assess exposure to risk in areas where actions remained outstanding.

10.2 The number of critical, major or significant priority recommendations fully implemented was 62%. This remained below the target of 70% but in line with expectations based on the complexity and timescales required for some of the actions originally agreed. A further 20% of recommendations were partially implemented at the time of our assessment.

10.3 Overdue recommendations are reported in more detail to Strategic Directors and Executive Members and in a separate report to Audit Committee providing details of the status of high risk and overdue priority recommendations.

Critical, Major or Significant Priority Recommendations by Directorate

Directorate	Number Due	Implemented	Partially Implemented	Referred Back to the Business	Outstanding
Corporate Core	39	25	10	0	4
Children's Services	25	15	2	0	8
Health and Care (Adult Services)	26	9	10	0	7
Neighbourhoods, Growth & Strategic Development	17	17	0	0	0
Total	**107**	**66**	**22**	**0**	**19**
		62%	**20%**	**0**	**18%**

11. Recommendation

11.1 Audit Committee is requested to Consider and comment on the Internal Audit Assurance Progress Report to 31 July 2020.

Appendix One: Audit Status, Opinions and Business Impact 2020/21

Audit Area	Audit Status	Assurance Opinion	Council Business Impact
Children's and Education Services 2020/21			
Children's Quality Assurance Framework (QAF)	Planning	Set at Draft	High
Chapel Street Primary – from block			Low
St Matthews High School – from block			Low
Children's Services Management and Oversight and Supervisions			High
Planning for Permanence	Not Started		High
School Financial Health Checks –block			High
Education Services Assurance - block			High
Health and Care (Adult Services) 2020/21			
Health and Social Care: Assurance Framework Review	Planning	Set at Draft	High
Adults Services Quality Assurance Framework (QAF)	Not Started		High
Integrated Neighbourhood Teams (MLCO)			High
Health and Care Commissioning including MHCC			High
Health and Social Care: Governance (MHCC)			High
Strength Based Approach			High
Mental Health Casework Compliance			High
Adults Services Quality Assurance Framework (QAF)			High
Adults Supervisions and Management oversight			High
Hospital Discharges			High
Corporate Core and Information Governance 2020/21			
Grant Certification: ABCitiEs	Delivered	Certified ●	Low
Grant Certification: Zero Climate Change (ZCC)	Delivered	Certified ●	Low
ICT: Cyber Security: Follow up	Delivered	Implemented	High

Audit Area	Audit Status	Assurance Opinion	Council Business Impact
		●	
Core Financial Systems –Block	Planning	Set at Draft	High
Recovery work streams and projects – Block	Not Started		High
Budget review and Medium Term Financial Strategy			High
Officer Decision Making			High
Annual Governance Statement / Register of Significant Partnerships			Medium
Climate Change Response			High
Our Town Hall			High
Grant Certifications – Block			Mandatory
Loans and Grants: Due Diligence			High
ICT Audit – Block			High
Early Years and Education System implementation (EYES)			High
GDPR: Data Protection Impact Assessments Follow Up			Medium
Neighbourhoods; Growth and Development 2020/21			
Civic Quarter Heat Network (CQHN)	Fieldwork	Set at Draft	High
Governance and Management of major projects	Not Started		High
Disabled Facilities Grant: Certification			High
Northern Gateway			High
Northward Housing (ALMO)			High
Highways Programme and Project Assurance			High
Highway Grant Certifications			Low
GMCA - Growth Deal			Low
Procurement, Contracts and Commissioning 2020/21			

Audit Area	Audit Status	Assurance Opinion	Council Business Impact
Use of Contract Extensions and Waivers	Fieldwork	Set at Draft	High
Factory Project	Not Started		High
Contract Management – Block			High
Supplier Relief Arrangements			High

Appendix Two: Audit Report Executive Summaries (Opinion Audits)

The following Executive Summaries have been issued for audit opinion reviews finalised since February 2020 and are attached below for information.

Reference in Appendix	Audit Area
ES 1	Early Help Delivery
ES 2	Adoptions Policy and Procedure
ES 3	Free Early Education Entitlement (FEEE)
ES 4	The Barlow RC High School
ES 5	Benchill Primary School
ES 6	Crosslee Community Primary School
ES 7	Heald Place Primary School
ES 8	Lily Lane Primary School
ES 9	Moston Fields Primary School
ES 10	Peel Hall Primary School
ES 11	Ravensbury Community School
ES 12	Sacred Heart RC Primary School (Gorton)
ES 13	The Birches Specialist Support Primary School
ES 14	Mental Health Casework Compliance – Follow Up
ES 15	Safeguarding Casework Management
ES 16	MHCC – Financial Sustainability Plan
ES 17	Deprivation of Liberties – Follow Up
ES 18	Disability Supported Accommodation Services: High Needs Decision Making
ES 19	Trading Standards
ES 20	Planning Applications
ES 21	Leisure Services Contract Performance Framework
ES 22	Contract Governance Framework Agreements – Follow Up
ES 23	Framework Agreements: Award and Selection

ES1 Internal Audit Report 2019/20

Children's Services – Early Help Service

Early Help and Troubled Families

Distribution - This report is confidential for the following recipients	
Name	**Title**
Julie Heslop	Strategic Head of Early Help, Responsible Officer
Paul Marshall	Director of Children's Services, Accountable Officer
Joanne Dalton	Strategic Lead for Early Help and Interventions
Ed Haygarth	Troubled Families Lead
The final report issued to the following recipients	
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Joanne Roney	Chief Executive
Carol Culley	Deputy Chief Executive and City Treasurer
Fiona Ledden	City Solicitor
Karen Murray	External Audit (Mazars)

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Lead Auditor	Emma Maddocks	35269
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Draft Report Issued	29 January 2020
Final Report Issued	2 June 2020

Executive Summary

Audit Objective	Assurance Opinion	Business Impact
To provide assurance over delivery of the Early Help offer.	Reasonable	Medium

Sub objectives that contribute to overall opinion	Assurance
The Early Help offer is aligned to the Early Help Strategy and the Troubled Families Framework	Substantial
Roles and responsibilities are clearly defined and understood	Reasonable
Delivery is in line with Early Help policies and procedures and Troubled Families audit standards	Reasonable
Management information informs decision making and performance monitoring	Substantial

Key Actions (Appendix 1)	Risk	Priority	Planned Action Date
The Strategic Head of Early Help should reinforce with all Early Help staff the importance of confirming that the family have consented to the referral before any action is taken, and that, once a referral has been accepted, a written record of this consent is obtained from all relevant family members and uploaded before information is shared with partner agencies.	Significant	6 months	30 July 2020
The Strategic Head of Early Help should develop a means of improving compliance with the requirement to create or update a child impact chronology at the start of the Early Help offer. Compliance should be monitored, either on a whole population or sample basis, and the results should be reported to senior management and fed back to individual team leaders.	Significant	6 months	30 July 2020

Assurance Impact on Key Systems of Governance, Risk and Control		
Finance	Strategy and Planning	Resources
Information	Performance	Risk
People	Procurement	Statutory Duty

1. Audit Summary

1.1. Manchester's Early Help Strategy, initially launched in 2015 and refreshed in 2018, emphasises that early intervention and the prevention of escalation of needs is a key strategic priority for the city. The Early Help approach aims to deliver coordinated, multi-agency, whole family interventions as soon as difficulties are identified. The work is delivered across three locality Early Help Hubs, where teams from across the Council and partner organisations are co-located. The Early Help offer is Manchester's vehicle for delivery of the Troubled Families (TF) programme.

1.2. This work aimed to provide both the necessary assurance to GMCA over the use of Troubled Families funding, and also wider assurance to the Council over the delivery of the Early Help offer.

1.3. Key risks include failure of the Early Help offer to achieve its objectives of reducing need and improving outcomes; failure to comply with the terms and conditions of the TF funding that could result in a loss or clawback of such funding or reputational damage; and non-compliance with policy and procedures that could impact on the quality of services provided.

2. Conclusion and Opinion

2.1. We are able to provide **reasonable** assurance over delivery of the Early Help offer.

2.2. We are satisfied that key elements of the service such as whole family assessments, regular progress monitoring, co-ordination of support from partner agencies, and a robust case closure process, were in place and consistently discharged. The main reason preventing us from providing higher assurance at this stage is due to instances of non-compliance with procedures identified in our testing, particularly in respect of consent, timeliness, chronologies, and post intervention reviews.

2.3. We carried out a review and issued a separate assurance report to Greater Manchester Combined Authority (GMCA) over Manchester's use of the Troubled Families funding as part of the annual certification process at the end of 2019. We provided substantial assurance that the Early Help offer had been designed to support delivery of the Troubled Families programme. Our opinion on the Troubled Families programme has contributed to our overall Early Help opinion.

3. Summary of Findings

Key Areas of Strength and Positive Compliance

3.1. The Early Help Strategy 2018-2021 clearly defined the programme's overarching aims and objectives; the principles and behaviours which underpin the approach; how these principles will be delivered; the governance

structure including operational delivery; and how impacts and outcomes will be measured and monitored. We were satisfied that the Early Help offer was in alignment with this strategy and appropriately supports delivery of the key objectives.

3.2. Roles and responsibilities were generally well defined, although we did identify a few areas where the Practice Standards needed additional clarity, which affected our overall assurance opinion for this area of the audit. There were clear processes in place for step-up / step-down between Early Help and Social Work, as well as joint working between Early Help and Social Workers.

3.3. Support for partner agencies, who make referrals, work jointly with Early Help Practitioners, or even act as the lead professional, was available in a variety of formats and was evolving in response to feedback. We conducted a survey of partners and feedback was generally positive in terms of their access to support and training, and the majority of respondents expressed confidence in their ability to deliver a high quality Early Help Assessment.

3.4. There was an Early Help Quality Assurance Framework in place which includes partner agencies, and the results were reported to senior management.

3.5. The Early Help Strategy 2018-21 defines the outputs to be reported either monthly or bi-monthly for performance management purposes and we were satisfied that actual reporting was in line with these expectations.

Key Areas for Development

3.6. Testing whether delivery was in line with Early Help policies and procedures identified two areas of significant risk and two areas of moderate risk. These related to consent, timeliness, chronologies, and post intervention reviews.

3.7. Early Help is a consent based model which is reliant upon each family's willingness to engage with the offer of support. It is also a multi-agency approach wherein Early Help practitioners are expected to work together with partner agencies to ensure a comprehensive package of support is offered. For both of these reasons, it is essential that the family, including children aged 16 and over as appropriate, have explicitly consented to the referral and to the sharing of their personal information with partners. Our testing identified a number of gaps in terms of lack of evidence of explicit consent at the point of referral, and lack of documented consent once support was underway.

3.8. It is a mandatory requirement that all children known to the Early Help team have a chronology on their record. A chronology is a brief summary of significant events in the child's life and is important in identifying risks and to aid decision-making. However, out of a sample of 20 families who received Early Help support, we found only two had up-to-date chronology on record.

3.9. The majority of cases were handled in line with expected timescales, but testing identified a number of instances of unexplained drift and delay at

various stages, including screening, allocation, home visits, and the completion of Early Help Assessments. Allocation to a practitioner was the stage where delays most commonly occurred (11 of 20). We were told that such delays were most likely due to resource pressures. Caseloads and capacity are closely monitored and recent reports showed that many teams were operating near or even above full capacity. However, explanations for the delays and evidence that the referrer and family were updated were not recorded.

3.10. More clarity is needed over whether and when post intervention reviews are to be carried out, as our testing identified inconsistencies between the policy and actual practice. The reviews were considered to be an important means of getting an update on the family's progress some months after the intervention had closed, enabling the practitioner to identify promptly whether an additional period of support may be needed before any issues escalate. However, we identified that four out of 20 families in our sample did not receive a post intervention review where it appeared that they should have.

ES2 Internal Audit Report 2019/20

Children's Services

Adoption

Distribution - This report is confidential for the following recipients	
Name	**Title**
Sean McKendrick	Deputy Director Children's Services, Responsible Officer
Paul Marshall	Strategic Director of Children and Education Services, Accountable Officer
Sean Walsh	Head of Locality and Principal Social Worker
Kim Scraggs	Agency Decision Maker
Sue Westwood	Regional Adoption Manager, Adoption Counts
The final report issued to the following recipients	
Councillor Bridges	Executive Member
Joanne Roney	Chief Executive
Carol Culley	Deputy Chief Executive and City Treasurer
Fiona Ledden	City Solicitor
Karen Murray	External Audit (Mazars)
John Pearsall	Head of Internal Audit, Stockport

Report Authors		
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Lead Auditor	Emma Maddocks	35269
Audit Manager	Kathryn Fyfe	35271

Draft Report Issued	18 June 2020
Final Report Issued	6 July 2020

Executive Summary

Audit Objective	Assurance Opinion	Business Impact
To provide assurance that the family finding element through to the adoption placement process following a SHOBPA (should be placed for adoption decision) decision is efficient and effective.	Substantial	Medium

Sub objectives that contribute to overall opinion	Assurance
Appropriate documentation is in place to support the decisions made	Reasonable
There are processes for joint working between the Council and Regional Adoption Agency (RAA) to support the prompt and effective matching and placement of children with potential adopters.	Substantial
Monitoring and reporting is in place to support planning, decision making and challenge from both the Council and RAA.	Substantial

Key Actions	Risk	Priority	Planned Action Date
Targeted training and support should be put in place for social workers who have produced a lower than acceptable quality Child Permanance Report (CPR). Consideration should also be given to make attendance at an adoption drop in clinic mandatory where a CPR has been judged as requiring improvement or less at SHOBPA decision stage to ensure that all of the relevant improvements are made.	Significant	6 months	At management discretion.

Assurance Impact on Key Systems of Governance, Risk and Control		
Finance	Strategy and Planning	Resources
Information	Performance	Risk
People	Procurement	Statutory Duty

1 Audit Summary

1.1 Internal Audit have not reviewed the controls around the adoption process since the Regional Adoption Agency, Adoption Counts was formed in 2017. The Agency was formed in partnership with Stockport, Salford, Trafford and Cheshire East Councils and has responsibility for recruiting potential adopters, assisting with matching adopters with children who have a SHOBPA (should be placed for adoption decision) and providing post adoption support to families. Manchester City Council remain responsible for making the SHOBPA decisions and have the final say on whether a match should go ahead. Given that the success of the adoption process is reliant on the joint working of Adoption Counts with the Council a review of the process post the SHOBPA decision was agreed.

2. Conclusion and Opinion

2.1 Overall we are able to provide substantial assurance that the family finding element through to the adoption placement process following a SHOBPA decision is efficient and effective overall. We consider there are overall strong systems and processes in place, including effective communication between Adoption Counts and MCC staff to support delivery of timely and effective adoption arrangements.

2.2 We have raised one significant risk recommendations in relation to potential options for working to improve the quality of CPR reports to be presented for SHOBPA decisions. However in our view given the strengths identified elsewhere with the process these improvement proposals do not adversely affect the overall opinion.

3 Summary of Findings

Key Areas of Strength and Positive Compliance

3.1 There were robust processes in place to ensure that children were tracked for matching from early on in the looked after process and that any drift within the case timeline was escalated as appropriate.

3.2 Joint working between the Adoption Counts Family Finder Team and Council Social Workers was openly encouraged, with Family Finders actively basing themselves with the Social Worker Teams at least once a week. This close working was welcomed by everybody we spoke to during the audit and they could see the value added.

3.3 There were seven family finders who worked solely on matching Manchester children, ensuring that workloads were not excessive.

3.4 Adoption Counts had a strategic matching process to ensure that priority was given to harder to place children and those that had been waited the longest from across all the Authorities and not on a ‘who shouts loudest’ basis.

3.5 Where siblings had previously been placed for adoption attempts were always made to determine whether the same adopters would consider adopting the

new child, seeking to allow siblings to grow up together. Maintaining contact between siblings was also a key consideration in the placement process.

3.6 There was clear communication and cooperation by social workers, family finders and other professionals between a match being made and an adoption order application being made. This was to ensure that progress was smooth with any issues identified being dealt with promptly and that those involved had a clear view of how events were progressing.

3.7 At the time of our audit testing we noted that there was limited use of the Adoption Pathway and that Child Permanence Reports (CPRS) were being completed outside of the Pathway. We understand that this was likely to be due to social workers not being aware of the need to use the pathway. However further controls have been introduced since our audit whereby a Child Permanence Reports cannot progress to a SHOBPA meeting if they are not in the adoption pathway. The Adoption Counts Team Manager confirmed this additional control has really helped improve use of the adoption pathway and it is now rare that a SHOBPA meeting has to be delayed because documentation has been completed in the wrong way.

Key Areas for Development

3.8 Child Permanence Reports (CPR) were often found to be low quality at SHOBPA decision stage. CPR statistics show that of 67 reports assessed at SHOBPA since August 2019 none were rated as outstanding; 11 were good; 34 required improvement; and 22 failed to meet the required standards to enable decisions to be made. The impact of this could be to cause delays to the SHOBPA decision being made and was demonstrated in one of the cases Internal Audit tested. The case was delayed four months while the report was sent back to the social work team to be redrafted five times before it was deemed sufficient to progress further. We do however understand that these reports are lengthy, detailed reports that require comprehensive knowledge of the child and of the situation in the case. Issues affecting the completion of the reports in some cases included staff turnover of Social workers close to the personal details. A number of staff talked about the need to ensure appropriate sensitivity was applied in recording some difficult stories which may be accessed by the child later in life and there was an acknowledgement of the need to get to the necessary quality which might require a number of drafts.

3.9 Drop in clinics were held by Adoption Counts at each of the local offices to allow Social Workers an opportunity to get advice and feedback from family finders for the CPRs that they were working on. We were advised that attendance at these events was ‘hit and miss’ so not everyone was involved. We were also advised that CPR reports were often not available to the family finders until the reports were submitted for panel papers and as such they are unable to provide feedback to help improve the standard of the report ahead of the initial quality assurance review.

4.0 There were some concerns raised by Social Workers that the Liquid Logic system locked down sections of the CPR report once they were completed making it extremely difficult for the social worker to make simple changes to wording. This was confirmed to be a design matter within the system to prevent later changes to

the CPR which remains the key document supporting the background to the Adoption. Lock down should occur when the document is agreed.

ES 3 Internal Audit Report 2019/20

Children's Services

Free Early Years Education Entitlement Compliance Review

Distribution - This report is confidential for the following recipients	
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Carrie Mooney	Team Manager, Access and Sufficiency
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Draft Report Issued	18 March 2020
Final Report Issued	20 July 2020

Executive Summary

Audit Objective	Assurance Opinion	Business Impact
To provide assurance that child care providers are complying with the requirements of the Manchester Early Education Provider Agreement and statutory requirements in relation to FEEE funding received.	Reasonable	Medium

Sub objectives that contribute to overall opinion	Assurance
To confirm that Providers are suitably qualified to provide FEEE	Substantial
Confirm that a process in place for the collection, recording and retention of evidence of eligibility of individual children which is effective and accurate	Reasonable
Ensure that suitable records are held to support attendance and pupil numbers reported	Reasonable
To confirm that free hours are provided in accordance with FEEE funding arrangements	Reasonable
Ensure communication to parents, in relation to hours received and any charges applied, is comprehensive	Reasonable

Key Actions	Risk	Priority	Planned Action Date
The Team Manager, Access and Sufficiency should develop an assurance framework around the current FEEE audit document to outline how the audit process works; set a timetable for audits; confirm audit reporting arrangements within the Council and to Providers; and identify any other assurances available outside of the audit process to contribute to the Council's view on compliance with the Provider Agreement (Agreement). The risk matrix that the Access and Sufficiency team have started to develop should be further developed using the results of our audit visits with a view to	Significant	6 months	31 January 2021

Key Actions	Risk	Priority	Planned Action Date
developing a risk based profile of all providers.			
The Team Manager, Access and Sufficiency should ensure that follow up audit visits are completed to the three Providers assessed as a red risk during this internal audit. Checks should also be completed in relation to one nursery highlighted to ensure that the children who have left the nursery have been removed from subsequent claims and funding reclaimed where necessary if there have been overpayments.	Significant	6 months	31 January 2021

Assurance Impact on Key Systems of Governance, Risk and Control		
Finance	Strategy and Planning	Resources
Information	Performance	Risk
People	Procurement	Statutory Duty

1. Audit Summary

1.1 Free Early Years Education Entitlement (FEEE) funding is available to providers of free early education based on the number of 2 and 3 year old children, in each establishment, who are entitled to free hours in line with national guidelines. This funding is around £18m per annum for Manchester. Providers are expected to maintain accurate and up to date records to verify their claims for the funding. This area is considered to be high risk in terms of the potential for fraud and error in relation to the claims made and it was agreed with management that Internal Audit would undertake a compliance audit of Providers, in terms of the Agreement in place and statutory requirements in order to provide assurance on the appropriateness and accuracy of claims made.

2 Conclusion and Opinion

2.1 Overall, we can provide **reasonable** assurance that providers are complying with the requirements of the Manchester Early Education Provider Agreement and statutory requirements in relation to FEEE funding received. There was a higher level of compliance by providers than during our previous audit of the area in October 2014 when there was only limited assurance over the claims. We consider that staff at providers demonstrated a good understanding of the requirements of the provider agreement and rated three of the providers visited as low (green) risk with very few housekeeping issues arising.

2.2 The audit process and linked risk assessment developed by the service is a positive step in ensuring providers are held accountable for their compliance. However in our view there is more work to do here in developing the audit document into a full assurance framework to ensure there is clarity over the process.

2.3 The main reason for us being unable to provide higher assurance at this stage was the widespread non-compliance with the Provider Agreements at four providers which resulted in assessing each as a red risk overall. There was work to do at these providers in particular to establish what the issues were leading to the very poor compliance and in seeking significant improvement.

3 Summary of Findings

Key Areas of Strength and Positive Compliance

3.1 All of the providers that we visited had the necessary evidence of OFSTED registration.

3.2 All providers were aware of the requirements to comply with the Provider Agreement and we found improved compliance overall since our last audit of this area We rated three providers as a green risk (low), with one having no issues and only minor administrative issues at the other two.

3.3 The MCC portal which had been introduced to allow providers to confirm eligibility for two year old funding had made records demonstrating compliance much clearer and more transparent and had removed the requirement for individual providers to collect copies of documentation from parents to confirm eligibility reducing the administrative burden.

3.4 The development of an audit document which had been used by the Access and Sufficiency team to audit compliance of a number of providers over the last 12 months provided an effective base for the development of a comprehensive assurance framework and allowed the Access and Sufficiency Team to challenge providers on areas of non-compliance with the Provider framework.

Key Areas for Development

3.5 There is a need to develop an assurance framework around the current audit tool to set out the timetable for audits, detail how providers will be selected for audit, to confirm reporting arrangements following audit to both providers and within the Council and how recommended actions made in the audit visits are monitored.

3.6 We found significant issues at three providers in terms of their compliance with the Councils provider framework which led to us assessing them as a red risk. The Access and Sufficiency teams should complete follow up visits to these providers to ensure action had been taken to address the issues raised during our audit

3.7 There were a number of common and recurring issues across a number of providers including some gaps in contracts with parents and gaps in register and eligibility records. We have recommended that the Access and Sufficiency team consider issuing reminders to providers of the need to comply with the provider agreement and emphasising key elements of the agreement. We have also suggested that consideration needs to be given as to whether schools need to fully comply with the provider agreement or whether an alternative agreement is needed for Schools.

ES 4 Internal Audit Report 2019/20

School Financial Health Check

The Barlow RC High School

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Draft Report Issued	11 February 2020
Final Report Issued	13 July 2020

Executive Summary

Audit Objective	Assurance Opinion	Business Impact
To provide assurance to the Governing Body and the Local Authority over the adequacy, application and effectiveness of financial control systems operating at your school.	Reasonable	Medium

Sub objectives that contribute to overall opinion	Assurance
Allocation of financial roles and responsibilities.	Reasonable
Long term financial planning, budget approval and monitoring.	Reasonable
Key financial reconciliations.	Substantial
Expenditure, specifically purchasing and payroll.	Reasonable
Income collection and recording.	Substantial

Key Actions	Risk	Priority	Planned Action Date
An Operational Financial Procedures Manual should be developed to support and enhance financial controls and staff development. This could bring together a number of existing guidance notes and procedures.	Significant	6 months	31 January 2021
The SDP should be linked to financial implications and cover a rolling three year period to enable prioritisation and effective decision making.	Significant	6 months	31 January 2021
The Head Teacher and SBM should review and confirm the procurement process to clarify the selection of suppliers including use of three quotes or alternatively market testing and decision making roles of managers and the Governing Body. Records should include information supporting decisions including market costs and the minutes of the Full Governing Body and Finance Committee should clearly	Significant	6 Months	31 January 2021.

Key Actions	Risk	Priority	Planned Action Date
demonstrate the involvement of the governors, as per the requirements of the Scheme of Financial Delegation, in supporting decision making. A specific review and confirmation should be taken to Governors in relation to the use of a company to provide timetabling services. This should include assessment of alternatives and market rates.			

Assurance Impact on Key Systems of Governance, Risk and Control		
Finance	Strategy and Planning	Resources
Information	Performance	Risk
People	Procurement	Statutory Duty

1. Audit Summary

1.1 The 2019/20 Internal Audit plan included an allocation of time to complete financial health checks at a sample of Local Authority maintained schools. We agreed to include The Barlow RC High School School in our audit programme due to the length of time elapsed since the previous audit in 2012. The school had recently appointed a new School Business Manager so it was timely to provide assurance to the School over financial governance arrangements and could also inform aspects of the induction process.

2. Conclusion and Opinion

2.1 We are able to provide reasonable assurance over the adequacy, application and effectiveness of financial control systems operating at your school.

2.2 The school was able to demonstrate a good separation of duties in all areas of financial control. Budget setting and monitoring was timely and senior staff and governors were involved in all aspects of the process. Reconciliation for banking and payroll was regular and up to date and we found no material errors.

2.3 There are some areas for development which will strengthen financial controls and business management and increase the level of assurance. Specifically this will involve the production of an Operational Financial Procedures Manual (OFP) which can be achieved by building on the existing stand-alone procedural documents; production of a costed three year school development plan for agreement with the Governing Body; and carrying out market testing for use of sole suppliers to demonstrate transparency in decision making.

3 Summary of Findings

Key Areas of Strength and Positive Compliance

3.1 The school had a Scheme of Financial Delegation (SOFD) which was comprehensive and subject to appropriate annual review by the Finance Committee. Levels of authorisation for key financial controls were included and signatory lists were up to date.

3.2 Budget setting and monitoring was found to be timely and effective. The school also a five year budget forecast. Senior staff and governors are involved in the process and receive regular budget monitoring reports in accordance with the requirements described in the SOFD.

3.3 Bank and Payroll reconciliations were found to be up to date. The school did not have a high level of cash income to manage. In our sample the income records for any cash handling which was required were comprehensive and could be reconciled to the bank paying in slips. Staff were clear about their role in this process and segregation of duties was operated as intend for counting cash and for banking.

Key Areas for Development

3.4 The school had a SOFD and more detailed procedure notes were held in a range of individual process notes. The development of an Operational Financial Procedures Manual would provide a comprehensive and consistent document to bring all key requirements together. This could be used to enhance awareness for all staff involved in financial processes and support operational compliance.

3.5 The review found that the decision making process for selection of suppliers was discharged by the School Business Manager and Head Teacher. A list of Service Level Agreements had been taken to the Governing Body but there was insufficient evidence of Governors approving sections and scrutinising quotations and the rationale for supplier selections. In the example of use of a trader described as a “sole supplier” we advise that evidence of market testing is required to demonstrate that the choice is reasonable and provides value for money. The overall process needs to be refined to ensure that the role of officers and governors is clear and discharged appropriately.

3.6 The current School Development Plan only covered one year and there was only minimal reference to the financial implications of developments which the SDP identified. The school needs to ensure that potential costs of developments are included allowing governors to consider and determine priorities linked to affordability and thereby improving the quality of decision making.

ES 5 Internal Audit Report 2019/20

School Financial Health Check

Benchill Primary School

Distribution - This report is confidential for the following recipients	
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Draft Report Issued	19 December 2019
Final Report Issued	4 February 2020

Executive Summary

Audit Objective	Assurance Opinion	Business Impact
To provide assurance to the governing body and the Local Authority over the adequacy, application and effectiveness of financial control systems operating at your school.	Limited	Medium

Sub objectives that contribute to overall opinion	Assurance
Allocation of financial roles and responsibilities.	Reasonable
Long term financial planning, budget approval and monitoring.	Limited
Key financial reconciliations.	Limited
Expenditure, specifically purchasing and payroll.	Limited
Income collection and recording.	Substantial

Key Actions	Risk	Priority	Planned Action Date
The Head Teacher should review a cost centre summary report and a cash flow forecast report each month, and sign/date/retain these in order to be able to demonstrate discharge of this key financial control. The Financial Procedures Manual should be updated to define the expected budget monitoring activity by the Head Teacher and governors.	Critical	3 months	31/01/2020
The School Business Manager should ensure that any proposed budget changes have been authorised in line with the Scheme and that signed budget changes sheets are retained. All budget changes must then be ratified (if within the Head Teacher's limit) or approved (if above the Head Teacher's limit) by the governing body or Finance Committee and the minutes should clearly evidence this, prior to being input into the financial management system.	Significant	6 months	31/01/2020
The Head Teacher and governing body	Significant	6 months	31/01/2020

Key Actions	Risk	Priority	Planned Action Date
should ensure that the timetable and procedures for constructing the School Development Plan and the budget are in alignment and that each covers at least three years.			
The School Business Manager should ensure that bank statements are stamped with the date of receipt and reconciled within seven working days. The Head of School should ensure that bank reconciliations are reviewed and countersigned in a timely manner.	Critical	3 months	31/01/2020
The School Business Manager should ensure that payroll reconciliations are completed promptly upon receipt of the reports and that these are reviewed by the Head of School in a timely manner.	Critical	3 months	31/01/2020
The School Business Manager should ensure that the Financial Procedures Manual is updated to define the thresholds for formal tendering and OJEU procurement. The School Business Manager should compile a register of all existing contracts and Service Level Agreements (SLA), including the total value and end dates of existing agreements. This should be monitored to ensure that quotation or tendering exercises are planned well in advance. This should be shared with governors annually so that they are aware of planned retendering exercises that may need their input and approval, depending on the value. For SLAs that are agreed annually but for which continuity of service is valued, governors should agree a frequency for periodically market testing the service (for example every three years), and this cumulative value will determine the procurement strategy.	Significant	6 months	31/01/2020

Assurance Impact on Key Systems of Governance, Risk and Control		
Finance	Strategy and Planning	Resources
Information	Performance	Risk
People	Procurement	Statutory Duty

1. Audit Summary

1.1 The 2019/20 Internal Audit plan included an allocation of time to complete financial health checks at a sample of Local Authority maintained schools. Benchill Primary School was selected as part of this programme of audits following a risk assessment which considered concerns raised by the Schools Finance team in relation to the Period 9 2018/19 monitoring return as well as the length of time since the last Internal Audit (2013).

1.2 The audit was carried out in October 2019 using our health check audit programme; there was overlap between this and a financial health check carried out by One Education in June 2019. In order to offer best value from our audit work we sought to assess progress against One Education's recommendations where possible and offer additional advice and support.

2 Conclusion and Opinion

2.1 We are able to provide **limited** assurance over the adequacy, application and effectiveness of financial control systems operating at your school. We identified three critical and three significant areas of risk, which prevent us from providing a higher assurance opinion at this time.

2.2 We were pleased to find that whilst the school had not operated within a Scheme of Financial Delegation for some time (as required by Schools Financial Regulations), this had been resolved with the drafting and agreement of a new comprehensive Scheme, which we provided comment on during its production. This was crucial to ensuring that the roles and responsibilities of the governing body, Head Teacher, and other staff in relation to financial decision-making and administration are clearly set out. Operational requirements were supported by a more detailed Financial Procedures Manual. On this basis we can provide reasonable assurance over the allocation of financial roles and responsibilities. However, it remains a concern that this control gap was not identified sooner by governors or the Head Teacher and it is important that governors ensure that the Scheme is kept updated and formally reviewed and approved annually.

2.3 The audit testing confirmed that processes to support effective budget monitoring and key reconciliations were inadequate. In particular, we were concerned in the following areas: cash flow forecast reports not being produced or reviewed; budget monitoring by the Head Teacher could not be evidenced; budget changes were not being authorised; and bank reconciliations and payroll reconciliations were not being performed and reviewed in a timely manner.

2.4 There was a high level of non-compliance with procurement procedures for both low and high value purchases. It is acknowledged that our testing included purchases from before One Education's review, and we could see some evidence of improved practice in the recent purchases. We had previously been advised that the school had breached Financial Regulations in the recent procurement of the new catering service as quotations were obtained rather than following a formal tendering process. We did not therefore include this in our testing, but consider that is it clear that lack of awareness of high value procurement procedures remained an issue.

2.5 We can provide substantial assurance over income collection due to the school's transition to an electronic payment system for the majority of income.

3 Summary of Findings

Key Areas of Strength and Positive Compliance

3.1 The newly adopted Scheme of Financial Delegation and recently revised Financial Procedures Manual provided clarity over roles and responsibilities for key controls and procedures.

3.2 We were satisfied that the Finance Committee carried out budget monitoring at least three times per year, and the full governing body received a finance update and Finance Committee minutes. Governors should be aware that under the new Schools Financial Value Standards, governing bodies are expected to scrutinise financial reports six times per year, so frequency or timing of meetings may need to be reconsidered.

3.3 A three-year budget forecast was produced, scrutinised by the governing body, signed by the Chair of Governors, and submitted to the Local Authority in line with submission deadlines. This included clear documentation of the assumptions made in developing the budget, using the pro forma.

3.4 The School Business Manager had recently developed an appropriate process to more explicitly evidence goods and services receipting.

3.5 The School Business Manager had recently replaced the school's two debit cards with purchase cards, which reduced the scale of potential losses in the event of theft, and can allow for a more transparent reconciliation process. We were told that the practice of allowing non-cardholders to use the cards had been stopped.

3.6 Risks around cash and the associated administrative burdens had been largely eliminated by going 'cashless' for all routine income.

Key Areas for Development

3.7 We have made three critical and three significant risk recommendations as a result of identifying:

- lack of evidence of the Head Teacher's monthly budget monitoring activity, and lack of cash flow forecast reports;
- lack of appropriate authorisation of budget virements;
- lack of clear alignment between the School Improvement Plan and the three-year budget;
- poor timeliness of bank reconciliations and review;
- poor timeliness of payroll reconciliations and review; and
- poor compliance with high-value procurement procedures.

3.8 We were concerned by a number of purchases for staff hospitality, such as catered lunches and fruit bouquets for staff training days, which were not only

outside the norms for a public sector organisation but also in breach of Schools Financial Regulations. One Education's review had identified several instances of use of the school budget to purchase gifts for staff and governors, which is not permissible. However, Financial Regulations also prohibits use of the budget on staff functions and hospitality "outside the normal course of employment", which we advise abiding by as stringently as possible to avoid reputational damage and ensure behaviour is consistent with the 'Nolan Principles'.

ES 6 Internal Audit Report 2019/20

School Financial Health Check

Crosslee Community Primary School

Distribution - This report is confidential for the following recipients	
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Draft Report Issued	26 May 2020
Final Report Issued	2 June 2020

Executive Summary

Audit Objective	Assurance Opinion	Business Impact
To provide assurance to the Governing Body and the Local Authority over the adequacy, application and effectiveness of financial control systems operating at your school.	Reasonable	Medium

Sub objectives that contribute to overall opinion	Assurance
Allocation of financial roles and responsibilities.	Reasonable
Long term financial planning, budget approval and monitoring.	Reasonable
Key financial reconciliations.	Substantial
Expenditure, specifically purchasing and payroll.	Reasonable
Income collection and recording.	Limited

Key Actions	Risk	Priority	Planned Action Date
The Head Teacher should remind all staff of the need to ensure compliance with the schools own purchasing procedures and the schools financial regulations. In particular that: • Orders are only raised with suppliers once an order has been raised on FMS and approved by the budget holder; • Delivery notes are signed and retained wherever possible and all staff should be reminded of this requirement.	Significant	6 months	31/12/2020
The Head Teacher should ensure that two officers are always involved in counting any cash received in the school and they should sign to confirm the amounts received. All records should be completed in ink at the time of creation and any mistakes/amendments should be crossed	Significant	6 months	31/12/2020

Key Actions	Risk	Priority	Planned Action Date
out but still visible for future reference and then initialled by another member of staff to validate the change made.			

Assurance Impact on Key Systems of Governance, Risk and Control		
Finance	Strategy and Planning	Resources
Information	Performance	Risk
People	Procurement	Statutory Duty

1. Audit Summary

1.1 The 2019/20 Internal Audit plan included an allocation of time to complete financial health checks at a sample of Local Authority maintained schools. We agreed to include Crosslee Community Primary School in our audit programme as the school has recently appointed a new Business Manager who had asked for assurance over existing controls in operation and was seeking input to plans for a service improvement programme.

2 Conclusion and Opinion

2.1 We are able to provide **reasonable** assurance over the adequacy, application and effectiveness of financial control systems operating at the school. It was positive to find that the recently appointed Business Manager, with support from the Head Teacher, had already introduced some revisions to the financial procedures particularly around key reconciliations which meant we were able to provide substantial assurance in that area.

2.2 However the main issues preventing us providing higher assurance is the lack of compliance with the Scheme of Financial Delegation, specifically in relation to the ordering of goods and services and in cash handling. Internal Audit support the school's plan to move to becoming a cashless school by implementing the use of Parent Pay which reduces risks in relation to cash reconciliation. To support further strengthening of the financial control and governance arrangements at the school Internal Audit have made, four moderate and two significant priority recommendations.

3 Summary of Findings

Key Areas of Strength and Positive Compliance

3.1 The Scheme of Delegation and Financial Procedures Manual included the main financial procedures required for effective financial control and governance, had been subject to recent review and was subject to regular review by the Governing Body.

3.2 Reconciliation processes for income and expenditure had been completed on a regular basis by appropriate officers and were up to date in line with expectations.

3.3 Budget planning and monitoring provided a basis for effective decision making and involved the Head Teacher and the Governors in all aspects of the processes.

Key Areas for Development

3.4 The school had only three people involved in the authorisation process, including the school business manager. She was also involved in some day to day financial operations and therefore could not authorise all payments if for example she had processed invoice payments or raised purchase orders. There were

insufficient officers on the bank mandate and at least one more member of staff should be added to support authorisation of key financial activities.

3.5 The School Development Plan covered one year but, in line with best practice, should be a three year rolling programme that links to the three year budget plan to ensure effective decision making in the use of financial resources.

3.6 The School needs to ensure compliance with the requirements of the Scheme of Financial Delegation in relation to purchasing arrangements. Purchase Orders should be raised in advance of the purchase being made with the supplier and prior to receipt of supplier invoices to ensure that appropriate consideration and authorisation for purchases takes place.

3.7 Income collection and monitoring procedures did not provide an appropriate level of control. Prime records were only completed in pencil in some instances and only one person was present when counting cash received presenting risks to control and to individuals should errors occur. The safe limit for cash held was £2K but there were occasions when the school had cash in the safe in excess of this.

ES 7 Internal Audit Report 2019/20

School Financial Health Check

Heald Place Primary School

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Draft Report Issued	16 March 2020
Final Report Issued	25 March 2020

Executive Summary

Audit Objective	Assurance Opinion	Business Impact
To provide assurance to the Governing Body and the Local Authority over the adequacy, application and effectiveness of financial control systems operating at your school.	Substantial	Medium

Sub objectives that contribute to overall opinion	Assurance
Allocation of financial roles and responsibilities.	Reasonable
Long term financial planning, budget approval and monitoring.	Substantial
Key financial reconciliations.	Substantial
Expenditure, specifically purchasing and payroll.	Reasonable
Income collection and recording.	Substantial

Key Actions	Risk	Priority	Planned Action Date
No critical or significant priority actions noted in the report			

Assurance Impact on Key Systems of Governance, Risk and Control		
Finance	Strategy and Planning	Resources
Information	Performance	Risk
People	Procurement	Statutory Duty

1. Audit Summary

1.1 The 2019/20 Internal Audit plan included an allocation of time to complete financial health checks at a sample of Local Authority maintained schools. We agreed to include Heald Place Primary School in our audit programme due to the length of time elapsed since the previous full audit in 2012, although the School did have a procurement audit review undertaken in 2018/19.

2 Conclusion and Opinion

2.1 We are able to provide **substantial** assurance over the adequacy, application and effectiveness of financial control systems operating at your School.

2.2 Overall the financial systems in place at the school provided a basis for effective control and the Governors and Head Teacher were involved in authorisation of, and decision making about, income and expenditure.

2.3 The review did highlight some areas for improvement that would enhance the existing procedures in place and these are outline below.

3 Summary of Findings

Key Areas of Strength and Positive Compliance

3.1 The School's Scheme of Financial Delegation and Financial Procedures provided a basis for effective financial control and were subject to regular review by the governors. We confirmed that there was a clear separation of duties in relation to key financial systems and that the Head Teacher was fully involved in authorisation and review processes in line with expectations.

3.2 Budget setting and monitoring was timely and the Governing Body were involved in all aspects of the budget process. Reconciliation processes for income and expenditure were completed regularly and there were clear lines of reporting for the information to be provided to staff and governors in terms of financial information.

3.3 Cash controls in place were generally effective, apart from the current system of cash collection in the classroom, with reconciliation and banking undertaken in a timely manner and no errors found.

3.4 High value procurement processes were effective, applied as designed and minutes demonstrated that governors were involved in the decision making process for approval of spend and also supplier selection.

Key Areas for Development

3.5 The Scheme of Financial Delegation had a schedule of authorisation limits but there was a gap between £10,000 and £15,000 that needs to be addressed by refreshing the SFD to avoid any inconsistency in terms of approving procurement projects.

3.6 Cash handling for schools trips needs to be reviewed to consider whether cash can be paid directly into the office rather than to teachers in the classroom. Reconciliations should always involve two people to ensure accuracy and reduce risk of error or omission. It is recognised that the school is looking to move towards a cashless system going forward which will substantially reduce the risk in this area.

3.7 The Scheme of Financial Delegation provided clear guidelines on raising of purchase orders and payment of invoices. The sample of transactions reviewed identified some none compliance with required processes and should be strengthened to ensure consistency.

ES 8 Internal Audit Report 2019/20

School Financial Health Check

Lily Lane Primary School

Distribution - This report is confidential for the following recipients	
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Draft Report Issued	12 June 2020
Final Report Issued	2 July 2020

Executive Summary

Audit Objective	Assurance Opinion	Business Impact
To provide assurance to the governing body and the Local Authority over the adequacy, application and effectiveness of financial control systems operating at your school.	Limited	Medium

Sub objectives that contribute to overall opinion	Assurance
Allocation of financial roles and responsibilities.	Reasonable
Long term financial planning, budget approval and monitoring.	Reasonable
Key financial reconciliations.	Limited
Expenditure, specifically purchasing and payroll.	Limited
Income collection and recording.	Substantial

Key Actions	Risk	Priority	Planned Action Date
The Head Teacher should ensure that detailed financial procedures are developed covering all key financial systems and controls.	Significant	6 months	31/01/2021
The Head Teacher and Chair of Governors should consider increasing the limit at which individual purchases require Governing Body approval. We would recommend a limit of at least £10k for Governor approval.	Significant	6 months	31/01/2021
The Head Teacher should ensure that when developing financial procedures, these include arrangements for completion of the bank reconciliation. Areas to be included are timely reconciliation and review following receipt of bank statements and inclusion of the unreconciled item review in all reconciliations and treatment of unreconciled items	Critical	3 months	31/10/2020
The Head Teacher should ensure that payroll reconciliations are completed	Critical	3 months	31/10/2020

Key Actions	Risk	Priority	Planned Action Date
monthly in a timely fashion following receipt of reports from the payroll provider. These reconciliations should be independently reviewed, ideally by the Head Teacher and evidence retained.			
The Head Teacher should remind staff of the need to comply with the Schools Financial Regulations and Schools own Scheme in making purchases. Particular attention should be given to the need for orders to be raised and approved prior to making the purchase with the supplier, ensuring authorisations are in line with those set out in the Scheme of Financial Delegation, the certification of invoices for payment, timely payment of suppliers and ensuring separation of duties. In instances where there are patterns of persistent non compliance with purchasing requirements by individual members of staff the Head Teacher should remind these individuals of the requirements.	Significant	6 months	31/01/2021
The Head Teacher should ensure that the School complies with the requirements of the Schools Financial Regulations in its purchasing activity. Where it is considered the purchase meets an exemption criteria which means quotations are not required (for example a unique supplier), this should be reported to Governors and the exemption from following the Financial Regulations approved prior to the purchase being made. Where purchases do not meet exemption criteria then quotations should be obtained or where relevant formal tendering exercises completed in line with the Schools Financial Regulations. The Head Teacher should ensure that the School has sufficient skills and time to complete such tendering exercises and where this is not	Critical	3 months	31/10/2020

Key Actions	Risk	Priority	Planned Action Date
the case should seek external support			
The Head Teacher should review and revise the system and processes around the use of the debit card and document them. Particularly ensuring that only the card holder uses the card, all purchases are approved in advance of the purchase being made and separation of duties between use of the card and completion of the bank reconciliation.	Significant	6 months	31/10/2020

Assurance Impact on Key Systems of Governance, Risk and Control		
Finance	Strategy and Planning	Resources
Information	Performance	Risk
People	Procurement	Statutory Duty

1. Audit Summary

1.1 The 2019/20 Internal Audit plan included an allocation of time to complete financial health checks at a sample of Local Authority maintained schools. Lily Lane Primary School was selected as part of this programme of audits following a risk assessment which considered concerns raised by the Schools Finance team in relation to the Period 9 2018/19 monitoring return as well as the length of time since the last Internal Audit. We did issue a summary of findings to the School in February to present to the Governing Body ahead of the draft report being issued.

2. Conclusion and Opinion

2.1 We are only able to provide **limited** assurance over the adequacy, application and effectiveness of financial control systems operating at your school. This is due to a number of issues found including key reconciliations not being fully completed on a timely basis and the issues raised in relation to purchasing controls, in particular the non-compliance with procedures and financial regulations for some higher value purchases. We identified three critical and four significant areas of risk which require action to strengthen controls.

2.2 We were also concerned with the drop in the budget position but appreciate that subsequent to our visit actions were taken to identify savings through not replacing a departing staff member to relieve budget pressures. Strong budget controls including regular review and challenge of the budget by both the Head Teacher and the Governing Body must be maintained to support delivery of a balanced budget and if necessary support should be sought from the Local Authorities Finance Team.

3. Summary of Findings

Key Areas of Strength and Positive Compliance

3.1 There was an approved Scheme of Financial Delegation in place and the Business Manager had recently developed an admin matrix to identify key roles and responsibilities in the admin team in preparation for her departure from the school.

3.2 We were satisfied with the engagement with Governors in relation to the budget and could see close involvement by the Head Teacher in relation to the budget.

3.3 The new multi-year School Development plan that the Head Teacher was in the process of developing more clearly demonstrated the financial implications of the school’s plans than the current plan.

3.4 The School was cashless (other than a small amount of petty cash)so there were minimal cash handling risks and strong controls over income.

Key Areas for Development

3.5 We have made three critical and four significant risk recommendations to help support improvements as a result of identifying:

- A lack of detailed financial procedures to support the Scheme of Financial Delegation;
- poor timeliness of bank reconciliations and reviews which were not comprehensive;
- late payroll reconciliations and review;
- inadequate compliance with purchasing procedures including a lack of compliance with high-value procurement procedures; and
- poor controls over the School debit card.

ES 9 Internal Audit Report 2019/20

School Financial Health Check

Moston Fields Primary School

Distribution - This report is confidential for the following recipients	
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Draft Report Issued	15 January 2020
Final Report Issued	5 February 2020

Executive Summary

Audit Objective	Assurance Opinion	Business Impact
To provide assurance to the Governing Body and the Local Authority over the adequacy, application and effectiveness of financial control systems operating at your school.	Reasonable	Medium

Sub objectives that contribute to overall opinion	Assurance
Allocation of financial roles and responsibilities.	Substantial
Long term financial planning, budget approval and monitoring.	Reasonable
Key financial reconciliations.	Reasonable
Expenditure, specifically purchasing and payroll.	Limited
Income collection and recording.	Reasonable

Key Actions	Risk	Priority	Planned Action Date
The Head Teacher and Governing Body should ensure that the School Improvement Plan and school budget cover three years, that the timetable and procedures for constructing both are aligned, and that the cost implications of planned improvement actions are defined and accounted for in the budget.	Significant	6 months	30 June 2020
The School Business Manager should ensure that both she and the Head Teacher sign and date the payroll reports to evidence their timely review.	Significant	6 months	31 January 2020
The School Business Manager should ensure that all purchases fully comply with Schools Financial Regulations and the School's own financial procedures, in particular that: • orders are authorised and raised on the system in advance of being placed with the supplier; • satisfactory receipt of the goods or	Significant	6 months	30 June 2020

Key Actions	Risk	Priority	Planned Action Date
services is confirmed; • there is demonstrable separation of duties between the individuals approving purchases, certifying receipt, and authorising the invoice for payment.			
The School Business Manager should ensure that a register of all existing Contracts and Service Level Agreements (SLA) is created, including the total value and end dates of existing agreements. This should be shared with governors annually so that they are aware of planned retendering exercises that may need their input and approval. For SLAs that are agreed annually but for which continuity of service is valued, such as psychological support, governors should agree a frequency for periodically market testing the service.	Significant	6 months	30 June 2020
The School Business Manager should ensure that the recommended changes in procedures to cash handling are made to improve transparency and accountability. In particular, that the source records of all cash received into the school (the 'Z' reports generated by the register) are independently checked to the totals banked and posted to the system, and that all staff sign and date the documents to evidence their involvement and responsibility.	Significant	6 months	31 January 2020

Assurance Impact on Key Systems of Governance, Risk and Control		
Finance	Strategy and Planning	Resources
Information	Performance	Risk
People	Procurement	Statutory Duty

1. Audit Summary

1.1 The 2019/20 Internal Audit plan included an allocation of time to complete financial health checks at a sample of Local Authority maintained schools. We agreed to include Moston Fields Primary School in our audit programme due to concerns raised by colleagues over the school's budget position. The 2019/20 budget was initially set to close on a cumulative deficit of £82k, and this had increased to £129k by Period 6. The last full audit was in 2011, though the school was included in a thematic audit on cash income in November 2018, at which time moderate assurance was given.

2. Conclusion and Opinion

2.1 We are able to provide **reasonable** assurance over the adequacy, application and effectiveness of financial control systems operating at your school.

2.2 Although we are satisfied that most key financial controls are operating effectively, we identified five significant areas of risk, which prevent us from providing a higher assurance opinion at this time. We offer limited assurance over the controls for expenditure due to some instances of non-compliance with routine and high-value procurement procedures and some gaps in the controls over the debit card.

2.3 We provide substantial assurance over the allocation of financial roles and responsibilities, and reasonable assurance over another three areas, and have identified a number of areas of good practice

3. Summary of Findings
Key Areas of Strength and Positive Compliance

3.1 The Scheme of Financial Delegation and Operational Financial Procedures Manual provided clarity over roles and responsibilities for key controls and procedures and reflected the requirements of Schools Financial Regulations. We identified only minor revisions for clarity.

3.2 A three-year budget forecast was produced and scrutinised by the Governing Body and submitted to the Local Authority in line with submission deadlines. This included clear documentation of the assumptions made in developing the budget, using the pro forma.

3.3 Whilst the School was in a challenging budget position, with a projected revenue deficit for 2019/20 of £129k, we were satisfied that the Governing Body meets nearly every month and have been closely monitoring the financial position, options for cost savings and recovery plans. The minutes evidence a good level of scrutiny and challenge. A Budget Scrutiny Committee has recently been established.

3.4 Bank reconciliations had been performed and reviewed in a timely manner, and during the Head Teacher's absence this had been picked up by the Deputy Head Teacher to maintain operation of this key financial task.

Key Areas for Development

3.5 We have made five significant risk recommendations, two of which relate to improvements in controls over expenditure. Testing identified instances of non-compliance with high value procurement procedures, poor evidence of goods / services receipting, and lack of demonstrable separation of duties.

3.6 No evidence was retained of the Head Teacher's review of payroll reports, nor were we able to confirm the timeliness of the School Business Manager's review of the payroll reports. This is considered a key financial control due to the high proportion of a school's overall budget which is spent on staffing costs.

3.7 The School has a three-year budget plan and one-year improvement plan, but these were developed at different points in the year and are not clearly aligned.

3.8 Finally, although testing did not identify any discrepancies, it was difficult to reconcile cash income back to source records and this reconciliation was not consistently being done, which has the potential to leave the school vulnerable to fraud or theft.

ES 10 Internal Audit Report 2019/20

School Financial Health Check

Peel Hall Primary

Distribution - This report is confidential for the following recipients	
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Draft Report Issued	25 March 2020
Final Report Issued	30 April 2020

Executive Summary

Audit Objective	Assurance Opinion	Business Impact
To provide assurance to the Governing Body and the Local Authority over the adequacy, application and effectiveness of financial control systems operating at your school.	Reasonable	Medium

Sub objectives that contribute to overall opinion	Assurance
Allocation of financial roles and responsibilities.	Reasonable
Long term financial planning, budget approval and monitoring.	Reasonable
Key financial reconciliations.	Substantial
Expenditure, specifically purchasing and payroll.	Reasonable
Income collection and recording.	Reasonable

Key Actions	Risk	Priority	Planned Action Date
The Head Teacher should ensure that all higher value purchases should be completed in line with the Schools Financial regulations. In particular that: • Three quotations are obtained and tendering exercises undertaken where necessary; • Where it is not possible to obtain three quotations the reason for this is recorded on supporting documentation; • The decision making process in choosing the preferred supplier and reason for choosing that supplier is clearly documented, reported to governors and retained with supporting documentation; • Governor involvement is evident; • Where the School does not comply with the Schools financial regulations in this area the exemption which is being applied is clearly documented.	Significant	6 months	September 2020

Key Actions	Risk	Priority	Planned Action Date
The School could consider having a "preferred supplier" list but also need to maintain evidence of regular market testing to demonstrate how these suppliers have been chosen and that they provide value for money.			

Assurance Impact on Key Systems of Governance, Risk and Control		
Finance	Strategy and Planning	Resources
Information	Performance	Risk
People	Procurement	Statutory Duty

1. Audit Summary

1.1 The 2019/20 Internal Audit plan included an allocation of time to complete financial health checks at a sample of Local Authority maintained schools. We agreed to include Peel Hall Primary School in our audit programme due to the length of time elapsed since the previous audit in 2010, although the school did have a procurement audit review undertaken in 2018/19.

2. Conclusion and Opinion

2.1 We are able to provide **reasonable** assurance over the adequacy, application and effectiveness of financial control systems operating at your school. While the main processes and procedures in place are sufficient there are some issues which require attention to strengthen key controls.

2.2 One issue identified was the need to enhance the arrangements around authorisation processes and ensuring that there is the involvement of a sufficient senior management team to offer segregation and accountability as well as cover for absence.

2.3 Procurement activities were not in accordance with best practice. The need to obtain quotes for all transactions over £1k in accordance with the Schools own procurement rules has placed an unnecessary burden on the school in terms of obtaining quotes for relatively low level spend. This can be addressed with a change to the guidance increasing the limit.

2.4 The Head Teacher and Governors were concerned that the School was facing a potential deficit budget going forward based on worse case scenario projections. It was recognised to be essential that the situation is monitored closely and governors should be provided with comprehensive and up to date information on a regular basis to enable effective decision making. The Council's Schools Finance Team were aware of the issues including the potential impact of falling pupil numbers and should be engaged with in options assessment and in seeking advice.

3 Summary of Findings

Key Areas of Strength and Positive Compliance

3.1 There was clear separation of duties in relation to all key financial systems. The Head Teacher was fully involved in authorisation and review processes which was good practice.

3.2 Budget setting and monitoring was timely and the Full Governing Body were involved in the budget process offering scrutiny and review.

3.3 Reconciliation processes for income and expenditure were completed regularly and there were clear lines of reporting for financial information and analysis which was generally provided to governors in good time to inform decision making.

3.4 Cash controls in place were generally satisfactory and reconciliation and banking was undertaken in an effective and timely manner.

Key Areas for Development

3.5 Authorised signatories are included in the Scheme of Financial Delegation but there is over reliance on key staff specifically the Head Teacher. Additional signatories for the key processes would provide for greater support by the schools senior management team and enhance transparency and accountability in the key financial controls.

3.6 The School's current authorisation limits for procurement did not reflect the recommended figures within the School Financial Regulations developed by the Council for all schools, for example the Head Teacher could authorise all transactions up to £5k where best practice recommends up to £2k and the school requires three quotes for all transactions. The School should revise its Scheme of Financial Delegation to reflect best practice. This would still enable value for money decisions to be reached but also free up time that is currently taken to comply with existing processes at low levels of spend.

3.7 There was a gap in the supporting evidence for procurement. The School should ensure that evidence of quotations obtained and reasons for selection of preferred suppliers is kept as part of a clear audit trail supporting decisions. The School should ensure this information is retained and is cross referenced to relevant Governing Body minutes to demonstrate good governance and decision making.

Ravensbury Community Primary School

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Draft Report Issued	21 February 2020
Final Report Issued	5 March 2020

Executive Summary

Audit Objective	Assurance Opinion	Business Impact
To provide assurance to the Governing Body and the Local Authority over the adequacy, application and effectiveness of financial control systems operating at your school.	Substantial	Medium

Sub objectives that contribute to overall opinion	Assurance
Allocation of financial roles and responsibilities.	Substantial
Long term financial planning, budget approval and monitoring.	Substantial
Key financial reconciliations.	Substantial
Expenditure, specifically purchasing and payroll.	Moderate
Income collection and recording.	Substantial

Key Actions	Risk	Priority	Planned Action Date
No critical or significant priority issues raised in the report			

Assurance Impact on Key Systems of Governance, Risk and Control		
Finance	Strategy and Planning	Resources
Information	Performance	Risk
People	Procurement	Statutory Duty

1. Audit Summary

1.1 The 2019/20 Internal Audit plan included an allocation of time to complete financial health checks at a sample of Local Authority maintained schools. We agreed to include Ravensbury Community Primary School in our audit programme due to the length of time elapsed since the previous audit (2011) and in addition, the school has only recently appointed a new Head Teacher and also a School Business Manager who are both seeking assurance on the effectiveness of the financial systems in place.

2. Conclusion and Opinion

2.1 We are able to provide **substantial** assurance over the adequacy, application and effectiveness of financial control systems operating at your school. Overall we considered the School's financial systems and controls to be appropriate and operating effectively. We have raised a small number of moderate and minor risk recommendations which when actioned will further strengthen already strong control systems.

2.2 In particular we considered the Scheme of Financial Delegation (SFD) was comprehensive and reflected the strong involvement of both senior management and governors in key financial processes, including a good segregation of duties.

2.3 The introduction of a cashless approach to all aspects of income including dinner monies and through use of the SIMSPAY system has left minimal risk in relation to the operation and control of school income systems.

3. Summary of Findings

Key Areas of Strength and Positive Compliance

3.1 The SFD and financial procedures are comprehensive, reflect actual practice at the School and are subject to regular review and update.

3.2 Budget planning and monitoring is comprehensive with the budget being subject to regular challenge by the Head Teacher (HT) and the Governing Body. We were satisfied overall that the budget was well controlled with clear longer term budget projections in place that linked to longer term school priorities. Key reconciliations were comprehensive, timely and independently reviewed on a timely basis by the HT.

3.3 There is a strong segregation of duties built into procurement, payroll and income processes. The cashless income system introduced has also significantly reduced risks around income collection arrangements.

Key Areas for Development

3.4 We have raised four moderate and one minor risk recommendations. Three of the moderate risk recommendations relate to expenditure controls. There is scope to further strengthen purchasing controls by retaining signed delivery notes as

evidence of satisfactory receipt, ensuring that an authorised purchase order is always raised prior to the purchase being made with the supplier and ensuring that copies of all quotations received and justification for choosing the appointed supplier is retained with purchasing documentation. All debit card transactions should be approved by the HT prior to the purchase being made.

3.5 Budget monitoring arrangements could be further strengthened by only fully revising the budget once during the financial year, usually after about six months. All other monitoring reports to Governors should simply highlight the current budget position against the original budget with commentary focused on any significant variances and reasons for these variances.

3.6 The School has a Lettings Policy, which has been approved by governors. All charges for lettings should be made in line with the policy. The charges currently included in the lettings policy should be reviewed to ensure they make allowances for additional payments to the caretaker in facilitating lettings by opening and closing the School.

ES12 Internal Audit Report 2019/20

School Financial Health Check

Sacred Heart RC Primary

Distribution - This report is confidential for the following recipients	
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Draft Report Issued	27 March 2020
Final Report Issued	15 July 2020

Executive Summary

Audit Objective	Assurance Opinion	Business Impact
To provide assurance to the Governing Body and the Local Authority over the adequacy, application and effectiveness of financial control systems operating at your school.	Limited	Medium

Sub objectives that contribute to overall opinion	Assurance
Allocation of financial roles and responsibilities.	Reasonable
Long term financial planning, budget approval and monitoring.	Reasonable
Key financial reconciliations.	Limited
Expenditure, specifically purchasing and payroll.	Limited
Income collection and recording.	Reasonable

Key Actions	Risk	Priority	Planned Action Date
The Scheme of Financial Delegation (SFD) and the Operational Financial Procedures (OFP) should be updated to ensure there is a consistency on requirements particularly in terms of timescales for completion of key financial procedures. The FMS bank balance should be reconciled to the monthly bank statement and adjusted for unreconciled items to balance to the closing balance on the bank statement. Once complete this should be signed off by both the Finance Manager and also the Head Teacher who should verify the process as being correct.	Significant	6 months	June 2020
The Scheme of Financial Delegation and Operational Financial Procedures should be updated to include the requirement for the payroll reconciliation to be undertaken monthly and that the Head Teacher should verify the reconciliation as an accurate record as part of that process. Action should be taken to ensure that the	Significant	6 months	June 2020

Key Actions	Risk	Priority	Planned Action Date
monthly reconciliation of the payroll report to budget figures is undertaken and the Head Teacher should review the process to verify the figures are accurate.			
Higher value procurement transactions approved by the Head Teacher and Chair of Governors should be formally reported to the Governing Body to ensure oversight of decision making on higher value spend as part of budget monitoring.	Significant	6 months	September 2020
All high value procurement should be subject to obtaining three comparable quotations and where this is not possible a clear rationale should be provided.	Significant	6 months	September 2020

Assurance Impact on Key Systems of Governance, Risk and Control		
Finance	Strategy and Planning	Resources
Information	Performance	Risk
People	Procurement	Statutory Duty

1. Audit Summary

1.1 The 2019/20 Internal Audit plan included an allocation of time to complete financial health checks at a sample of Local Authority maintained schools. We agreed to include Sacred Heart RC Primary School in our audit programme as the school had not been audited since 2011.

2 Conclusion and Opinion

2.1 We can provide **limited** assurance over the adequacy, application and effectiveness of financial control systems operating at your school at this stage. We found that operational processes did not always reflect best practice and have discussed some changes with the Head Teacher and Finance Manager which when implemented will strengthen controls.

2.2 The main issues identified were a need to ensure full compliance with the Scheme of Financial Delegation, particularly in relation to procurement and some limitations in reconciliation and verification procedures. Limited resources involved in the finance team gave rise to the potential for some delays in the timing of some actions and non-compliance with best practice. We consider that there is a need to ensure that the Head Teacher further demonstrates her role by being more involved in authorisation and verification of key financial procedures. In particular Payroll and Bank Reconciliation processes were not comprehensive and there was no evidence of verification by the Head Teacher when completed.

2.3 This report includes four moderate and four significant priority recommendations to support strengthening the control environment and implementation will support achievement of a higher level of assurance. We also note that there will be further opportunity for development and strengthening of financial control procedures with the planned appointment of a new business manager in the next school year.

3 Summary of Findings

Key Areas of Strength and Positive Compliance

3.1 Budget planning and monitoring provided a basis for effective decision making and involved the Head Teacher and the Governors in all aspects of the processes.

3.2 The School Development Plan was a three year rolling plan and included reference to finance and resources that linked to the budget. The Plan was also subject to termly updates which were presented to the Full Governing Body. This is good practice.

Key Areas for Development

3.3 The Scheme of Financial Delegation and Operational Financial Procedures need to be reviewed to ensure they include all the key financial procedures, for

example payroll reconciliation, and that they are consistent in terms of activities and timescales in both documents.

3.4 Bank and Payroll Reconciliations need to be completed in accordance with best practice in line with the Schools Financial Regulations, and also subject to demonstrable verification by the Head Teacher to ensure they are accurate and up to date.

3.5 The School needs to ensure compliance with the requirements of the Scheme of Financial Delegation in relation to procurement and in particular ensuring that quotes are obtained as necessary, and payment of suppliers is undertaken within the 30 days period.

3.6 It was acknowledged that the school only have two administrative staff involved in the financial processes and therefore the involvement of the Head Teacher and other Senior Teaching Staff to support some of the processes could enhance the accountability and transparency of the procedures in place and also reduce overreliance on the limited resource of the Finance staff.

ES13 Internal Audit Report 2019/20

School Financial Health Check

The Birches Specialist Support Primary School

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Draft Report Issued	15 January 2020
Final Report Issued	2 July 2020

Executive Summary

Audit Objective	Assurance Opinion	Business Impact
To provide assurance to the Governing Body and the Local Authority over the adequacy, application and effectiveness of financial control systems operating at your school.	Reasonable	Medium

Sub objectives that contribute to overall opinion	Assurance
Allocation of financial roles and responsibilities.	Reasonable
Long term financial planning, budget approval and monitoring.	Reasonable
Key financial reconciliations.	Reasonable
Expenditure, specifically purchasing and payroll.	Reasonable
Income collection and recording.	Limited

Key Actions	Risk	Priority	Planned Action Date
The School Business Manager should revise the Scheme of Financial Delegation to make clear that all purchases over £2k must be subject to competition, and to clarify responsibility for goods receipting. Purchases and contracts must not be divided into smaller parts to avoid quotations / tendering thresholds. All high value contracts and SLAs must be market tested on expiry or on a defined periodic basis.	Significant	6 months	31/01/2021
The Head Teacher and SBM should ensure that they meet monthly to review, at a minimum, a cost centre summary report and a cash flow forecast, and that evidence of their involvement is retained, such as by signing and dating the reports.	Significant	6 months	31/01/2021
The SBM should ensure that payroll reports and reconciliations are printed, signed, and	Significant	6 months	31/01/2021

Key Actions	Risk	Priority	Planned Action Date
dated by both the SBM and Head Teacher to evidence their timely preparation and review.			
The Head Teacher should ensure that suitable contingency plans are in place to ensure the continuity of financial control in the event of absence of key staff. This should include, at a minimum, arrangements for ensuring that monthly budget monitoring and bank, payroll, and income reconciliations continue to be performed and reviewed within expected timescales.	Significant	6 months	31/01/2021
The School Business Manager should ensure that financial procedures are revised to clearly define controls over use of the purchase cards and monthly reconciliation and review, including: advance authorisation; goods receipting; use restricted to the named cardholders only; and a full and independent reconciliation of the purchase card statements.	Significant	6 months	31/01/2021
The Head Teacher and School Business Manager should ensure that controls over cash income are improved. We recommend use of personalised receipt books; dual counting of all envelopes containing cash; independent reconciliation of income back to source records; and, increased scrutiny over the dinner money audit log. Consideration should be given to the introduction of an electronic payment system.	Significant	6 months	31/01/2021

Assurance Impact on Key Systems of Governance, Risk and Control		
Finance	Strategy and Planning	Resources
Information	Performance	Risk
People	Procurement	Statutory Duty

1. Audit Summary

1.1 The 2019/20 Internal Audit plan included an allocation of time to complete financial health checks at a sample of Local Authority maintained schools. We agreed to include The Birches Specialist Support School in our audit programme due to the length of time elapsed since the previous audit, which was completed in 2013.

2. Conclusion and Opinion

2.1 We are able to provide **reasonable** assurance over the adequacy, application and effectiveness of financial control systems operating at your school.

2.2. We are satisfied that most key financial controls are operating effectively. We provide reasonable assurance over four of five areas tested and have identified a number of areas of good practice.

2.3 However, we identified six significant areas of risk which prevent us from providing a higher assurance opinion at this time. We had particular concerns over control of cash income and could only offer limited assurance over this area as there are a number of weaknesses that could leave staff exposed to allegations of wrong-doing and the school exposed to the possibility of theft.

3. Summary of Findings

Key Areas of Strength and Positive Compliance

3.1 The Scheme of Financial Delegation and Operational Financial Procedures Manual provided clarity over roles and responsibilities for key controls and procedures. Although we identified some areas that need further expansion or revision, overall the procedures were clear and comprehensive.

3.2 A three-year budget forecast was produced and scrutinised by the Governing Body and submitted to the LA in line with submission deadlines. This included clear documentation of the assumptions made in developing the budget, using the pro forma.

3.3 The Finance Committee met half-termly in line with LA submission deadlines, and minutes evidenced a robust level of scrutiny and challenge. The Governing Body also met half-termly and each meeting included a verbal finance update at a minimum.

3.4 Robust procedures for checking and authorising additional hours claims were in place. Procedures for performing payroll reconciliations as described to us were robust, including spot-checks and investigation of any variances, but as these were only retained electronically, evidence of involvement, particularly the Head Teacher’s sign-off was not clearly retained.

3.5 The School Business Manager (SBM) and Head Teacher meet monthly to work through a narrative report with 15 standing agenda items, such as key

deadlines, review of the budget / cost centre summary, bank recs, cash flow, catering, etc. We were not able to confirm completion of these each month, but the format allows for a comprehensive monthly review.

Key Areas for Development

3.6 We have made six significant risk recommendations, two of which relate to improvements in controls over purchasing, including use of the purchase cards. Testing identified instances of non-compliance with high value procurement procedures, poor evidence of goods / services receipting, and poor oversight of purchase card use.

3.7 Though procedures as described to us for budget monitoring and for payroll reconciliation and review were robust, evidence of these key controls being carried out each month as expected was not consistently retained.

3.8 We have recommended the school consider their contingency arrangements to ensure continuity of key financial controls in the absence of key members of staff.

3.9 Although testing did not identify any discrepancies, we identified a number of weaknesses with the controls over cash income which have the potential to leave the school vulnerable to fraud or theft. Some of these are inherent to being a special school and are more difficult to mitigate; for instance, because many pupils arrive via minibus, not all parents have the opportunity to hand over cash payments directly to accountable members of the finance / admin team. We have made a number of suggestions to improve controls and reduce risks around cash. Full implementation of an electronic / “cashless” payment system would not only eliminate the risks of cash but also reduce the administrative burdens of accounting for it. We understand that the school has been reluctant to introduce such a system because it is thought that parents would not be willing or able to use it. We have heard similar concerns raised at other schools who have nonetheless been able to successfully implement a cashless system and so we have advised governors to consider this option.

ES 14 Manchester City Council Internal Audit Report 2019/20

Adults Services: Mental Health Follow Up Audit

Mental Health – Casework Compliance

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Draft Report Issued	10 January 2020
Final Report Issued	28 January 2020

Audit Objective	Overall Implementation Status
To provide assurance over the implementation of audit recommendations agreed in response to the audit of Mental Health Casework Compliance issued April 2019.	Partially Implemented

1. Audit Summary

1.1 In late 2018 Internal Audit undertook an audit review of Mental Health Casework Compliance to provide assurance over delivery of delegated statutory social care functions by the Greater Manchester Mental Health Foundation Trust in line with relevant policies and procedures.

1.2 Based on the work undertaken we provided a limited assurance opinion and made nine recommendations for improvement with agreed target dates for implementation between 30 June and 30 September 2019.

1.3 In order to provide assurance to the Accountable Officer (Executive Director of Commissioning & DASS), SMT, and Audit Committee, that progress had been made to reduce risk, we undertook a follow up audit in 2019/20 in line with policy where a limited opinion has been provided. The scope was to assess whether agreed actions had been completed to address the recommendations.

1.4 This was an assessment of progress made with the implementation of the agreed audit recommendations and not a full re-review. Some sample testing was undertaken in order to assess use of the Trust's new case management system and to determine whether compliance with expected procedures had improved.

2. Conclusion and Opinion

2.1 Our review of progress confirmed that three recommended actions - to improve the transparency of the system audit trail, the timeliness of annual reviews of care packages, and the controls over protection plan review dates - had been fully implemented.

2.2 Two recommendations, in relation to the timeliness of manager approvals and the timeliness of the conclusion of safeguarding referrals, were partially implemented. Whilst there was evidence of new mechanisms in place for monitoring timeliness and oversight, there was still a lack of full compliance with expected timescales and procedures. The remaining four recommendations were assessed as outstanding.

2.3 We therefore conclude there is a partial reduction in the overall exposure to risk in this area. The original recommendations and current confirmed status is summarised in the table below:

Category	Total	Implemented	Partially Implemented	Outstanding
Critical	0			
Major	4	3.3	3.1	4.1, 4.2
Significant	4	1.1	3.2	1.2, 2.1
Moderate	1	1.3		
Minor	0			
Total	**9**	**3**	**2**	**4**

2.4 As progress towards achieving full compliance with safeguarding procedures was not found to be as advanced as expected, the Trust have reassessed their approach and compiled a new Safeguarding Action Plan to work towards full implementation of all recommendations. There are timescales for individual actions on the plan to be completed between now and March 2020, including:

- Safeguarding training to be updated to reflect expected standards by 31 December 2019;
- All appropriate staff to attend and complete training by 31 March 2020;
- Audit tool to be reviewed to monitor compliance by 31 December 2019.

2.5 However, the Trust's own plan acknowledged that it was estimated to be 31 December 2020 before practice changes were fully embedded and consistent. Whilst system changes were considered relatively straightforward to develop and put into place, the behaviour change needed to embed changes was recognised and is acknowledged by management to be less straight forward to achieve.

2.6 To monitor performance during implementation of the action plan, a set of performance metrics and thresholds will be agreed with Trust management. Progress in addressing audit recommendations will also be regularly discussed at the Mental Health Partnership meetings between the Trust and the Council. We support these actions, which should help to keep activity on track.

2.7 The explanation of recommendation prioritisation and follow up assurance is attached at appendix 2. Note that Internal Audit now use four prioritisation categories.

2.8 Based on the work completed and assurance obtained we will include the reported status of these actions in our quarterly update reports to SMT and Audit Committee.

3 Management Response Received

3.1 GMMH and Manchester Community Mental Health Teams have been through a significant Transformation programme over the past three years with new models of care being delivered from January 2019. This programme of transformation has included introducing a new clinical recording system for Manchester services so that GMMH uses one system. All teams and services have made significant progress over the past 12 months and this is highlighted within the audit. The audit identifies areas for improvement and non-compliance however this needs to be taken in to context of the progress to date and significant assurance gained following this audit. The trajectory of improvement has continued since the audit took place and systems and processes further embedded within the integrated MDT's.

Appendix 1: Status Update

Recommendation 1.1 (Significant)

The Director of Adult Services should seek assurance from the Trust that the new case management system, Paris, will include an automatic audit trail, and that all future outcomes reporting will be based on system generated dates to ensure accuracy of reporting.

Internal Audit Assessment:

Our initial visit identified discrepancies between the "version control" log in Paris, which records the name and date/time of workers who amend a form, and the manually entered names and dates, which are used in management reporting to confirm completion and authorisation of the forms. For example, in one instance, a manager's name had been typed into the 'authorised by' box but version control shows that only the worker had ever amended the form.

A job was raised with the system's designers to build an authorisation tick-box to automatically record the name and date/time of the person ticking this box. We advised that it be further modified to enable only a user with 'manager' credentials to authorise a form. A subsequent visit confirmed that these system changes had been made.

As such we consider this recommendation is now **implemented**.

Recommendation 1.2 (Significant)

The Director of Adult Services should seek assurance from the Trust over consistency in recording safeguarding investigation activities, including whether the new case management system, Paris, can enforce correct procedures via system workflows. This may involve strengthening timely management oversight on case work and enhanced training for all case workers to ensure that procedures are understood.

Internal Audit Assessment:

Within Paris, workers are meant to record all activity within progress notes and then, if the activity is related to a safeguarding referral/enquiry to tick the 'safeguarding' tick-box. These progress notes will then be pulled through to the Safeguarding tile within Paris, to form (in theory) a complete record, visible in one place, of all actions taken in relation to the safeguarding referral.

We were told that these safeguarding recording requirements were communicated to all staff and built into formal safeguarding training. However, our testing of a sample of five safeguarding referrals which proceeded to a Section 42 enquiry found significant gaps in all of them: relevant progress notes which had not been ticked as 'safeguarding' or simply a complete lack of any notes at all.

As such we consider this recommendation is **outstanding**.

Recommendation 1.3 (Moderate)

The Director of Adult Services should seek assurance from the Trust in regards to improved controls over the review of protection plans following conclusion of a

safeguarding investigation. For example, the Review Date field could be mandatory, with only future dates accepted or explicit confirmation that no review is required. The system could then prompt the case worker to carry out a review based on the input date.

Internal Audit Assessment:

We did not find any issues with the review dates in our sample of five safeguarding enquiries, and we confirmed that the Trust's weekly DQ report of investigations highlighted where review dates have passed. However, the DQ report also showed that there were still a large number of instances (21 of 47) where the review date is the same date as the conclusion of the enquiry. A request has been made to the system designers to allow only future dates for the review date.

There was also a gap in that, although past-due reviews are flagged on the DQ report, there was no mechanism to record a completed review which would turn off this flag. The Trust agreed that there was still work to be done on this area from both systems and practitioner perspectives. Nevertheless, this is a moderate risk recommendation and the Trust have reported that this action is completed, and we are satisfied that the remaining risk can be managed internally by the Trust.

As such we consider this recommendation is now **implemented**.

Recommendation 2.1 (Significant)

The Director of Adult Services should seek assurance from the Trust in regard to whether Paris, the new case management system, offers improved controls over the initial response to safeguarding concerns, such as requiring management sign-off within 24 hours of receipt of the referral.

Internal Audit Assessment:

We randomly sampled five safeguarding referrals and still found issues with a lack of management oversight of the initial decision-making: one of five randomly sampled referral forms had been completed and authorised by the same individual with no reference to having held a discussion with a manager about the decision. However, the system change described above in recommendation 1.1 will prevent this from occurring in future.

The Trust's response to this recommendation was to issue guidance to all staff to promote awareness of recording responsibilities, and to have in place a “daily DQ report”. We confirmed that this report does highlight where referral forms have been started but are not yet authorised, but it does not appear that sufficient actions are taken to escalate where these are excessively overdue; the most recent report showed 11 unauthorised referrals that were more than a month, and up to 9+ months, since the date of the referral.

Our testing also identified one instance where no action was taken in response to a safeguarding referral for nearly two months. When the referral form was finally begun, the referral date was recorded as this latter date, so the initial two-month delay would not have been flagged in any way.

We cannot therefore consider that this risk has been adequately addressed. In addition to the DQ report, an escalation process needs to be put in place and

enforced to ensure that all excessively overdue referral forms are authorised or otherwise resolved. Finally, a mechanism needs to be developed to ensure that all safeguarding referrals that are received in to the Trust are actioned in line with procedures, and that any that haven't been are immediately identified for escalation. We have been told that, in response to this finding, a new control has been introduced to ensure all referrals are input immediately upon receipt, but we have not yet validated this.

As such we consider this recommendation is **outstanding**.

Recommendation 3.1 (Major)

The Director of Adult Services should seek assurance from the Trust that manager approval is actively monitored to ensure compliance with quality and time standards.

Internal Audit Assessment:

The Trust previously self-assessed this recommendation as implemented on the basis of the “DQ reports” being in place which provide oversight of outstanding work:

- The Daily DQ report shows that 69 safeguarding referrals were received from the LA in the last month, and of these, 42 (61%) were authorised within one day.
- The Weekly DQ report of investigations only shows those where some aspect remains incomplete and does not directly report on timeliness between conclusion of the enquiry and management authorisation. However, this shows 24 investigations where an outcome has been recorded (indicating the enquiry is complete) but the assessment form has not been authorised; for these, between 1 and 10 months have elapsed since the start of the Section 42 assessments.

Testing of the timeliness of management authorisation of referral forms found delays of 3.5 weeks and 15.5 weeks for two of five, and one of five had not been authorised by a manager at all. Testing of the timeliness of management authorisation of investigation forms did not identify any issues.

We are satisfied that these reports provide a mechanism for monitoring timeliness and outstanding work, and yet we remain concerned that these reports indicate (and testing confirmed) that there are still unaddressed issues with performance.

As such we consider this recommendation is now **partially implemented**.

Recommendation 3.2 (Significant)

The Director of Adult Services should seek assurance from the Trust over how the timely and appropriate conclusion of investigations can be better managed and monitored – for example, system workflows to ensure adherence to procedure, and system generated reports of open investigations for which no recent activity has been logged.

Internal Audit Assessment:

The Trust previously self-assessed this recommendation as implemented on the basis of the “DQ reports” being in place which provide oversight of outstanding work:

- The Daily DQ report flags up where a decision was made to proceed to a Section 42, but a Section 42 assessment is not yet present on the system – as of the

time of our review, there were 17 such instances within the last month, and 43 from previous months.

- The Weekly DQ report flags up where a Section 42 assessment has been started but not yet completed / authorised – as of the time of our review, there were 29 of these, all of which were at least 4 weeks elapsed.

Testing of five randomly sampled safeguarding investigations identified delays in the conclusion of three.

We are satisfied that these reports provide a mechanism for monitoring outstanding work, and yet we remain concerned that these reports indicate (and testing confirmed) that there are still issues with performance.

As such we consider this recommendation is now **partially implemented**.

Recommendation 3.3 (Major)

The Director of Adult Services should seek assurance from the Trust on the timeliness of Annual Reviews and the plan to address the backlog of overdue Annual Reviews.

The Trust's performance reporting on Annual Reviews is addressed below in recommendation 4.2.

Internal Audit Assessment:

We were shown a report on the backlog of annual reviews indicating that, of the original 488, just 14 annual reviews were yet to be started, and 79 were currently in progress; the balance have either been completed or were found to be not necessary. The Trust's aim was to work through these remaining cases by the end of December 2019. We also confirmed that a monthly "DQ report" is in place to highlight where annual reviews are coming due.

On this basis of the reduced backlog and controls in place to monitor timeliness, we can consider this recommendation is now **implemented**.

Recommendation 4.1 (Major)

The Director of Adult Services should ensure that a formal process is agreed and established with the Trust for a monthly reconciliation between safeguarding referrals sent and received.

Trust and MCC staff should work together to ensure that the new case management systems in each organisation – Paris and Liquid Logic, respectively – consistently record outcomes of safeguarding referrals, so that these can more easily be transferred across systems to ensure completeness of MCC's records and ability to monitor outcomes.

Internal Audit Assessment:

Conversations with colleagues in PRI (MCC) and with the Trust confirmed that system for reconciling safeguarding referrals passed to the Trust with outcomes reporting received back from the Trust was not yet in place. Issues arising from the Council's move to Liquid Logic and the Trust's move to Paris have impacted on both organisations' abilities to prioritise this work. We were told that workshops between

MCC and the Trust were planned for the near future to work out processes between Liquid Logic and Paris. As such we consider this recommendation is **outstanding**.
Recommendation 4.2 (Major) The Mental Health Commissioning Manager should undertake a review of performance reporting against the agreed KPIs to ensure that performance is being reported accurately and consistently in line with the Section 75 agreement. **Internal Audit Assessment:** We were told by the Trust that more system work is needed to enable Paris to produce the data necessary for the KPIs. A clear timeline for completion was not possible, as the work was complicated by a key member of staff's long term absence, though we have since been informed that the Trust are now progressing this via the Professional Lead. As such we consider this recommendation is **outstanding**.

ES 15 Internal Audit Report 2019/20

Adult Social Care

Safeguarding Casework Management

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Draft Report Issued	10 March 2020
Final Report Issued	27 May 2020

Executive Summary

Audit Objective	Assurance Opinion	Business Impact
To provide assurance that the case management of adult safeguarding incidents is dealt with in accordance with Council policies and procedures.	Limited	High

Sub objectives that contribute to overall opinion	Assurance
The collection, recording and retention of information	Limited
Decision-making in line with procedures, including appropriate approvals and authorisations	Limited
The timeliness of activity	Limited
The appropriate reporting and communicating of action and outcomes	Reasonable

Key Actions	Risk	Priority	Planned Action Date
The Service Lead (Safeguarding Adults) to determine if it is possible to make the initial screening and decision to safeguard a mandatory form. If not and in the interim they should obtain Management Information to monitor that this is taking place.	Significant	6 months	Aim for 31/01/2021 but to confirm with management once Covid19 position stabilised to confirm if this is a realistic and achievable date
There should be further training for all Social Care staff undertaking or approving safeguarding. Safeguarding activity (particularly its recording) should be a key aspect of the management assurance arrangements.	Significant	6 months	Aim for 31/01/2021 but to confirm with management once Covid19 position stabilised to confirm if this is a realistic and achievable date

Key Actions	Risk	Priority	Planned Action Date
The Assistant Director (Adult Social Care) should identify what management information could support the timely and appropriate recording of the closure of safeguarding activity.	Significant	6 Months	Aim for 31/01/2021 but to confirm with management once Covid19 position stabilised to confirm if this is a realistic and achievable date

Assurance Impact on Key Systems of Governance, Risk and Control		
Finance	Strategy and Planning	Resources
Information	Performance	Risk
People	Procurement	Statutory Duty

1. Audit Summary

1.1 The Council has a duty to protect adults at risk of harm and to investigate and act on any suspicion or allegation of abuse to reduce the potential risk. Failure to act appropriately in terms of engagement, timeliness or recording of information can put adults further at risk and have legal and reputational consequences. Management are aware of the ongoing risks in this area, particularly during this period where they are undertaking substantial activities aimed at strengthening and improving key aspects of governance and control within Adults Services and when aspects of the core business could suffer from lapses of compliance with agreed processes as workers focus on improvement areas.

2. Conclusion and Opinion

2.1 We can only provide **limited** assurance that the case management of adult safeguarding incidents is dealt with in accordance with Council policies and procedures. We had particular concerns regarding the effectiveness of recording of initial screening of referrals where this took place; the absence of contemporaneous records; the appropriateness of closure of some referrals; and the inconsistent quality of the records themselves. In a number of cases it was therefore difficult to evidence that timely activity took place as required, particularly during the first few days after a referral was received.

2.2 The quality of recording information during the progress of cases was varied and we identified issues on all case records reviewed in our sample. The extent of non-compliance ranged from individual omissions to extensive gaps in the records. In our view this is indicative of embedded issues in the approach taken by social workers in recording information and is in part a cultural norm in Adults Social Care

as these were not isolated errors. Our assurance opinion is based on the cumulative effect of these issues on the quality of recorded safeguarding within our sample.

2.3 There was no evidence in the sample we tested that client safety had been compromised by any of the issues identified, however the failure to record actions taken increase the risk that cases are not managed appropriately. Whilst some adults remained at risk after safeguarding activity this was recorded as being due to their choice and a lack of consent to proceed. Our testing also identified that in a number of cases the safeguarding activity could have been closed earlier and the actions taken recorded as general casework.

2.4 It was clear that limitations in understanding of and experience in using the new Liquidlogic Adults System (LAS) had impacted on the effectiveness of recording of safeguarding activities. One social worker had recorded that they were having difficulty closing a safeguarding referral on the system. However, it should also be noted that we did find examples where the activity undertaken, either in its entirety or in elements of it, had been well documented.

3. Summary of Findings

Key Areas of Strength and Positive Compliance

3.1 Liquidlogic Adults System (LAS) had been introduced in July 2019 to replace Frameworki (MiCare). Audit testing covered some cases that had been migrated from MiCare and some were entirely from early usage of LAS. Testing confirmed that the system had the functionality to clearly record safeguarding investigations as intended. The implementation phase enabled feedback to be given to inform potential enhancements and phase 2 implementation was already under consideration which could enable minor changes to the system or processes to be introduced.

3.2 Some cases were well recorded with activities clearly captured in line with expectations. This included the customer's views (or those of the next of kin where there were capacity issues); clear explanations of any delays to the process; information sharing with other relevant parties; and immediate actions to protect the customer where necessary.

3.3 Cases generally moved through the contact centre stage in a timely manner and were appropriately allocated. Where the Multi Agency Safeguarding Hub (MASH) was involved there were clear recommendations made with a rationale behind them.

Key Areas for Development

3.4 The Council's policies and procedures and those of the Manchester Safeguarding Adults Board for safeguarding adults had not been updated for over four years. As such they should be reviewed and updated to ensure that they reflect any changes in legislation and processes.

3.5 A key element of the safeguarding process is the initial screening of safeguarding referrals by a qualified worker and the decision to proceed or not. This

initial screening requires management oversight to ensure activity is appropriately focussed. We reviewed 25 cases and only five had evidence of this decision (and of these only two were completed to a reasonable level and in a timely manner). In some cases, we identified that these decisions (and discussions) had taken place but were recorded elsewhere in the LAS system. However, there were a significant number of cases where there was no evidence of immediate consideration, discussion or approval held in the system.

3.6 Four referrals remained open five months after the initial referral, with three of these having multiple referrals still open. We identified an example where a Safeguarding Closure form had not been completed three months after the client had moved out of area, and was no longer considered an active case.

3.7 The safeguarding process was clear that referrals can be closed at any point when the professional decision was that the safeguarding investigation was not needed. There seemed to be a reluctance, or lack of understanding of the recording process, to close safeguarding enquiries and to proceed with casework outside of the safeguarding framework in LAS. Accordingly, we identified referrals which were not safeguarding but had been completed using the safeguarding documentation.

3.8 There were inconsistencies with the timeliness of recording activity, and an absence of contemporaneous notes. Although there were examples where immediate discussions, planning, and activity were recorded in a timely manner; in 10 of 25 cases the Enquiry and Planning form was started over a month after the referral. In six cases this Enquiry and Planning form was completed on the same day the Closure form was started. Combined with the absence of the initial decision form it was difficult to determine if timely activity took place.

3.9 Some referrals and enquiries were well recorded but most safeguarding records contained some omissions or insufficient amounts of detail however there was no pattern to these omissions. Some of this could be down to migration from MiCare, some from an absence of understanding of LAS, but for some we could establish no obvious explanation. For example we identified one case where a MASH recommendation was to consider the Mental Capacity Act and potential Court of Protection with regard to a client's mental capacity. The Social Worker undertaking the enquiry simply recorded "No" in the form regarding concerns about the client's capacity. From the information available it is difficult to determine if the recommendation from the MASH was considered and assessed but badly recorded or if it was ignored.

3.10 The safeguarding process required review and authorisation by a Team Manager (or Senior Social Worker) for a number of key forms; specifically the decision to safeguard; the Enquiry and Planning form; and Case Closure. We identified some instances where there was a record of challenge to the quality of the recorded activity which demonstrated oversight, however we also identified incomplete or insufficiently detailed records which had also been signed off.

3.11 The LAS system was designed so that a SA (Safeguarding Area) Tab was at the top of the record where there was ongoing or recently closed safeguarding activity. A significant number of our sample did not contain this tab although we were able to access the safeguarding area via other menus. Initial discussions with the

LAS implementation team indicate this could be related to which elements of the process were being completed on the LAS and confirmed that they will undertake work to identify where this error occurs in LAS and to correct it.

3.12 At the time of our audit there were recognised limitations in the management information available from LAS. Regular, accurate and targeted management information was recognised to be essential to enable management to identify issues as they emerged and to therefore enable prompt action to be taken.

ES 16 Internal Audit Report 2019/20 Manchester Health and Care Commissioning (MHCC) Review of MHCC Financial Sustainability Plan Delivery	
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Draft Report Issued	14 January 2020
Final Report Issued	26 May 2020

Executive Summary

Audit Objective	Assurance Opinion	Business Impact
To provide assurance over the arrangements to monitor the delivery of the MHCC Financial Sustainability Plan	Reasonable	High

Sub objectives that contribute to overall opinion	Assurance
Effectiveness and timeliness of the monitoring process	Reasonable
Response to deviation from plans	Reasonable
Effectiveness of management oversight and challenge	Reasonable
Effectiveness of reporting into and out of MCC and Manchester Local Care Organisation (MLCO)	Reasonable

Key Actions	Risk	Priority	Planned Action Date
The savings forecasts should be determined based on the actual savings to date and realistic expectations of anticipated savings for the remainder of the year.	Significant	Aim for 31/01/2021 but to confirm with management once Covid19 position stabilised to confirm if this is a realistic and achievable date	
Consideration should be given to agreeing a standard format for Deep Dive meetings. This could include a model agenda and standard template for documenting the meeting and reporting outcomes. In addition consideration should be given to introducing the process for all projects with a lesser frequency where there are no known significant issues to ensure the optimal approach has been undertaken and that any changes have been reflected.	Significant	Aim for 31/01/2021 but to confirm with management once Covid19 position stabilised to confirm if this is a realistic and achievable date	

Assurance Impact on Key Systems of Governance, Risk and Control		
Finance	Strategy and Planning	Resources
Information	Performance	Risk
People	Procurement	Statutory Duty

1. Audit Summary

1.1 The overall aim of the Financial Sustainability Plan (FSP) is to create savings to improve services and/or provide additional services to satisfy ever increasing demand. The process involves the Council working with Manchester Clinical Commissioning Group (CCG) colleagues to develop projects to generate savings. There is a potentially high risk to overall service provision should planned savings targets not be achieved.

1.2 In 2018/19 the FSP savings target was set at £20.394m split £9.639m for Manchester City Council (MCC) and £10.755m for the CCG. The savings achieved were £8.167m (MCC £6.205m and CCG £1.962m) which was below the original target by £12.227m. The monthly forecasts for January 2019 (£9.169m), February 2019 (£8.513m) and March 2019 (£8.591m) referred to this variance but the actual outturn was still lower than forecast by £0.424m.

1.3 In 2019/20 the total planned FSP savings target was £18.305m. Initially, 23 potential projects were identified and 19 were selected and developed as Table 1 below:

Table 1 – Original FSP Savings Target 2019/20

Scheme Cat.	Scheme Heading	MCC	CCG	MHCC Savings 2019/20
		Target	Target	Target
New Care Models	Assistive Technology	852	0	852
New Care Models	Assistive Tech. - Meds Mgt Operational	310	0	310
New Care Models	Crisis	0	2,354	2,354
New Care Models	Extra Care	0	49	49
New Care Models	Home from Hospital	0	223	223
New Care Models	Prevention - Citywide	0	52	52
New Care Models	Reablement	2,422	459	2,881
New Care Models	Reablement - Complex	797	0	797
New Care Models	Reablement - Discharge to Access	0	916	916
New Care Models	HIPC	153	1,047	1,200
Other	High Cost Placements - Learning Disability	500	0	500
Other	Homecare - Implement Outcomes Based Commissioning	750	0	750
Other	Contract Review	500	0	500
Other	Prepaid Cards	200	0	200
Other	Strength Based - High Cost Mental Health	775	0	775
Other	Strengths Based - All ASC Packages	500	0	500
Other	Shared Lives	150	0	150
Other	Prescribing	0	3,700	3,700
Other	Adalimumab Drug	0	1,596	1,596
TOTAL		**7,909**	**10,396**	**18,305**

1.4 The audit was undertaken to provide assurance to stakeholders in MCC and MHCC that the progress towards achieving savings was being effectively monitored and that timely action could be implemented if necessary to enable achievement of agreed savings targets. We conducted the audit with colleagues from MCC and MHCC to ensure that the effectiveness of the partnership working in terms of monitoring the Financial Sustainability Plan could be examined and information shared.

2. Conclusion and Opinion

2.1 We are able to provide **reasonable** assurance that the arrangements in place to monitor the delivery of the Financial Sustainability Plan (FSP) are effective. We confirmed that the processes in place provided a basis for effective monitoring and that the CCG and MCC finance officers worked in partnership providing comprehensive and up to date financial information for key stakeholders. However

in our opinion there were some gaps in the reporting framework and there were challenges experienced in ensuring that the savings targets were realistic or that timescales set were achievable.

2.2 Given the FSP is the vehicle for delivery of significant savings (£18.305m in 2019/20) we found that some information provided in delivery monitoring reports was not sufficiently comprehensive, accurate or up to date to allow for timely action to be taken to address any issues arising. In 2018/19 we found that the savings targets were overstated mainly due to delays in implementation, for example, when appropriately skilled staff could not be appointed. We confirmed that whilst there was a process in place to review any scheme that was failing to achieve target savings, there were inconsistencies in approach particularly in how the findings and proposed actions were recorded. Savings schemes also incur 'start up' and ongoing operational costs to support the processes that will generate the savings. It should be made clear to stakeholders that savings targets are not adjusted to cover the operating costs which need to be accounted for prior to allocating any savings achieved.

3. Summary of Findings

Key Areas of Strength and Positive Compliance

3.1 Manchester CCG in conjunction with MCC have a framework to provide regular monitoring of the Financial Sustainability Plan (FSP). The Board and Finance Committee for MHCC were attended by senior managers and members from both organisations and received regular detailed reports on the FSP delivery.

3.2 There were effective working arrangements between finance and planning officers from Manchester CCG and MCC to support delivery of the FSP. There was regular liaison between the finance officers to ensure MCC and Manchester CCG financial information was available for scrutiny for all aspects of the FSP.

3.3 The reporting framework between Manchester CCG and MCC provided an effective information flow for the FSP. It was noted that, while there was no formal reporting process direct to the Manchester Local Care Organisation (MLCO), the Director of Adult Social Care and the MLCO Director of Finance met every six weeks to discuss budgets and financial issues including progress on the FSP. MLCO were actively involved in the delivery of the MCC projects and therefore there was regular dialogue to support the FSP Progress Report.

Key Areas for Development

3.5 The FSP Progress reports needed to provide comprehensive and timely information to key stakeholders and should include costs associated with the development of the projects to generate savings. We confirmed the costing information was recorded by the finance teams but not then covered in monitoring reports to key stakeholders. The monitoring of savings generated should reflect the current position and the impact in terms of the scheme's ability to achieve the target set. In our opinion this was not clear in the reports we reviewed.

3.6 Deep Dive meetings were an effective management tool to review issues that could potentially impact on achievement of the forecast savings targets. There was inconsistency in how the meetings were recorded, particularly in relation to

identifying timescales for action to be taken and clear reference to the financial implications in terms of revised savings targets.

3.7 We were assured that there was review of progress and issues however the minutes of the Finance Committee examined were insufficiently detailed to demonstrate that the stakeholders were fully aware of issues arising, particularly where the savings target was not going to be reached or that appropriate challenge had been made and in our view could be enhanced The Finance Committee had oversight of overall financial performance and provided scrutiny of financial reports and assurance to the MHCC Board on matters of financial probity. We acknowledge that detailed discussions may take place in other forums such as the regular monthly finance officer meetings and 'deep dive' meetings for specific projects, but in our view should be referenced in the finance committee reports in relation to the key issues identified.

ES 17 Manchester City Council Internal Audit Report 2019/20

Adults Services

Follow Up Audit: Deprivation of Liberty Safeguards (DOLS)

Distribution - This report is confidential for the following recipients	
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Draft Report Issued	27 March 2020
Final Report Issued	28 May 2020

Audit Objective	**Overall Implementation Status**
To provide assurance over the implementation of audit recommendations agreed in response to the audit of Deprivation of Liberty Safeguards issued May 2019.	Implemented

1. Audit Summary

1.1 In early 2019 Internal Audit undertook an audit review of Deprivation of Liberty Safeguards (DOLS) to provide assurance over the arrangements for the statutory discharge of the legal requirements of the Mental Capacity Act 2005, and compliance with the Council's processes with regards to DOLS Urgent and Standard Authorisations.

1.2 Based on the work undertaken we provided a limited assurance opinion and made seven recommendations for improvement with agreed target dates for implementation between 30 August and 30 October 2019.

1.3 In order to provide assurance to the Accountable Officer (Executive Director of Commissioning & DASS), SMT, and Audit Committee, that progress had been made to reduce risk, we undertook a follow up audit in 2019/20 in line with policy where a limited opinion has been provided. The scope was to assess whether agreed actions had been completed to address the recommendations. This was an assessment of progress made with the implementation of the agreed audit recommendations and not a full re-review.

2. Conclusion and Opinion

2.1 The service had undertaken a significant level of work to address the issues identified in our report, despite the demands on staff due to the introduction of Liquid Logic and the unanticipated demands on staff due to issues with the data migration. Our review of progress confirmed that all of the seven recommended actions agreed had been implemented in line with expectations specifically:

- An increase in staffing and capability to deliver DOLS assessments.
- Improved process for screening and allocation of referrals.
- An increase and focus on capacity to authorise deprivation of liberty.
- An increase in direct recording.
- Improved engagement with Managing Authorities (and the contact centre) to reduce unnecessary referrals.
- Improved support for Managing Authorities for DOLS renewal process.
- Improved monitoring of DOLS conditions.

2.2 To comply with legislation DOLS referrals should be assessed within 21 days. For 2017/18 the average time taken nationally was 138 days, in Manchester it was 130. Due to the shortage of reporting currently available in Liquid Logic we were unable to determine the current status. It was clear from our testing that this would have been reduced significantly, although our testing identified that there were still cases taking over five months between referral and approved assessment. For example, there was clear evidence that there had been significant decreases in both the number of unallocated cases and the age of them.

	31 December 2018 (Original Audit)	9 March 2020 (Latest Figures)

Total number of referrals awaiting allocation.	1,014	280 (includes 27 awaiting screening)
Maximum age of unallocated referral	>24 Months	< 3 Months

2.3 At the time of our audit, management were clear that the recommendations and actions agreed could significantly improve the Council's management of DOLS, however it was also understood that it was unlikely to fully address them. This was agreed because at the time of the original audit we recognised that there were national issues with DOLS and that revised legislation was due to be introduced which would significantly impact on statutory requirements. This change is likely to include changes to standards, timescales and coverage. This legislation is still with parliament and the new standard (currently known as Liberty Protection Safeguards, LPS) has yet to be introduced.

2.4 We therefore concluded at the time of our work that there had been a significant reduction in overall risk and that the service is still working on further embedding the actions they have taken to reduce this risk. There are significant practical and resource challenges both locally, and national, to comply with the (soon to be replaced) legislation, and as such the Council is still exposed to risk in this area.

2.5 The original recommendations and current confirmed status of each are summarised in the table below:

Category	**Total**	**Implemented**	**Partially Implemented**	**Outstanding**
Critical	0			
Major	2	1, 2		
Significant	0			
Moderate	5	3, 4, 5, 6, 7		
Minor	0			
Total	**7**	**7**	**0**	**0**

2.6 Internal Audit now use four prioritisation categories, although five were in operation at the time of our original work.

2.7 Based on the work completed and assurance obtained we will include the reported status of these actions in our next update reports to SMT and Audit Committee.

Appendix 1: Status Update

Recommendation 1 (Major) The Assistant Director of Adult Social Care, supported by the Service Lead for Safeguarding Adults, should formally report to the

Director of Adult Social Care setting out what is realistically achievable within the current funding envelope, an indicative level of funding that would be required to meet statutory duties, and an assessment of the legal, reputational and financial risks should this shortfall not be addressed. We are aware that work has already been undertaken to make efficiencies in the processes. We are also aware that at the time of the audit the structure and processes were also being reviewed. Whilst this may make some improvement it is unlikely to be sufficient to address the shortfall between workload and capacity without further financial investment.

Internal Audit Assessment:

As part of the ASC Improvement Plan an investment business case had been developed and funding approved for the recruitment of extra Social Workers. Three of these were planned to be Best Interest Assessors (BIA) and to be located in the DOLS team, at the time of our review two had been appointed. The service had also offered support to existing Social Workers who wished to become Best Interest Assessors, to further increase the capacity of the team.

Based on the latest information provided which showed cases awaiting allocation up to 10 weeks old, and a small sample (10) cases reviewed where the assessment had been completed, the service is still not achieving the statutory requirement for an assessment to be undertaken within 21 days of the referral for all cases. At the time of our review a complete and accurate data set from LAS was not available to determine the average time taken. This issue also needs to be viewed in the context of a national average for assessment of over 130 days (based on reported figures for 2017/18).

The actions taken, whilst not fully addressing the issue, have reduced the risk to the service and the residual risk, is understood and accepted. As such we consider this recommendation **implemented**.

The service rightly considers that once the proposed legislative change to DOLS (currently called Liberty Protection Safeguards) passes parliament a further review of the service will be required. This legislation is likely to make fundamental changes to the eligibility and requirements for assessment which will significantly impact on the work of the service.

Recommendation 2 (Major) Following the screening of referrals using the ADASS Screening Tool the Service Lead for Safeguarding should ensure that where a case needs an assessment it should be assigned to a BIA to enable assessment at the earliest opportunity. Management advised they would address the backlog and improve the screening of referrals. Rather than allocate to BIA straight away the Team Manager would risk assess cases and allocate work based on professional judgment and competencies at the appropriate time.

Internal Audit Assessment: Despite delays due to the unexpected volume of work required for the implementation of Liquid Logic, there has been significant progress made in this area. Actions taken have included new processes, appointment of new staff, and a new focus on closing referrals where appropriate, including during initial screening. At the time of our original audit we identified that there were 1,014 unallocated referrals with 17 of them over 2 years old. The service has made major

improvements in screening and allocations. Based on the latest information provided there were 280 cases awaiting allocation, which included 27 recent cases awaiting screening, and none of these referrals was over 3 months old. However, the current statutory requirement is for the whole assessment to take 21 days from referral to decision, and this is still not achieved. Given the actions taken and progress made to reduce the risks in this area, the ongoing work to further reduce unallocated referrals, and the knowledge that the DOLS legislation itself is due to be superseded we consider this recommendation to have been **implemented.**

Recommendation 3 (Moderate) The Assistant Director of Adult Social Care, should determine which officers should, and have sufficient capacity to, undertake authorisations. Arrangements should then be developed to ensure sufficient authorisers are available to authorise DOLS assessments on a timely basis. As legislation doesn't make any specific requirements, it could be decided that the ADASS screen prioritisation tool could also be used to determine who is required to provide authorisation. With Senior officers involved where the ADASS tool identifies potentially problematic cases but with more routine cases being authorised at a less senior level. Once it has been determined who is going to undertake authorisations on behalf of the Council, the Service Lead for Safeguarding Adults should ensure that they undertake ongoing suitable and sufficient training to ensure that they are able to discharge their duties appropriately.

Internal Audit Assessment:

Those able to authorise DOLS were reviewed and a revised, slightly larger, list of Officers considered suitable was issued. At the same time a new rota was drawn up so that those included would be able to schedule the need to undertake the necessary approvals of assessments approximately once every 2 weeks. We were advised that individual conversations were being held with appropriate senior managers to determine if further training for them was required. At the same time the DOLS Team were available to offer support, training and guidance to Senior managers to enable the completion of this important area of work. As such we consider this recommendation has been **implemented**.

Recommendation 4 (Moderate)

The DOLS Team Manager, should brief his team (and the BSOs) to ensure that where possible all activity is recorded directly into MiCare, and monitor that this is the case. This includes recording in MiCare the reason cases are closed as No Further Action, and BIA assessments (excluding external BIA).

The MiCare replacement, Liquid Logic, may potentially include the facility to have a portal to enable external parties to report directly. Although a portal will not be available when Liquid Logic goes live, the Service Lead for Safeguarding should continue to engage with the project. Managing Authorities, external BIA, and MHA could all record directly if a portal to do so was available.

Internal Audit Assessment:

As part of the Liquid Logic implementation project all users were trained in the use of the system, this included the need to record activity directly. This has been further

reinforced by the Team Manager advising the team of the need to record directly.

The team's strategic goal is to move to in house assessments and thus minimise the need for external assessments which resulted in recording outside of the system and the requirement to then record into the primary record (previously MiCare and now Liquid Logic).In the short term, the need to address the backlog necessitated the use of external social workers who don't have access to Liquid Logic. The longer term plans, including the appointment of extra BIA, should result in an increased internal capacity and thus increase direct recording.

The Liquid Logic Team have advised that portals are not likely to be available in the immediate future, so no work on this has yet progressed. We consider this recommendation has been **implemented**.

Recommendation 5 (Moderate)

The DOLS Team Manager should continue to engage, either through training or improved guidance, with the Contact Centre to ensure that they are aware of the need to record referrals and contacts on open referrals differently.

We have been informed that the process for this in Liquid Logic should support the use of contacts on open cases generally, and thus reduce the likelihood of this arising as an issue post implementation

The DOLS Team Manager should continue to seek improved communication with Managing Authorities in order to support and educate them in respect of DOLS. (With a view to reducing multiple referrals.)

Internal Audit Assessment:

The Team Manager has provided a briefing to the Contact Centre on their role in the DOLS process and how they can help the process. The Team Manager has also engaged the three hospitals in Manchester (the largest Managing Authorities) to train them in the DOLS process and to try to influence how they deal with DOLS requests; particularly as there is a tendency for requests for relatively short term arrangements and multiple referrals for these. The Team Manager has also started to liaise with the other, smaller, Managing Authorities (e.g. care homes) with a view to improving their knowledge of the process and reducing duplication of work, however the level of return from this is relatively low due to smaller number of DOLS cases they manage.

Although not all Managing Authorities have yet been engaged, if multiple referrals from the large ones are stopped and if there is improved handling of referrals by the Contact Centre; then the risk of multiple referrals has been reduced significantly and as such we consider this recommendation is now **implemented**.

Recommendation 6 (Moderate)

The DOLS Team Manager should review the process for renewing authorised DOLS, where such renewals are likely to be needed, to ensure this is consistently

done in a timely manner and to ensure no gaps in authorisation.

Internal Audit Assessment:

A process is now in place for Business Support to monitor and manage renewal requests, and reminders are sent out to Managing Authorities 6 weeks before existing DOLS expire. This process is manual as Liquid Logic does not have the functionality to do this automatically, however we have confirmed as part of our testing that this monitoring is taking place and that reminders have been sent.

It should be noted that even though reminders are going out the onus is on the Managing Authority to request a DOLS renewal, and the reminders are not a guarantee that requests for renewals are made. In order to comply with the current legislation the Managing Authority who is depriving an adult of their liberty is required to make the request. One of the changes proposed for the Liberty Protection Safeguard (DOLS replacement) is that renewals for long standing cases will only be required every three years, however this has yet to be approved by parliament.

Although the risk still remains due to the requirement for Managing Authorities to make the request, as the DOLS team have made every accommodation to support them in this we consider this recommendation has now been **implemented**.

Recommendation 7 (Moderate)

The DOLS Team Manager should establish a process to confirm that DOLS conditions have been met once authorised.

Internal Audit Assessment:

A process is now in place, which includes a pro-forma report issued for confirmation to the Managing Authority of the conditions under which DOLS was granted. The Managing Authority is also contacted to verbally confirm conditions have been met, and this is then recorded on Liquid Logic. The BIA also confirms any conditions in place as part of any reassessment and this information is included as part of the renewals process.

We consider this recommendation has been **implemented**.

ES 18 Internal Audit Report 2019/20

Adults Directorate – Disability Supported Accommodation Service

Supported Accommodation: High Needs Decision Making

Distribution - This report is confidential for the following recipients	
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Draft Report Issued	14 February 2020
Final Report Issued	6 August 2020

Executive Summary

Audit Objective	Assurance Opinion	Business Impact
To provide assurance over the processes for assessment and funding decisions where additional needs for citizens in supported accommodation have been identified and delivered.	Limited	Medium

Sub objectives that contribute to overall opinion	Assurance
Strategy and policy	No
Governance arrangements including roles and responsibilities	Reasonable
Arrangements for assessment and review of need	Limited
Agreement and approval of funding	Limited
Monitoring and reporting to inform decision making	Reasonable

Key Actions	Risk	Priority	Planned Action Date
The DSAS Service Manager should ensure that there is a policy statement defining key principles and expectations for additional needs and a process map confirming actions and approval requirements. This should include any differences in the process for temporary, short-term, long-term, or permanent changes, and outline roles and responsibilities of Support Coordinators, Registered Managers, Social Workers, DSAS Management, and the Quality Assurance and Monitoring Panel, and make realistic allowances for workarounds where, for example, a reassessment by a social worker has been requested but not delivered.	Critical	3 months	Completed 1 August 2020
The Service Manager, Learning Disability and Shared Lives, should ensure that social work reassessments for all current DSAS citizens are completed as planned.	Significant	6 months	31 October 2020.
The chair of the QAM Panel should ensure	Significant	6 months	

Key Actions	Risk	Priority	Planned Action Date
that all decisions are not only recorded in the QAM minutes but also transferred to case notes of the relevant citizen's Liquid Logic record, to ensure a complete record of the decisions made about that person's care and support. Where approval for additional hours has been granted on a short-term or temporary basis, a mechanism should be devised to trigger further review and approval after the defined period and this should be defined in the supporting policy and procedures. The QAM should maintain an 'action tracker' to monitor such cases and request that the Social Worker or Registered Manager return to Panel to provide an update prior to expiry.			31 December 2020
Relevant DSAS staff, including at a minimum Registered Managers and the DSAS Operations Manager but possibly also Support Coordinators, should be given access to Liquid Logic. These staff should record case notes on the citizen records to ensure there is a complete record of: changes in care and support needs (whether due to specific events such as a safeguarding issue or fall, or due to gradual deterioration); requests for additional hours and the rationale for them; what additional hours have been put in place as a temporary measure and who has agreed these; and, requests for formal reassessment and reviews (there are already social work system processes in place for recording the outcomes of these reviews).	Significant	6 months	31 March 2021

Assurance Impact on Key Systems of Governance, Risk and Control

Finance	Strategy and Planning	Resources
Information	Performance	Risk
People	Procurement	Statutory Duty

1. Audit Summary

1.1 The in-house Disability Supported Accommodation Service (DSAS) provides support for around 140 citizens. The service budget for 2019/20 was forecast to be overspent by around £3m (27%) primarily due to increasing workforce spend, and agency costs in particular and this was being scrutinised by finance and adult services teams to assess the reasons for the overspend.

1.2 The budget for the service has remained relatively static since 2013/14 when the 'assignment' for each property was set, based on the care and support needs of the residents at that time. Changing or new care and support needs that cannot be met from the 'assignment' are considered 'additional hours'. Because these hours are not part of the budget, these can only be filled by agency staff. Approximately 40 citizens have been allocated a significant number of additional hours of support, and these costs are one of the primary drivers behind the budget pressures.

1.3 Internal Audit was asked to support the review into the overspend on the DSAS budget by providing assurance over the systems of control around decision making for assigned additional hours. We consider this is a high impact area given the size of the overspend and carried out a review of the arrangements from decisions through to authorisation for payment of additional hours.

2. Conclusion and Opinion

2.1 Overall, we can provide only limited assurance over the processes for the assessment and funding of additional hours. This was primarily due to a lack of clearly defined approach and supporting procedures for how and by whom such decisions should be made and authorised, and our testing found significant variation in practice. Numerous staff were involved in the delivery and management of the care and support of the citizens, including Support Coordinators, Registered Managers, Social Workers, Senior Managers within the Adults Directorate, and the Quality Assurance and Monitoring Panel (QAM). Roles and responsibilities of these staff in regards to high needs decision-making were not clearly defined.

2.2 Our testing found numerous gaps in the records to demonstrate when and on what basis the additional hours were introduced and who approved them. In nearly all cases, we could see that Social Workers were involved in the discussions, and they often created system case notes to document these. DSAS staff including Support Coordinators and Registered Managers did not have access to Liquid Logic (and previously MiCare) to record case notes, and decisions were approved via email making the record vulnerable to loss. The QAM discussions and decisions were minuted, but were inconsistently transferred to citizen case notes. Historic QAM minutes were not easily searchable to retrieve decisions. Where we were able to confirm that the additional hours had been clearly defined and formally approved, we often found that the new support plan had not been reviewed or the citizen's needs reassessed for up to several years.

2.3 A dedicated social work team had recently been put in place to undertake reviews of all DSAS citizens, some of whom had not been formally reassessed for many years. Around a third of the reviews had been completed by February 2020 and management have confirmed that the reviews have for the most part validated the existing additional hours. These early results provide some assurance that, while the historic introduction of the additional hours may not have always been approved in line with expectations, this had not resulted in inappropriate or excessive spend.

2.4 Controls in place for use of agency staff were examined due to concerns previously raised over the discrepancies between the hours of agency staff commissioned and actual hours billed and paid. The use of agency staff is necessary not just for additional hours, but also to cover for vacancies and staff absences. We identified some potential areas of weakness and non-compliance with established procedures, but detailed testing was not possible in the time available. The Senior Finance Manager and Resourcing Team Manager are continuing to investigate the discrepancies in more depth.

3 Summary of Findings

Key Areas of Strength and Positive Compliance

3.1 Weekly leadership meetings were attended by all Registered Managers and the DSAS Operations Manager and Service Manager to discuss and recommend placements of newly referred citizens. If a suitable placement at an in-house DSAS property is identified, the support plan is quality assured and the costs, including any additional hours, must be agreed by the QAM. Two of 11 citizens in our sample were new referrals and we confirmed that their initial support plans were agreed by the QAM as expected.

3.2 The DSAS Operations Manager and Service Manager had worked with Support Coordinators and Registered Managers to establish a single record (maintained on a google sheet) of all citizens currently receiving additional hours, including the reason and effective date. Our testing confirmed these hours were consistent with what was actually being delivered in line with documented assignments and staff rotas in each property, and where there were discrepancies, these could be explained.

3.3 Our testing sought to review the decision-making and approval process for a sample of 11 citizens with significant additional hours. We reviewed the citizens' MiCare / Liquid Logic records and asked each Registered Manager and co-chairs of the QAM to provide any further evidence held outside the system, such as emails or minutes. This exercise identified some good examples of clearly defined support plans that were approved by the QAM and decisions clearly recorded as per expectations.

Key Areas for Development

3.4 QAM minutes evidenced scrutiny and challenge of requests for additional hours, as well as formal approval. However, extracts of the minutes were inconsistently transferred as case notes to the relevant individual's system record (Liquid Logic / MiCare). Full minutes were retained as google documents, but searching for confirmation of a specific decision was difficult, and the documents themselves are vulnerable to loss through accidental deletion or staff turnover.

3.5 There was no overarching policy and procedure to describe the expected process for requesting, approving and implementing additional hours.

3.6 Citizen support plans should be formally reassessed by a Social Worker every 12 months at a minimum, or earlier in response to a change in needs. It was widely acknowledged that this has not been happening, primarily due to workforce resourcing pressures, and this was confirmed in our testing. Our sample included citizens who had been reassessed in response to changing needs and whose support plan reflected their current care package, but whose needs had not been reviewed since then (up to three years), as well as citizens whose needs and support packages had significantly changed without any formal social work reassessment. The lack of timely reassessments contributed to our overall opinion, but we recognise that senior management were already aware of the issue and have taken action in establishing a time-limited social work team to undertake reviews of all DSAS supported citizens. This work to update reviews is fundamental in driving improvements in this area and ensuring that all support plans are current and supported by a timely reassessment. We have therefore raised a significant recommendation to help ensure that impetus to complete remaining reviews is maintained.

3.7 Our testing of the decision-making and approval process for a sample of 11 citizens identified numerous instances of a lack of clarity and transparency; for example, where the records were conflicting or unclear, or where there was no clear and obvious approval of the decision. Our sample identified several instances where

the decision / approval was clearly temporary pending further review, and we could not determine whether the review either did not happen or it happened but was not recorded, and the additional hours continued to be delivered in the longer-term without further formal approval.

3.8 We found examples of support plans that had been approved by the QAM as expected, but the additional hours were not clearly defined and/or the costs did not appear to have been calculated correctly.

3.9 There was a Resourcing Team responsible for arranging agency cover as needed, and who also approved agency workers' timesheets by cross-referencing hours claimed against the records of commissioned hours. This team had experienced a high degree of turnover and coupled with the high volume of agency use, this had created pressures on the team's capacity. In our view this could potentially explain some of the discrepancies between commissioned and claimed hours. We agree with management that further work in this area is needed.

3.10 Property rotas were created on a six-weekly cycle by the Support Coordinators, and should have been signed off by the Registered Managers. Both Registered Managers we met about this acknowledged that their sign-off was usually verbal, despite an agreed process that required physical sign-off. This also meant that the Resourcing Team Manager had no confirmation that any changes in staffing levels had been approved at an appropriate level prior to commissioning additional agency shifts.

ES19 Internal Audit Report 2019/20

Neighbourhoods and Growth & Development – Community Safety, Compliance and Enforcement

Trading Standards

Distribution - This report is confidential for the following recipients	
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Draft Report Issued	12 March 2020
Final Report Issued	19 March 2020

Executive Summary

Audit Objective	Assurance Opinion	Business Impact
To provide assurance that there are effective arrangements in place to reduce the supply of unsafe products/services through advice and enforcement action.	Substantial	Low

Sub objectives that contribute to overall opinion	Assurance
There is an established process for handling Trading Standards referrals	Reasonable
Referrals are progressed in line with the established process	Substantial
Case records are regularly updated in a timely manner with appropriate information	Substantial
Appropriate management information is produced to support case and performance management and inform decision making	Substantial

Key Actions	Risk	Priority	Planned Date
No significant or critical recommendations	NA	NA	NA

1. Audit Summary

1.1 Trading Standards has not previously been subject to internal audit therefore we agreed with the Strategic Director to include this area on the 2019/20 audit plan. The service undertakes various types of work covering counterfeiting; product safety; sale of age restricted products; rogue traders; doorstep scams and regulation of weights and measures. We agreed to review the arrangements in place for product safety (including sale of age restricted products) as per the key priorities and actions in the service's 2019/20 delivery plan.

2. Conclusion and Opinion

2.1 We can provide a **substantial** assurance opinion of the arrangements in place to reduce the supply of unsafe products/services through advice and enforcement action.

2.2 System design and team structure was appropriate to respond to risks and roles and responsibilities were clearly defined. Although formalised written procedures were not available for all aspects of Trading Standards, procedures for unsafe products/services were created prior to our fieldwork start and there were established processes for how to progress complaints and enquiries that were held

consistently by management and officers with many years of experience in these areas.

2.3 There was a high level of positive compliance with referrals. Over 95% of cases reviewed were progressed in line with both case level procedures/management expectations and the broad approach outlined in the Corporate Enforcement Policy. Case records were regularly updated in a timely manner with appropriate information.

2.4 Various levels of management information were produced to support case and performance management as well as to inform decision making.

3 Summary of Findings

Key Areas of Strength and Positive Compliance

3.1 There is a clear structure and clear roles and responsibilities within Trading Standards and management have a comprehensive and reasonable approach to the service.

3.2 We reviewed 50% of the service requests from Quarter 1 of 2019/20 (28 of 56) and 21% of the annual programmed inspections from 2019/20 (11 of 52). Action taken showed high levels of positive compliance. 37 of the 39 cases reviewed were in line with the corporate enforcement policy and procedures and expectations (95%).

3.3 Case files on Flare (the case management system currently used in Neighbourhoods) were comprehensive and enabled progression of the cases and enforcement action taken to be easily tracked. Case records were updated in a timely manner with appropriate information.

3.4 Trading Standards use the Corporate Enforcement Policy which clearly outlines enforcement expectations and were involved in its design.

3.5 Management reporting was undertaken at various levels both internally and externally. Internal reporting includes the high risk inspections programme and reporting on workload and officer cases to inform supervisions/performance. The Data and Intelligence Team also undertake quarterly Flare reporting and quarterly ward reporting (which feeds into the annual Compliance and Enforcement Service report to scrutiny). External reporting includes the value of unsafe/non-compliant products prevented from entering the country (sent to National Trading Standards quarterly), statutory returns on Weights and Measures and quarterly reports on seizures and counterfeiting to Trading Standards North West (TSNW). It was clear where these were being used to inform decision making, for example quarterly reporting of fraud, unfair trading & safety cases referred via Citizens Advice are used to identify trends & develop actions for repeat rogue traders.

3.6 There was adequate management oversight of casework. Regular supervisions were documented and included casework review and setting of relevant objectives.

Key Areas for Development

3.7 There was limited formally documented procedures for a number of the areas of work within Trading Standards (procedures were created for unsafe products and services prior to our fieldwork start).

3.8 There were a number of cases with minor administrative errors. These did not impact on the action taken or compliance with procedures or the Corporate Policy therefore no formal recommendation has been made, however some could lead to reporting errors therefore should be rectified. A list of these has been provided to management.

3.9 The use of Flare templates and embedded documents in Flare would improve consistency and reduce the number of administrative errors. Whilst we note the experience of staff, management accepted this as a development area, particularly given the potential arrival of new staff.

3.10 Identification of high risk premises was largely reliant on intelligence / complaints being received as there was no requirement for this type of premises to be registered. Whilst this is accepted as an inherent risk, the service have agreed to consider whether any more proactive steps can be taken to ensure the number of high risk premises captured on the system is maximised and included in the programme.

3.11 We note that case updates and time stamps on the Flare system can be edited therefore it is difficult to know when actions were actually taken and if notes are contemporaneous. There was no suggestion that there had been any edits to cases, however we have raised with management that the issue be considered as part of the planning for the replacement of the Flare system (a supplier is due to be selected over the coming months).

3.12 Trading Standards is a service that has found Performance Indicators difficult to establish. A data return to the Association of Chief Trading Standards Officers (ACTSO) was completed for the first time last year which appears to establish more meaningful reporting and potential KPIs. Trading Standards should continue to work with the Data and Intelligence team to try and develop this reporting and also use the information to inform the new system design.

ES20 Internal Audit Report 2019/20

Growth & Development

Planning Applications

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Draft Report Issued	19 March 2020
Final Report Issued	12 May 2020

Executive Summary

Audit Objective	Assurance Opinion	Business Impact
To provide assurance that there are effective arrangements in place to ensure that all planning applications are processed in line with local and national guidelines.	Substantial	Medium

Sub objectives that contribute to overall opinion	Assurance
Applications are validated and the correct fees received	Substantial
Adequate and timely consultations take place where appropriate	Substantial
Decisions are authorised in line with delegated powers	Substantial
A complete record of all documents, including the decision, is maintained	Substantial
Adequate responses are provided to appeals made	Substantial
Management information supports performance management and decision making	Substantial

Key Actions	Risk	Priority	Planned Action Date
We have not made any significant or critical recommendations.			

Assurance Impact on Key Systems of Governance, Risk and Control		
Finance	Strategy and Planning	Resources
Information	Performance	Risk
People	Procurement	Statutory Duty

1. Audit Summary

1.1 Most new developments, major changes to the structure or use of existing buildings or the local environment require planning permission from the local planning authority.. Manchester City Council (the Council) is responsible for this function and if it is in line with the Government's planning guidance and local planning policies. In 2018/19 the Council received 4,279 planning applications which generated £3.4 million in related fee income.

1.2 The planning application process had not been audited for a number of years and was therefore included in the 2019/20 annual audit plan. We selected a sample of planning applications that had been determined to ensure that:

- Applications had been validated and the correct fees were received.
- There was evidence of adequate and timely consultations with neighbours and other interested parties.
- Decisions were appropriately authorised.
- All documents (including the Decision) were retained and recorded as part of the Councils' Planning Register.
- Adequate responses were provided to the Planning Inspectorate regarding any appeals made.
- Management information supported performance management and decision making.

1.3 Building Control and Planning Enforcement operations were not included as part of this review.

2. Conclusion and Opinion

2.1 Overall we can provide **substantial** assurance over the system for determining planning applications. Staff demonstrated a clear understanding of the processes and timelines required and the system had been mapped to ensure that key actions and controls were understood. There had been no operational issues with the Uniform system, which provided sufficient case management functionality.

2.2 Arrangements for validation and processing of planning applications and fees were effective. Applications were only processed when the correct fees had been received. Most applications were made via the national Planning Portal which only transmitted the application to the Council once the correct fee had been paid. Applications were only passed onto Planning Officers after they had been validated by the Technical Support Team.

2.3. All necessary notifications, consultations and comments received relating to planning applications had been recorded on the UNIFORM system and could also be viewed on the Public Access website. On all applications we tested, decisions were made within Government prescribed timescales.

2.4 The Council complied with its statutory requirement to maintain a Planning Register. The public access element of the UNIFORM system (which could be viewed via the Councils' website) was the Planning Register and it recorded

details of all applications made and determined since 1974 and all appeals since 2003.

2.5 Adequate and timely information was provided to the planning inspectorate for the cases that we reviewed. We considered that management information was sufficient to support performance management.

3 Summary of Findings

Key Areas of Strength and Positive Compliance

3.1 All Planning Applications received by the Council were recorded on the UNIFORM system, which was then used to process all planning applications. The system produced two versions of the application: the complete version and a public version (with personal information redacted). The public version allowed comments and objections to be made during the consultation period and complied with the statutory requirement for the Council to maintain a Planning Register.

3.2 The UNIFORM system automatically calculated the date by which an application had to be determined depending on whether it was a minor or a major application. These dates were recorded on the paper files used by the Planning Officers to ensure that applications were determined within the statutory guidelines.

3.3 The system had built in controls with permission levels granted to Planning Officers dependant on their grade and assigned responsibilities which allowed for the review and authorisation of planning decisions together with the generation of Decision Notices when applications had been determined. Only the system administrator had the ability to make amendments to determination deadlines or data once an application had been finalised.

3.4 We examined 17 planning applications where decisions had been made after 01 April 2019 and we found that the fees charged were correct and correctly accounted for.

3.5 We reviewed five planning applications where an appeal had been submitted to the Planning Inspectorate. All information requested had been provided and the decisions had been recorded on UNIFORM as well as the public version of the Planning Register in line with requirements.

3.6 The UNIFORM system allowed various reports to be produced. Examples included: numbers of applications, type of applications and fee income. Senior Managers and Principal Officers could view or generate reports. These could be viewed in various ways including for the whole service, by team/area and for individual officers against targets. Each planning officer could see their own performance when they logged into the system. The team used this information to effectively manage performance and support decision making.

Key Areas for Development

3.7 There are no key areas for development identified from the work we have completed. We have made two minor administrative recommendations to enhance compliance.

ES 21 Internal Audit Report 2019/20

Neighbourhoods Directorate

Leisure Services Contract: Performance Management Framework

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Draft Report Issued	24 March 2020
Final Report Issued	29 April 2020

Executive Summary

Audit Objective	Assurance Opinion	Business Impact
To provide assurance over the design and operation of the leisure services contract performance framework.	Reasonable	High

Sub objectives that contribute to overall opinion	Assurance
There is a robust process in place for contract performance management.	Reasonable
Roles, responsibilities and expectations are clearly defined and met.	Substantial
There are established Key Performance Indicators and targets which reflect the objectives of the contract and are linked to continuous improvement.	Reasonable

Key Actions	Risk	Priority	Planned Action Date
Improvements in the evidence trail supporting decisions to allow changes to pricing, programme and buildings.	Significant	6 months	31 December 2020

Assurance Impact on Key Systems of Governance, Risk and Control		
Finance	Strategy and Planning	Resources
Information	Performance	Risk
People	Procurement	Statutory Duty

1. Audit Summary

1.1 The Council's leisure services are commissioned through a contract with Greenwich Leisure Limited (GLL) which began in December 2018 and is for nine years and three months with a further extension of five years built in. The contract was valued at around £18 million and was performance managed by MCRactive which is a wholly owned subsidiary of the Council. Given the importance of the need for the contract to be successfully delivered for citizens of Manchester Internal Audit agreed to review the design and operation of the performance framework as it moved into the second year of the contract. Given the level of expenditure associated with this contract and its importance to the Council and citizens we classified this area of Council operations as having a high business impact.

2. Conclusion and Opinion

2.1 We are able to provide a **reasonable** level of assurance over the design and operation of the leisure services contract performance framework.

2.2 Performance monitoring activity was wide ranging and took place on a regular basis. There was an established and well embedded governance structure to enable robust review and challenge over performance and there was evidence of action plans being developed to address areas requiring further action or improvement. Tracking tools were in place to allow for outstanding actions and progress to be monitored until resolved.

2.3 The importance of continuous improvement throughout the life of the contract was evident and there was a positive and constructive working relationship between the client and contractor. This was evidenced by examples where a more pragmatic approach over some processes were adopted without compromising the terms of the contract. There was an appetite from the contract management team for the performance framework to continue to develop and evolve which was helped by the Contractor's openness to change and improvement.

2.4 Some of the data included in quarterly client reports to the contract management team was presented in isolation and not against a target or previous position making it difficult for the reader to interpret what the data showed. However we acknowledge that comparative figures will be included moving forward as the aim of the first year involved gaining an accurate baseline against which to monitor future performance. This will make the data presented more meaningful and should enable more analysis and targeted challenge to take place where required.

3. Summary of Findings

Key Areas of Strength and Positive Compliance

<u>Roles and Responsibilities</u>

3.1 The responsibilities of both the Council and contractor were clearly defined in contract documentation. Our work confirmed these were well understood by the contract team who could articulate expectations and roles.

3.2 A dedicated and experienced contract management team was in place which provided assurance that there were resources assigned to ensuring the contract was managed. Whilst the team previously had been impacted by some staff turnover our review nonetheless confirmed the check and challenge role had continued to be maintained to ensure the day to day fulfilment of the contract.

3.3 There was evidence of a high degree of engagement with the Contractor through the governance structure which included review meetings with key officers with an involvement in the running of the contract and open dialogue.

3.4 Contract documentation included key performance requirements of the contract and in the first 12 months of the contract the purpose was to capture a baseline of performance as an accurate benchmark against which performance can then be assessed. This was being achieved.

3.5 The Council's Commercial Lead had become the assigned contract manager and cost centre manager following the contract team's transfer to MCRactive. This change had prompted some minor adjustments as a result of a different perspective, having not been involved in the contract previously. This also provided some additional assurance that the data being reported was complete and sufficient for the Council's needs.

Performance Management

3.6 The contract team had direct access to the Legend system (leisure management software used by the leisure centres) allowing contract management officers to drill down into reported figures and prompt further discussion or enquiry where necessary.

3.7 The need for manual entry of data onto the Legend system had reduced since the previous contract due to increased use of electronic entry by visitors to record participation statistics rather than manual recording by reception staff. This provided greater assurance over the accuracy of data being reported particularly in relation to participation figures and member details.

3.8 The Contractor submitted a suite of reports quarterly as required which facilitated scrutiny ahead of the quarterly review meeting. This enabled any clarification points to be addressed effectively.

3.9 The importance of continuous improvement throughout the contract term was demonstrated through the flexible approach to the amendment and improvement of monitoring arrangements. Recent examples of the evolving performance framework included the introduction of statutory and best practice compliance checks by the Facilities Contracts Manager and the exploration of options for Council officers visiting the centres in their spare time to provide feedback or comments on service quality.

3.10 We were informed that roll out of CPAD (the electronic system used to maintain data on all the Council's land and property portfolio) is imminent. This will help to provide assurance over the building and property related checks as it enables ease of access by the contract management team to relevant records to confirm compliance and this includes for example service history.

3.11 Neighbourhoods DMT was provided with a quarterly dashboard including statistics around attendance at sports and leisure facilities. The most recent report highlighted that over the last 12 months visits have almost reached the 3.5m mark against a target of 3.08m and were up on 6% on the same period last year which was a positive outcome.

3.12 Issues logs were in place to allow recording and tracking of outstanding issues at leisure centres which provided assurance that focus continued to be given to required actions resulting from monitoring visits undertaken by the contract management team. A review of the logs confirmed issues were grouped under the following headings; staffing, facilities issues, complaints, programming, community development and membership.

3.13 There were regular performance reviews to gain assurance over the delivery of the statutory element of the contract around Education Swimming with half termly review meetings and actions required in areas of slippage.

4. Key Areas for Development

4.1 The Contractor should not make any changes in regard to product, pricing or building modifications without the expressed permission of the Council. Our review highlighted much of the supporting evidence to assure change management actions taken was held within Council email accounts and therefore inaccessible and at risk of loss over time. We recommend that a key decision log is introduced as part of the contract management records and reliance on email reduced. In our view this should also be used to record any formal contract variations which may occur throughout the life of the contract and needs to be formally recorded. The view of the Head of Parks, Leisure, Youth and Events was that the email accounts and proposal documents are accessible to the Council as all decisions would have been approved by him and these could still be retrieved however, we still consider this to be a risk should there be changes in IT systems and key officers during the life of the contract.

4.2 The contract had not been signed although Legal Services were currently working to progress this. We acknowledge there were legitimate reasons for this delay which management confirmed as including:
-Clarifications and further considerations resulting from the procurement process.
-In early 2019, the Council asked GLL to step in and add an additional asset to the contract following another contractor going into partial administration, which required extensive negotiation.
-In January 2020, the Council asked for changes to the contract to include another facility - Ghyll Head.

Once completed it was intended that this should be signed by both parties for completeness but there was no confirmed date at the time of our work.

4.3 Application of the corporate classification tool by Neighbourhoods commissioning officers determined the contract to have a gold rating. This meant that the contract presented the Council with a high level of inherent risk based on the nature and scale of the service provision. Whilst there was a

clear focus on the performance of the contract we identified a shortfall in checks undertaken to assure the ongoing financial stability of the Contractor. We have recognised through other recent work that inadequate ongoing financial due diligence could place Council contracts at risk. As recommendations are already being taken forward by the Head of Integrated Commissioning and Procurement (which include enhancing contract management guidance to include a section on ongoing due diligence), an assessment of whether this is required for this particular contract in advance of the development of a more robust approach to this challenge corporately should be undertaken. Once a corporate approach to this has been defined this should be adopted to provide ongoing assurance over the financial resilience of the contractor.

4.4 Social value related performance was being reported however this would benefit from some greater consistency. The contract management team identified that some of the social value KPI's have been reported in the wrong section and a high proportion of additional community based social value outcomes and environment sustainability improvements were in a separate community quarterly report. This has recently been addressed with the contractor and the contract management team anticipate this feedback will be reflected in the next quarterly submission.

4.5 The contract management team had recently begun data verification checks to confirm the accuracy of data submitted by leisure centres. However there was no record of this to confirm which figures or leisure centres were checked. There was no means by which to demonstrate comprehensive checking and or whether future monitoring activity was being targeted where required.

4.6 Profit and income figures were included in the quarterly client report. The contract management team should work with the Contractor to determine how they can get assurance over the accuracy and completeness of the financial information being reported given this sits outside of the Legend system.

4.7 There was a large amount of raw data collected in relation to citizens use of leisure facilities which is a requirement of the contract and there are clear KPI’s that are reported against, monthly, quarterly and annually to the contract management team. We however considered the reporting within the Council to be fairly limited focusing on footfall. We are aware that options for enhancing the data being reported is in progress in order to maximise the use of the raw data and a Digital Investment Case has been developed and approved to design and build a solution that will help to improve this. This work is currently in development and is due to be completed by September 2020.

ES 22 Manchester City Council Internal Audit Report 2019/20

Corporate Core: Corporate Services Directorate

Follow Up Audit: Framework Agreements - Contract Governance

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Report Issued	19 February 2020

Audit Objective	Overall Implementation Status
To provide assurance over the implementation of audit recommendations agreed in response to the audit of Framework Agreements - Contract Governance issued January 2019.	Implemented

1. Audit Summary

1.1 In January 2019 Internal Audit undertook an audit/assurance review of Framework Agreements - Contract Governance to provide assurance over the contract governance arrangements supporting Council framework agreements.

1.2 Based on the work undertaken we provided a limited assurance opinion and made the following number of recommendations for improvement with agreed target dates for implementation of 31 December 2019.

Priority	Accepted	Rejected
Critical	0	0
Significant	5	0
Moderate	2	0
Minor	0	0

1.3 In order to provide assurance to the Accountable Officer (SMT Chief Officer), SMT and Audit Committee we undertook a follow up audit to confirm whether the exposure to risk had reduced.

1.4 This was not a full re-review of contract framework governance but rather an assessment of progress made with the implementation of the agreed audit recommendations.

2. Conclusion and Opinion

2.1 Our review of progress against these recommendations shows that all recommendations have now been implemented. As a result we therefore conclude there is a reduction in the overall exposure to risk in this area.

2.2 The original recommendations and current confirmed status are attached at appendix 1.

2.3 The explanation of recommendation prioritisation and follow up assurance is attached at appendix 2.

2.4 Based on the work completed and assurance obtained we will include the reported status of these actions in our quarterly update reports to SMT and Audit Committee.

Appendix 1: Status Update

Recommendation 1 (Significant)

The Head of Integrated Commissioning and Head of Procurement should ensure that there are clear tools to ensure that the distinct responsibilities of call off managers and the overall framework manager are defined and shared from the outset. This could form part of the corporate guidance currently being produced for contract managers. We suggest the use of a template to outline the allocation of key responsibilities along with any reporting expectations and escalation procedures. This should be completed as part of the implementation documents for a framework.

The template should include the following key responsibilities:

- Supplier insurance checks.
- Monitoring of social value contributions.
- Collection of KPI information.
- Complaints escalation.
- Any key information specific to the individual framework.

Internal Audit Assessment:

The Integrated Commissioning and Procurement Team have produced guidance on the management of frameworks, this includes the expectation of who will manage the aspects outlined above and the importance of ensuring clarity over roles for any framework requirements which are not included in the guidance.

The guidance has been now been published on the Integrated Commissioning intranet pages and as such is available to all officers.

As such we consider this recommendation is now implemented.

Recommendation 2 (Significant)

The Head of Integrated Commissioning should provide guidance for framework managers outlining minimum standards of monitoring to be undertaken in order to assess overall performance of the framework. This may include:

- The value and number of call offs allocated to each supplier.
- Number of complaints received.
- Any work allocated outside of the approved allocation system and reasons for this.
- Amount / type of social value received (potentially on a per supplier/per call off basis).
- Client satisfaction.

This should also include the need for senior officer scrutiny, oversight and assurance to ensure that value is not lost from the contract, to assist with decision making and to inform future commissioning. Thought should also be given as to whether this information should be incorporated into the framework agreements as framework level KPIs and how the development of such framework KPIs can be

developed going forward.

Internal Audit Assessment:

The guidance produced by Integrated Commissioning and Procurement includes key measures that should be recorded and monitored by the Framework Manager in order to ensure that the framework is working efficiently and effectively and to allow oversight and scrutiny by Senior Management.

This guidance is now available on the Integrated Commissioning intranet pages and as such is accessible to all officers. As such we consider this recommendation is now implemented.

Recommendation 3 (Significant)

The Head of Procurement and Head of Legal Services should ensure that a set method for selecting suppliers from a framework is agreed at the beginning of the framework and recorded within the contract report and, as required, the contract documentation. This will ensure the justifications over selection decisions can be shown to be fair and transparent to prevent the risk of legal challenge.

Internal Audit Assessment:

Legal Services and Corporate Procurement reviewed the process in June 2019 following the recommendation being made. Key officers confirmed they were satisfied with the existing process which includes the completion of tender templates and report templates (which require the rules of the framework to be included), and is supported by a template stakeholder framework pack. The requirement for the framework selection method to be recorded in framework contracts was communicated at the Contracts Lead Group in September. Our review of recent contract reports show that these have all included the relevant details.

As such we consider this recommendation is now implemented.

Recommendation 4 (Significant)

The Head of Strategic Commissioning with the Head of Procurement should ensure that expectations around framework cost control are determined along with the need for this to be suitably resourced. This could be framed as part of wider guidance on required resources to manage different elements of a framework such as dealing with queries from other authorities where the framework is open to use by other parties or guidance over the level of sample testing that should be undertaken based on the value and number of transactions processed.

Internal Audit Assessment:

The guidance produced by the Integrated Commissioning and Procurement Team covers how cost control responsibilities should be split between the Framework and Call Off Managers which clarifies the respective roles of each. The guidance also makes clear the need to share information between the two roles to ensure that each can carry out their role effectively.

As such we consider this recommendation is now implemented.

Recommendation 5 (Moderate)

The Head of Strategic Commissioning with the Head of Procurement should ensure responsibilities over monitoring the delivery of social value are clearly allocated at the outset of the framework and should be incorporated into the roles and responsibilities document recommended at 1 above.

The Head of Procurement should ensure that tender documents are clear on whether there is the ability to aggregate social value across call off agreements and the process that will be used for this should be set out based on the specific terms of the framework. (E.g. a framework with a few high value call offs is unlikely to need such a clause while it may be more beneficial to one with lots of smaller call offs).

The Head of Integrated Commissioning in liaison with the Head of Legal Services should raise awareness as part of the planned training for contract managers over the actions that can be taken for non-delivery of aspects of the agreed tender.

Internal Audit Assessment:

The guidance issued by the Integrated Commissioning and Procurement team clarifies the respective roles of the Framework and Call Off Managers in respect of Social Value. It also provides an overview of the different approaches that frameworks can take in regards to social value with indicators of where to go if further guidance is needed for individual frameworks. We were informed that key officers have decided that it is not beneficial to aggregate social value over multiple call off agreements on revenue contracts, this will however be kept under review as future framework contracts are let.

As such we consider this recommendation is now implemented.

Recommendation 6 (Significant)

The Head of Strategic Commissioning with the Head of Procurement and Head of Legal Services should review and enhance the documentation used for framework allocations. This should address how penalties for lack of, or inadequate, delivery of key aspects of the contract (including social value) can be imposed.

Internal Audit Assessment:

We have reviewed a number of recent framework contracts and confirmed that the wording has been amended to make clearer the implications of non-compliance and the ability of the Council to suspend or remove suppliers from the framework.

As such we consider this recommendation is now implemented.

Recommendation 7 (Moderate)

The Head of Integrated Commissioning should create guidelines over the level of supplier interaction/ meetings expected in regards of frameworks. This should include recommendations based on the value and amount of work allocated via the

framework and whether suppliers who have not been allocated work should also be subject to regular meetings.

Internal Audit Assessment:

The guidance issued by Integrated Commissioning and Procurement makes clear that management of a framework falls within the remit of the Council's standard contract monitoring guidelines and therefore the level of supplier interaction should link to the criticality level assigned. It also clarifies the need to monitor agreements at both the framework and call off level dependent on the criticality of each and that as such monitoring should be set at each level.

As such we consider this recommendation is now implemented.

ES 23 Internal Audit Report 2019/20

Corporate Core – Capital Programmes

Capital Frameworks: Call off Selection and Award

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Draft Report Issued	20 January 2020
Final Report Issued	19 February 2020

Executive Summary

Audit Objective	Assurance Opinion	Business Impact
To provide assurance over the contractor selection and award process in respect of capital framework call off contracts.	Reasonable	High

Sub objectives that contribute to overall opinion	Assurance
Awards are made in compliance with the terms specified in the framework agreement.	Reasonable
There is transparency over decision making.	Substantial
There is appropriate oversight and monitoring arrangements to assist in decision making.	Reasonable

Key Actions	Risk	Priority	Planned Action Date
Responsibility for undertaking insurance checks should be clearly allocated and communicated and checks should be undertaken annually.	Significant	6 months	29 February 2020
The process for recovering management fees for capital frameworks should be reviewed.	Significant	6 months	30 June 2020

Assurance Impact on Key Systems of Governance, Risk and Control		
Finance	Strategy and Planning	Resources
Information	Performance	Risk
People	Procurement	Statutory Duty

1. Audit Summary

1.1 During 2018/19 we undertook work to provide assurance over the contract governance arrangements for a sample of revenue framework agreements culminating in recommendations to improve the overall approach to the management of Council frameworks. Given the inherent risks associated with framework agreements and requests from Audit Committee for further work in this area we agreed to build on this work with a focus this time on capital frameworks.

1.2 The Capital Programmes Division responsibilities include the management of construction and property frameworks on behalf of the Council. Our audit considered the controls in place surrounding the three frameworks that form the North West Construction Hub (NWCH) and the Small Works Framework. Given the level of expenditure associated with capital frameworks and the risks associated with contractor selection and award of work we have classified this area as having a high business impact.

2. Conclusion and Opinion

2.1 We are able to provide a reasonable level of assurance over the contractor selection and award process. While responsibility for undertaking call offs for NWCH was split between the NWCH framework team and the client there was a clear expectation for clients to provide copies of information in support of the decisions made. From our sample testing we were assured that this was being received and for the small works framework a direct allocation reasoning sheet was used to support the allocation of a contractor. We suggested a small adjustment to the form during our work to further enhance the decision making records being maintained.

2.2 There was some ambiguity around the completion of checks to confirm sufficient insurance cover was in place. The NWCH client guide stated that the NWCH framework team would complete insurance checks on contractors which was not taking place, while the position regarding insurance checks had yet to be clarified for the Small Works Framework. It was confirmed after the draft report had been issued that the Commercial Performance and Compliance Team had recently started a process of confirming insurance levels for contractors across Capital Programmes including the NWCH.

2.3 We also reviewed the process around the recharging of the management fee and found that as charges were not made until after a contract was signed this could mean there are significant delays in invoicing the fee. In some cases a project may be cancelled before a contract is signed meaning no fee is received despite work being undertaken by the team on this.

3. Summary of Findings

3.1 As part of our audit testing we reviewed the three frameworks that form the NWCH framework and also the Small Works framework.

3.2 The NWCH frameworks cover capital works with a split on the basis of value, the individual frameworks are known as the low, medium and high framework. Call offs from the frameworks will be for projects with values between £500,000 and £35million+, with the framework open to a wide number of

clients including Manchester City Council. Call offs are allocated via a mini competition process.

3.3 The Small Works framework covers capital projects with a value of up to £500,000. They are normally projects which need to be undertaken quickly and at short notice, as such allocations from this framework are normally by direct allocation (an individual supplier is identified and offered the work) though it is possible to undertake mini competitions on the framework. This framework is open to other authorities to access, however the main client so far has been Manchester City Council.

Key Areas of Strength and Positive Compliance

3.4 The responsibilities of both the framework team and call off client were clearly defined for the three NWCH frameworks within the client guide. Our work confirmed these were well understood by the framework team with the exception of the discrepancy over insurance checks as described above.

3.5 A dedicated contract management team was in place for all frameworks examined which provides assurance that there are assigned resources to the frameworks.

3.6 There was evidence of a high degree of engagement with the NWCH framework from contractors resulting in multiple bids for all NWCH tenders reviewed meaning clients could be assured that they were achieving competitive bids through the call off process.

3.7 KPIs were outlined within the overall framework contract with additional detail being held by the team should the calculation method need to be clarified.

3.8 Templates were in place to support NWCH clients through the tender process in a manner that ensures compliance with the framework. Copies of documents supporting a tender and the decisions made throughout the tender process were retained by the Hub.

3.9 A process for recording and reviewing the direct allocation decisions made as part of the Small Works framework was in place and work confirmed this was being followed. We highlighted that this could be improved further by recording why a decision had been made where the standard criteria was not the reason.

3.10 A robust monitoring process was in place for the NWCH frameworks which allowed the team to ensure that performance levels were high amongst contractors and that accurate, timely and complete information was being received. This included regular ‘washing machine’ meetings with suppliers to ensure all issues are dealt with promptly and a process for verifying the information supplied as part of the KPI process. The Small Works framework was in the process of putting in place a similar performance monitoring framework for its contractors.

Key Areas for Development

3.11. The client guide stated that the NWCH will undertake checks on the levels of insurance held by each contractor as part of the annual health checks undertaken. This was not being undertaken and our discussions with the team confirmed there was an assumption that these checks were being undertaken by the client. The client guide for the Small Works framework had not yet been completed and we were unable to confirm that insurance checks were being undertaken as part of the framework arrangements. We were informed after issuing our draft report that the Commercial Performance and Compliance Team had recently started a process of checking the insurance levels for contractors across Capital Projects which would include the NWCH hub. The process for this is still in development and the Framework Manager should liaise with the team to ensure that checks over all contractors from NWCH are included. This should include notification where insurance levels are not as expected. Confirmation over whether the Small Works Framework will be included within the team's remit should also be sought.

3.12. It was not always clear from the information on file where an activity had been cancelled or abandoned prior to work commencing, nor was there a clear process for how this information should be relayed to the NWCH to ensure any attempts to circumvent payment of management fees are avoided.

3.13. The fee process means that only limited charges (based on pre-construction contract) are made where a project is abandoned even where a full procurement process has been undertaken. This is because the fee is due from the contractor not the client and is therefore not due until work is guaranteed. However this leads to the likelihood of delays and a possibility of fees not being recovered where work has been undertaken by the Hub team.

3.14. Fee letters were not stored on the project file for NWCH so it was not immediately clear if a payment request had been issued on an individual project.

3.15. Initial fee letters had not yet been issued for the Small Works framework. The framework agreement states that these will be due at the point that the work is allocated however it was communicated with suppliers at the first framework management meeting that the fee would only be invoiced once a contract is signed. The team are currently in the process of confirming which projects have signed contracts in place in order for invoices to be raised.

3.16. While the team maintained a spreadsheet with details of all projects tendered under the NWCH frameworks there was no strategic review of this information to determine whether particular suppliers were dominating the tender process (or failing to engage with it) or whether any action was required to address bid patterns.

3.17. The Small Works framework is still in its infancy and as such some of the processes which will be needed over its lifetime have not yet been fully developed and put into practice. This includes processes around the collection and monitoring of performance information and the invoicing of management fees. Due to the nature of the work to be undertaken on this framework these will need to be developed quickly to ensure that the first projects through the framework do not omit these steps.

3.18. There was a lack of clarity over the allocation of roles for the Small Works framework (as appears in the Client Guide for NWCH) in terms of the responsibilities of the call off manager and those of the Framework team. It was confirmed by the Framework Manager that a Client Guide is being drafted and should be completed by the end of the current financial year.

3.19. The majority of call offs from the Small Works framework are directly allocated to a contractor, to support the decision making process a checklist is in place which is signed by the framework manager to say she is satisfied with the decision. While the checklist confirms the rationale over the selection of a particular contractor it does not make it clear when these criteria are not in place that the allocation has been made on the basis of allocation levels across the framework. We would suggest that this is added to the form for clarity.

Appendix Three: Basis of Audit Assessment

Level of Assurance	Description
The level of assurance is an auditor judgement applied using the following criteria	
Substantial	Sound system of governance, risk management and control. Issues noted do not put the overall strategy / service / system / process objectives at risk. Recommendations will be moderate or minor.
Reasonable	Areas for improvement in the system of governance and control, which may put the strategy / service / system / process objectives at risk. Recommendations will be moderate or a small number of significant priority.
Limited	Significant areas for improvement in important aspects of the systems of governance and control, which put the strategy / service / system / process objectives at risk. Recommendations will be significant and relate to key risks.
No	An absence of effective governance and control is leaving the strategy / service / system / process open to major risk, abuse or error. Critical priority or a number of significant priority actions.

Priority	Assessment Rationale		
The priority assigned to recommendations is an auditor judgment applied using an assessment of potential risk in terms of impact and likelihood.			
Critical	**Significant**	**Moderate**	**Minor**
Actions < 3 months	Actions < 6 months	Actions < 12 months	Management discretion
• Impact on corporate governance • Life threatening / multiple serious injuries or prolonged work place stress • Severe impact on service delivery • National political or media scrutiny • Possible criminal or civil action • Failure of major projects • SMT required to intervene. • Statutory intervention triggered. • Large (25%) impact on costs/income • Impact on the whole Council.		• Some impact on service governance • Some risk of minor injuries or workplace stress • Impact on service efficiency • Internal or localised external scrutiny • Procedural non compliance • Impact on service projects • Handled within Service • No external regulator implications • Cost impact managed at Service level • Impact on Service or Team	

Impact	
Impact is the auditor assessment of criticality of the strategy / service / system / process being audited to the achievement of the Council's priorities and discharge of functions and duties in the following areas. This is described in the Audit Terms of Reference	
Strategic Objectives	Key Partnerships
Safety and Welfare	Finance and Resources
Corporate Risk	Key Service Fulfilment
Organisational Change	Statutory Duty

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Manchester City Council
Report for Information

Report to: Audit Committee – 15 September 2020

Subject: ICT Software Licences – Software Asset Management (SAM)

Report of: Director of ICT

Summary

Audit Committee receive regular updates on progress in the implementation of audit recommendations. Previous reports have highlighted that there were recommendations assessed as partially implemented from an audit of ICT Software Licensing. This report explains the actions taken to reduce risk, barriers to full implementation and management's rationale for accepting the current, reduced level of risk.

Recommendations

Audit Committee are requested to consider the actions taken in response to the Internal Audit of software licensing and the decision of management to accept a much reduced level of residual risk.

Wards Affected: None

Environmental Impact Assessment - the impact of the decisions proposed in this report on achieving the zero-carbon target for the city
Not applicable

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Background documents (available for public inspection):

The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Internal Audit Assurance and Recommendation Monitoring reports to Audit Committee 2018/19 and 2019/20

1. Background

1.1. Manchester City Council has a complex ICT environment and a key component of this is the number of software applications in operation. These range from simple systems with a small number of users, to complex major systems such as SAP and Liquid Logic, through to full enterprise wide solutions that are used across the entire Council such as GSuite and Microsoft. Ownership and management of a number of these applications has historically been decentralised, with responsibilities devolved to numerous teams across the organisation, often resulting in an inconsistent and largely informal approach to software licensing management.

1.2. ICT initiatives over recent years have brought a number of critical applications under central ICT control, whilst also introducing a requirement for all future applications to be centrally procured and managed. Due to the increasingly varied and complex ways of licensing software applications, through rental models, cloud based solutions and software-as-a-service, rather than outright ownership, effective software management controls are imperative to ensure we can demonstrate a position of compliance, both internally to demonstrate value for money and externally to software suppliers.

1.3. The impact of poor software licensing management could range from the Council incurring expenditure on licences that may no longer be required, through to the imposition of significant fines or application access being restricted by the supplier.

2. Internal Audit Report

2.1. Given the inherent risks around software licensing this was an area of focus in the 2018/19 Internal Audit Plan. This audit was completed and the report issued in July 2018. This provided limited assurance “due to the general lack of formal software licensing management controls and the resulting number of significant risk findings that have been identified across each area of our scope”. The report noted that progress had been made but there was significant amount of work required to address risks in relation to policy, procedures, resources and license reviews.

2.2. The report made two major and three significant priority recommendations for implementation by April 2019. A major priority recommendation relating to the software asset management policy and procedures and a significant priority recommendation in respect of SAP licenses have been confirmed by Internal Audit as implemented. Work to address the remaining recommendations has been progressed but the original, agreed actions have not been fully implemented and as such have not been signed off as fully complete by audit.

3. Actions to Date

3.1. Action has been taken to reduce risk exposure, however, based on the specific actions agreed with Internal Audit, these recommendations are classed as ‘partially implemented’. The current position is as follows:

Systems and Resources

3.2. Two of the recommendations were based on the development of a business case for dedicated staffing resource and the acquisition of software licensing tools to track licenses and activity across all systems. The business case was developed and a full time resource has been appointed to a new role of Licensing Manager. This has resulted in a dedicated focus in this area and the development of an inventory of licenses using spreadsheets and other existing tools. The Licensing Manager has led 'deep dives' in key systems to obtain a more accurate view of the licensing entitlement position and actual usage. This has been done for the five major software vendors used by the Council, including SAP and Microsoft, and provides positive assurance over both value for money and compliance. Whilst this is time intensive it does provide confidence to management and to Internal Audit over the management of risk.

3.3. Confidence has also been obtained through the Public Services Network (PSN) compliance project which includes regular scans of the Council's ICT infrastructure. This is designed to highlight potential vulnerabilities but also enables out of date or other software anomalies to be identified and addressed.

3.4. Further assurance has been obtained through the redesign of processes as recommended by Internal Audit and that have been confirmed as implemented. These include the establishment of gateway processes and the formal recording of any new software requests or purchases through the ICT ServiceNow system. This system is designed to prevent the acquisition of local applications or software within services and provides a level of confidence over the accuracy of licensing records and levels of compliance with supplier terms and conditions. Software licensing is also a standing agenda item for the Commissioning and Contract Group, in which all directorates are represented, to reinforce the requirement for all ICT investment and software acquisitions to be sourced centrally via the ICT service.

3.5. The original intention and agreed action in the audit report was to procure a specific Software Asset Management (SAM) system to minimise manual effort and centralise all license records in a single system. This has not been progressed as review of the market indicates that a system would cost in the region of £75k-100k per annum. This investment is currently included on the 2021/22 ICT plan but is unlikely to be progressed as a result of the need to allocate finite resources to higher priority investment projects such as telephony replacement, wide area network upgrade and the implementation of Office 365. In addition, a new system would require capacity from the ICT Enterprise Architecture team to oversee the technological solution and associated investment and this team will be focused on other high priority projects for at least the next 12 months.

Policy and Process

3.6. The other significant priority recommendation was to confirm roles and responsibilities in respect of ICT licensing and to ensure that this was communicated to relevant stakeholders both within ICT and across the Council.

In response a policy that includes details of roles and responsibilities has been approved and published, but it is recognised that awareness of this remains low. The intention is to highlight this and other relevant policies as part of the launch of the new intranet in 2020/21. Supporting processes and procedures have also been developed as described above and whilst there remains a need to continue to check and challenge ICT investment activity the overall risk in this area has been significantly reduced.

4. Conclusion

4.1. Actions agreed in response to the Internal Audit report from July 2018 have been largely addressed. These have taken longer than originally planned but the work of the Licensing Manager, PSN project, new gateway processes and agreement of the SAM policy means the level of exposure to risk as described in the report has been significantly reduced.

4.2. These mitigating actions and plans were discussed with Internal Audit and whilst the preference of audit and ICT would remain for a specific SAM system, it was agreed that the current arrangements have significantly reduced the exposure to risk and it was accepted that other ICT projects required for 2021/22 are likely to take priority. On this basis the recommendations were assessed as having been largely addressed and that this position should be reported to Audit Committee and agreement sought for these recommendations to be removed from the ongoing audit monitoring processes.

5. Recommendation

5.1. Audit Committee are requested to consider the actions taken in response to the Internal Audit of software licensing and the decision of management to accept a much reduced level of residual risk.

Manchester City Council
Report for Information

Report to: Audit Committee - 15 September 2020

Subject: Outstanding Audit Recommendations

Report of: Deputy Chief Executive and City Treasurer / Head of Audit and Risk Management

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Summary

In accordance with Public Sector Internal Audit Standards, the Head of Audit and Risk Management must "establish and maintain a system to monitor the disposition of results communicated to management; and a follow-up process to monitor and ensure that management actions have been effectively implemented or that senior management has accepted the risk of not taking action". For Manchester City Council this system includes reporting to directors and their management teams, Strategic Management Team, Executive Members and Audit Committee. This report summarises the current implementation position and arrangements for monitoring and reporting internal and external audit recommendations.

Recommendations

Audit Committee is requested to note the current process and position in respect of high priority Internal Audit recommendations.

Wards Affected: All

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Background documents (available for public inspection):

The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of the background documents are available up to four years after the date of the meeting. If you would like a copy, please contact one of the contact officers above

- Outstanding Audit Recommendations Report to Audit Committee 11 February 2020

1 Introduction

1.1 Audit Committee are provided with regular reports on actions taken to address outstanding high priority recommendations made by both Internal and External Audit. As a result of Covid19 there was a pause on the formal review and reporting of recommendation implementation as services focused on crisis response and recovery actions. Internal Audit sought to keep informed about progress on outstanding recommendations however there are some gaps in the updates received.

1.2 There have been understandable delays in progressing some of the agreed actions as officers across the Council have been refocused on unplanned essential activities that were required to respond to the pandemic. As a result Internal Audit will be re-engaging with services to understand the impact on timescales agreed pre Covid19 and what the realistic, achievable revised dates for completion of actions is likely to be. This work will continue over the next couple of months and required changes will be shared with Audit Committee in the next update report. As a result of Covid19 it is not surprising therefore that the number of recommendations overdue has increased.

1.3 There are four categories of recommendation priority: critical, significant, moderate and minor. This report provides the details of progress to address outstanding recommendations in the high risk (critical and significant) categories and an update on proposed next steps. This report focuses solely on Internal Audit recommendations, as there are currently no high priority External Audit recommendations currently outstanding.

2 Standard Process

2.1 Internal Audit usually follows up management actions on high risk recommendations at least quarterly to obtain assurance that progress is being made to address risk. Management are required to provide demonstrable evidence to support implementation. Internal Audit considers this evidence and may choose to re-test systems and controls on a risk basis to provide assurance that agreed improvement actions have been implemented and are operating effectively.

2.2 Progress made in the implementation of agreed actions from audit reports is reported quarterly to Directorate Management Teams (DMTs), Strategic Management Team (SMT), and Audit Committee. Executive Members are notified of high priority recommendations reaching six months overdue. At nine months overdue, Strategic Directors are required to attend Audit Committee with the relevant Executive Member to explain the position and progress to either address or accept the reported risks.

2.3 If recommendations are not implemented within 12 months of the due date and subject to any additional requirements or actions agreed by Audit Committee, Internal Audit refer the risks back to Strategic Directors to consider as part of their own assurance risk assessment.

2.4 Strategic Directors gain wider assurance over the implementation of recommendations as part of DMT reports, Internal Audit reporting and annual governance statement questionnaires, which are completed by all Heads of Service.

3 Current Implementation Position

3.1 The position in terms of high priority internal audit recommendations is summarised below and in detail at **Appendix 1.**

3.2 Since the last formal update in February 2020 Internal Audit has confirmed that services have been able to complete actions to address nine high priority recommendations in six audits as follows:

- Core: Framework Agreements – Contract Governance (3)
- Core: Compliance with Public Contracts Regulations 2015 (2)
- Core: Capital Frameworks – Call off Selection and Award (1)
- Adults: Deprivation of Liberties Safeguards (1)
- Neighbourhoods: Neighbourhood Investment Fund (1)
- Core: Google GSuite Application Controls (1)

Outstanding Recommendations

3.3 There are currently 40 recommendations, from 15 audit reports that are overdue past the agreed implementation dates. This is an increase from 30 outstanding recommendations reported to Audit Committee in February. These are being monitored and can be summarised as:

- 19 over twelve months overdue.
- 6 between six to nine months overdue.
- 15 between one and six months overdue.

3.4 The overdue recommendations comprise actions that remain fully outstanding (26) or have been partially implemented (14). Actions have continued to progress in some areas but some have been delayed in others due to Covid19 response and recovery requirements.

Overdue More than Nine Months (Appendix 2)

3.5 There are 19 recommendations which have been outstanding over 12 months, of which 11 are deemed as partially implemented based on actions taken to date. Internal Audit will continue to monitor progress and discuss with Directors the likely timescales for implementation of these given delays due to Covdi19. The current outstanding recommendations are:

- Adults: Transition to Adult Services (3 of which 2 partially implemented)
- Adults: Disability Supported Accommodation Services: Quality Assurance Framework (2 partially implemented)
- Adults: Management Oversight and Supervision (1)
- Adults: Mental Health Casework Compliance (6 of which 3 partially implemented)

- Core: ICT Software Licensing (3 of which 2 partially implemented)
- Core: Purchase Cards (1)
- Childrens Services: Assessed and Supported Year in Employment (2 partially implemented)
- Children Services: Management Oversight and Supervision (1)

3.6 The majority of recommendations which are currently more than nine months and up to 23 months overdue relate to matters within Adult Services and many of the actions to address these were captured in the Adults Service Improvement Plan. Progress to implementation of recommendations has been impacted by the response to Covid19 and the Improvement Plan was paused formally for a period of time with priorities currently under review. It has been agreed that follow up audit reviews will be carried out on the audits of Mental Health Casework Compliance and Adults Quality Assurance Framework to assess how effectively changes have been embedded. The Executive Director for Adult Services attended Audit Committee to report on the service improvement plan and mitigation of risks including outstanding recommendations in December 2019 and will be invited to provide a further update to Audit Committee in November 2020.

3.7 Three recommendations on ICT Software Licensing remain partially implemented and the Director of ICT will attend the September Audit Committee to confirm the reason for the delay and the actions taken to mitigate risk. ICT have discussed these actions with Internal Audit and the original proposal to procure a bespoke Software Asset Management tool software solution, which is the key outstanding action, will not be progressed due to the need to prioritise funding and resources in other higher risk areas. The Director of ICT has confirmed that he considers that the risks are within tolerance for the service and Internal Audit is supportive of the actions taken to date and this acceptance of remaining risk.

3.8 There are two audits in Childrens Services that are over 9 months overdue. A recommendation remains outstanding on Management Oversight and Supervisions and this will be reviewed as part of a formal follow up audit in 2020/21 and the outcomes reported to Audit Committee. Similarly a specific follow up will be undertaken to reengage with colleagues to understand the steps taken and timescales for any further actions required to address risks noted in the audit of Assessed and Supported Year in Employment where two recommendations are deemed to have been partially implemented. If risks remain outstanding the Director will be invited to provide an update to Audit Committee.

3.9 The audit of purchase cards and provision of guidance on hospitality has been delayed from its revised due date of July 2020 and is now scheduled for action by November 2020. Audit Committee will be appraised of latest position in the next update report.

Overdue for 6 – 9 months (Appendix 3)

3.10 Six recommendations have been overdue for between six and nine months, from six audit reports. Internal Audit is monitoring these and if these recommendations are not implemented within the next three months an update will be provided to Audit Committee by the relevant Strategic Director and Executive Member.

- Core: Social Value (1 partially implemented)
- Core: Prevention and Detection of Procurement Fraud (1 partially implemented)
- Core: Penalty Notices (1)
- Adults: Management Oversight and Supervision (1)
- Childrens: Procurement in Schools (1)
- Adults: Floating Support - Support to Homeless Citizens in Temporary (Dispersed) Accommodation (1)

Overdue less than 6 months (Appendix 4)

3.11 There are 15 recommendations which have been overdue for between one and six months in seven audit reports. Some of these reports also include additional recommendations which have not yet fallen due and/or moderate risk recommendations.

3.12 Internal Audit will continue to monitor these as part of an active programme of review and as part of scheduled follow up audits where appropriate and some progress was being made. The recommendations are shown in appendix four and relate to the following:

- Core: Capital Frameworks – Call off Selection and Award (1 partially implemented)
- Core: Contract Spend Review (1)
- Core: Prevention and Detection of Procurement Fraud (1)
- Core: GDPR Post Implement Review and Privacy Impact Assessments (4 of which 3 are partially implemented)
- Childrens: Early Help and Troubled Families (2)
- Adults: Planning for Permanence (3)
- Adults: Improvement Plan (3)

4 Recommendations

4.1 Audit Committee is requested to note the current process and position in respect of high priority Internal Audit recommendations.

Appendix 1 – Implemented Recommendations

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
Framework Agreements – Contract Governance 21 January 2019	31 Dec 2019	The Head of Integrated Commissioning and Head of Procurement should ensure that there are clear tools to ensure that the distinct responsibilities of call off managers and the overall framework manager are defined and shared from the outset. This could form part of the corporate guidance currently being produced for contract managers. We suggest the use of a template to outline the allocation of key responsibilities along with any reporting expectations and escalation procedures. This should be completed as part of the implementation documents for a framework. The template should include the following key responsibilities: • Supplier insurance checks. • Monitoring of social value contributions. • Collection of KPI information. • Complaints escalation. Any key information specific to the individual framework.	Action to be taken: • develop guidance and tools on the responsibilities of call off managers and framework managers, in collaboration with practitioners • incorporate into training materials • communicate widely, including to senior managers and SROs whose responsibility it is to oversee these contracts • coach framework and call off managers on what they need to do in future • Role for Strategic Directors, DMTs and directorate contract leads in checking and monitoring this is in place for each of their framework contracts.	The Integrated Commissioning and Procurement Team have produced guidance on the management of frameworks, this includes the expectation of who will manage the aspects outlined above and the importance of ensuring clarity over roles for any framework requirements which are not included in the guidance. The guidance has been now been published on the Integrated Commissioning intranet pages and as such is available to all officers. **Internal Audit Opinion:** Implemented	**No further action required**

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
Framework Agreements – Contract Governance 21 January 2019	31 Dec 2019	The Head of Integrated Commissioning should provide guidance for framework managers outlining minimum standards of monitoring to be undertaken in order to assess overall performance of the framework. This may include: • The value and number of call offs allocated to each supplier. • Number of complaints received. • Any work allocated outside of the approved allocation system and reasons for this. • Amount / type of social value received (potentially on a per supplier/per call off basis). • Client satisfaction. This should also include the need for senior officer scrutiny, oversight and assurance to ensure that value is not lost from the contract, to assist with decision making and to inform future commissioning. Thought should also be given as to whether this information should be incorporated into the framework agreements as framework level KPIs and how the development of such framework KPIs can be developed going forward.	Action to be taken • develop, in collaboration with practitioners, guidance for framework managers on the minimum standards of monitoring to assess the overall performance of the framework • Develop indicative framework KPIs, develop standard KPI sections for contracts, and share good examples • incorporate into training materials • communicate widely, including to senior managers and Senior Responsible Officers whose responsibility it is to oversee these contracts • role for Strategic Directors, DMTs and directorate contract leads in assuring and overseeing the governance and implementation of framework contracts. Ensure that KPIs are in place and are monitored and reported to senior management, and escalated to DMTs as necessary. Ensure there are forecasts and reports on performance, spend and compliance, and require explanation of variance and remedial action. • Action on KPIs should sit with Framework Managers. Potential action points	The guidance produced by Integrated Commissioning and Procurement includes key measures that should be recorded and monitored by the Framework Manager in order to ensure that the framework is working efficiently and effectively and to allow oversight and scrutiny by Senior Management. This guidance is now available on the Integrated Commissioning intranet pages and as such is accessible to all officers. **Internal Audit Opinion:** Implemented	**No further action required.**

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
			• Strategic Directors to ensure framework /contract managers in their directorates are skilled in KPIs or attend training • Strategic Directors ensure that framework managers (and all contract managers) have job objectives on developing and monitoring contract KPIs		
Framework Agreements – Contract Governance 21 January 2019	31 Dec 2019	The Head of Strategic Commissioning with the Head of Procurement should ensure that expectations around framework cost control are determined along with the need for this to be suitably resourced. This could be framed as part of wider guidance on required resources to manage different elements of a framework such as dealing with queries from other authorities where the framework is open to use by other parties or guidance over the level of sample testing that should be undertaken based on the value and number of transactions processed.	Action to be taken • develop, in collaboration with practitioners, guidance for framework managers on setting rules for, forecasting, monitoring and reporting expenditure on frameworks • develop clearer statements of roles in relation to rule-setting, forecasting, monitoring and reporting expenditure, for framework managers, finance officers, and others • establish and maintain list of budget holders for contracts and frameworks • incorporate into training materials • communicate widely, including to senior managers and senior responsible officers whose responsibility it is to oversee these contracts • Role for Strategic Directors, DMTs and directorate contract leads in assuring and overseeing the governance and	The guidance produced by the Integrated Commissioning and Procurement Team covers how cost control responsibilities should be split between the Framework and Call Off Managers which clarifies the respective roles of each. The guidance also makes clear the need to share information between the two roles to ensure that each can carry out their role effectively. **Internal Audit Opinion:** Implemented	**No further action required.**

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
			implementation of framework contracts. Recommend they scrutinise, demand forecasts and reports on performance, spend and compliance, and require explanation of variance and remedial action.		
Compliance with Public Contract Regulations 2015 2 September 2019	31 January 2020	A process for confirming that documents have been uploaded and all relevant steps completed should be put in place. This could be through the use of sample checks or if available through utilising reports within the Chest system. Procurement should seek confirmation from the service over the position of the contract identified and ensure that the Chest is appropriately updated and all relevant notifications issued.	As recommendation	Evidence received of reminders in team meetings and ongoing work to get the alerts from the Chest working correctly. We also received a copy of the updated checklist which includes completion of Chest as a step. Information on the contract identified during the audit was updated on Chest to reflect that this was taken over by the service. **Internal Audit Opinion:** Implemented	**No further action required.**

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
Compliance with Public Contract Regulations 2015 2 September 2019	31 January 2020	The Head of Integrated Commissioning and Procurement should explore whether the Chest system has the functionality to provide alerts in advance of key dates being reached to ensure we comply with the Public Contracts Regulations. In the interim staff should be asked to diarise key dates so that they are clear on when action should take place. If needed this could be supported by a completion checklist or random checks by management. The system should also be investigated to determine if a report can be run to identify any activities where the tender seal has been broken / awards issued on tenders more than 30 days ago but further actions have not been completed. This can then be run periodically to pick up on any cases which may have been missed due to human error.	As recommendation	We confirmed that Chest functionality has been checked and alerts are being sent. The procurement checklist has been updated to show this as an added step. A member of the team has been given responsibility for checking the contract register on Chest to ensure that tender information is up to date. Reporting functionality within the system remains an issue however senior procurement officers have been asked to sample check tender activities to ensure actions are being completed and the team continue to work with the Chest suppliers to improve functionality. **Internal Audit Opinion:** Implemented	**No further action required.**
Capital Frameworks – Call off Selection and Award 19 February 2020	29 Feb 2020	The North West Construction Hub (NWCH) Framework Manager should liaise with the Commercial Compliance and Performance Team to ensure that all contractors on the hub are included within their checks, whether the Small Works Framework will also be included in the checks and to ensure that there is a process for notifying him where	Agreed with Compliance team that insurance check will be carried out on Small Works Framework Contactors for Council Projects. Existing NWCH Client guide has been updated to reflect that the hub is not undertaking insurance checks on behalf of the client.	We confirmed that the Commercial Performance and Compliance Team are now monitoring all NWCH frameworks, Capital Programme (CAPPS) and Small Works contractors' insurance cover. A spreadsheet has been set up to facilitate this with expiry dates and reminder dates to prompt the team which has been checked by Internal Audit. The Framework team have updated and issued the client guide.	**No further action required.**

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		insurance levels are not as expected. The client guide for NWCH should be updated immediately to reflect that the Hub is not undertaking insurance checks on behalf of the client. The Small Works Framework Manager should ensure that the Client Guide for this framework clearly states how responsibility for insurance checks will be divided. Management should be aware that the Integrated Commissioning and Procurement Team are in the process of issuing guidance for Framework Managers which should be considered when updating the client guides.	Small Works Client guide will clearly state who has responsibility for insurance checks. 1st draft available for comment 29 February 2020. As part of NWCH quarterly health checks, we will request an update from the compliance team regarding the status of the insurance checks.	**Internal Audit Opinion:** implemented	
Deprivation of Liberty Safeguards 03 May 2019	30 Oct 2019	Following the screening of referrals using the Association of Directors of Social Services (ADASS) Screening Tool the Service Lead for Safeguarding should ensure that where a case needs an assessment it should be assigned to a Best Interest Assessor to enable assessment at the earliest opportunity. We understand that actions are already underway to address the unassigned 'screened' cases. This needs to be done as a matter of	The social work allocation process is done via an awaiting allocation list that the Team Manager/Senior Social Worker takes responsibility for risk assessing and determining the appropriate time to allocate the incoming assessment work based on professional judgment and competencies appropriate to the role. Action to be taken: Once the outstanding cases have been addressed, the additional posts should reduce the likelihood of a	Despite delays due to the unexpected volume of work required for the implementation of Liquid Logic, there has been significant progress made in this area. Actions taken have included new processes, appointment of new staff, and a new focus on closing referrals where appropriate, including during initial screening. At the time of our original audit we identified that there were 1,014 unallocated referrals with 17 of them over 2 years old. The service has made major improvements in screening and	**No further action required.**

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		urgency so that the Council only migrates those DoLS episodes needed into Liquid Logic.	similar occurrence. Cases which do not require assessment will be recorded as such.	allocations. Based on the latest information provided there were 280 cases awaiting allocation, which included 27 recent cases awaiting screening, and none of these referrals was over 3 months old. However, the current statutory requirement is for the whole assessment to take 21 days from referral to decision, and this is still not achieved. Given the actions taken and progress made to reduce the risks in this area, the ongoing work to further reduce unallocated referrals, and the knowledge that the DOLS legislation itself is due to be superseded we consider this recommendation to have been implemented. **Internal Audit Opinion:** Implemented	
Google GSuite Application Controls 10 September 2019	31 March 2020	The Head of ICT Service Operations, supported by the Strategic Business Partners as required, should develop a policy for GSuite account suspension and retention. This should include an assessment of the costs associated with the current and proposed approach, and should be presented to management stakeholders to gain their endorsement on the proposed approach to data retention. The policy should also include some guidance to staff on the management of suspended	Ensure development of a policy for GSuite account suspension and retention, submitted to SMT for approval including: • assessment of the costs associated with the current and proposed approach. • processes and guidance to ensure management of suspended accounts.	The Head of ICT Operations confirmed that accounts are now suspended when a user leaves, with a process for archiving the contents and deletion of the account from GSuite in a timely manner. This is tracked through the ServiceNow portal for all leavers. **Internal Audit Opinion:** Implemented	**No further action required.**

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		accounts, including increased password security. This could be in the form of introducing a formal review process to validate the status of the suspended accounts, and could potentially be extended to monitor any subsequent access after the account has been suspended.			
Neighbourhood Investment Fund (NIF) 2 September 2019	6 Sept 2019	Management should ensure that NIF funding is only be paid where there has been a community group application, and this should be reinforced to all Neighbourhood officers. Team leaders should not approve payment at the request of Members where there is no community group application in support of the payment.	No NIF grant to proceed without written record of decision (email or signature to confirm verbal discussion). The NIF expenditure in Chinatown addressed urgent issues raised by the Accountability Board (drug dealing and rat infestation) however there were no Community Groups available so the cost of this work should have fallen elsewhere. This will need reinforcing with local Members.	The NIF guidance has been updated and includes reference to exemptions to the application process. Internal audit have confirmed evidence that the guidance has been formally approved and shared across all three neighbourhood teams. **Internal Audit Opinion**: Implemented	**No further action required**

Appendix 2 – Recommendations Over 9 Months Overdue (to end of July 2020)

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
Transition to Adult Services 15 Feb 2018	31 October 2018	The Deputy Director of Adults Social Services should ensure that within six months an operational plan is in place for delivering the revised transitions offer in line with the agreed strategy and vision. This plan should include the formalisation of policy and procedure, roles and responsibilities and the use of transition specific documentation referred to in National Institute for Clinical Excellence (NICE) guidance.	Operational Plan in place for delivering the revised transitions offer in line with the agreed strategy and vision	Management reported to Audit Committee in December 2019 that a draft Transition policy had been developed that had been presented to the Transition board and which was within a consultation period and out to key stakeholders. The plan was for it to be reviewed by the agreed governance process for sign off by mid-January. Following policy sign off via the agreed governance processes, the policy was to be launched and disseminated across Manchester by the end of February 2020 along with completion of training for relevant staff. We have not received confirmation that this was completed as planned. Therefore we are currently still reporting this as partially implemented. **Internal Audit Opinion:** Partially implemented	**Director:** Bernadette Enright, Executive Director of Adult Social Services **Executive Member:** Councillor Craig **Status:** 21 months overdue **Action:** Internal Audit will seek assurance from management that the policy was launched as planned.

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
Transition to Adult Services 15 Feb 2018	30 April 2018	The Deputy Director of Adults Social Services should develop a clear transitions strategy and vision in conjunction with Children's Services and other key partners, in line with Care Act requirements. Once developed the strategy and vision should be used to inform the development of a clear service offer for transitions. This offer should be clearly communicated to confirmed key stakeholders including service users. Advice could be sought from other Local Authorities including the Council's Adults Services improvement partner, and differing approaches considered.	Transitions Strategy and Vision to be developed	Management reported to audit committee in December 2019 that Significant work has been completed since March 2019 to influence and inform the strategic priorities of the Transition offer across Manchester. Three transition planning workshops have been undertaken which considered the key priorities to develop what a good Transition offer would look like across Manchester. The work shops were attended by key partners including representatives from children's, adults, mental health, health (community and Trust), and carers. A formalised strategic plan was to be drafted based on the extensive discussions and consultations that had been completed including identifying key principles agreed at the transition planning workshops. The plan was for this to be consulted upon and signed off in January 2020. We have not received confirmation that this action was completed. **Internal Audit Opinion**: Partially Implemented	**Director:** Bernadette Enright, Executive Director of Adult Social Services **Executive Member:** Councillor Craig **Status:** 27 months overdue **Action:** Internal Audit will re-engage with management to confirm the strategic plan is now in place.

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
Transitions to Adult Services 15 Feb 2018	30 June 2018	To support day to day performance management the Interim Deputy Director of Adults Social Services should introduce a suite of Key Performance Indicators. This should be defined once the strategy and vision in place. A long term solution should be considered and built into Liquid Logic to help identify performance trends and provide assurance to senior management.	Key performance Indicators (KPIs) introduced.	Management reported to Audit Committee that a Performance framework was to be devised and reported via a dashboard to each Transition Board meeting They reported that the performance measures put in place will reflect agreed measures from all partner agencies within the transition process They planned for a Draft framework to be developed by Service Manager, Transition Planning Team by January 2020 and operational from 1 April 2020**.** We have not yet received confirmation that this action was completed. **Internal Audit Opinion**: Not Implemented	**Director:** Bernadette Enright, Executive Director of Adult Social Services **Executive Member:** Councillor Craig **Status:** 25 months overdue **Action**: Internal Audit will re-engage with management to confirm the performance framework is now in place.
Disability Supported Accommodation Services: Quality Assurance Framework 14 February 2018	31 August 2018	Management should consider which key areas of the Care Act registered managers and support coordinators should provide assurance over for all citizens in their properties. To support this, there will need to be: • A register of each citizen, staff member and property which should be monitored centrally to ensure full, timely coverage. • Each Centre's own registered manager and support coordinators should complete these checks as soon as possible to support the CQC	I agree with the activity identified within recommendation 1. Register of all details including residents; staff and properties to be sent to Performance, Research and Intelligence team.	Management reported to Audit Committee in December 2019 that significant changes have been made to the audit tool to strengthen it following workshops and discussions with Internal Audit, Managers and Support Coordinators. They reported the tool was ready to go onto the intranet to be launched. They planned to start using the new tool from January 2020 and thought it would therefore be fully operational by the end of January.	**Director:** Bernadette Enright, Executive Director of Adult Social Services **Executive Member:** Councillor Craig **Status:** 23 months overdue **Action:** Internal Audit will re-engage with management confirm whether the tool was launched as planned and will review the tool to confirm it

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		inspections and provide results to the Interim Service Manager (DSAS) and Programme Lead. • Accountability for registered managers and support coordinators to implement any actions that are identified. Results can then be assessed and addressed at a strategic level if further support or resources are needed. • Clarity as to how registered managers assure themselves that quality control checks are built into day to day service provision. This should help inform the Quality Assurance (QA) Framework, allowing auditors to provide an opinion on these arrangements rather than lower level, task specific compliance.		We are therefore assured that work was ongoing in addressing this recommendation but have not seen evidence of the successful launch of the tool and therefore are reporting the recommendation as partially implemented. **Internal Audit Opinion:** Partially Implemented.	addressed the issues raised in the audit.
Disability Supported Accommodation Services: Quality Assurance Framework 14 February 2018	31 August 2018	Management should consider integrating oversight of the Supported Living QA process into the role of Adults QA team and revise the content of the Framework. This could include: • A workshop including key partners, support coordinators and registered managers used to inform a revised framework. • Supporting an effective QA audit process and clarifying whether inquiry or inspection of evidence is required for each question/section and QA auditors	With regard to recommendation 2 whilst I have welcomed the support and expertise the Adults QA Team have provided to date and would want this to continue going forward I do not think it is appropriate to integrate oversight into the role of the Adults QA Team. The service is a commissioned In House Provider and is regulated and inspected by CQC and is also	Management reported to Audit Committee in December 2019 that a wider quality assurance process had been developed which included guidance for service audits and the moderation process along with a new schedule of activity. This process still needed management sign off at the time and therefore management were planning it to be fully implemented by 31 January 2020. We have not received confirmation that the process was launched as planned and therefore we continue to report this recommendation as	**Director:** Bernadette Enright, Executive Director of Adult Social Services **Executive Member:** Councillor Craig **Status:** 23 months overdue **Action:** Internal Audit will re-engage with management to confirm the QA framework was launched and that it covers the issues raised in our recommendation.

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		recording where this has been done. • Where assurance is being, or should be, sought from more specialist input such as HR, Health and Safety, Risk and Resilience, Corporate Property, Contract Monitoring and Learning and Events teams. Internal Audit propose to support development action by assisting management in the development and delivery of a redesign workshop.	subject to commissioning reviews by the contracts team. However it will be helpful to be able to access the QA Team's support for the further development work we have planned. Also in terms of oversight and challenge this will be provided through the Adults Quality Assurance and Performance Board. Workshops with staff and stakeholders to review and propose any desired changes to: QA Framework; Audit Tool and Guidance Documentation to be delivered throughout March and April.	partially implemented until we receive this. **Internal Audit Opinion**: Partially Implemented	
Purchase Cards 19 September 2018	31 Dec 2018	The Deputy Chief Executive and City Treasurer should develop guidelines setting out the general principles for providing hospitality to others, including where a Council officer or member also benefits from the expenditure. This should be supported by examples as appropriate. Internal Audit will support implementation of this recommendation by providing an outline of potential areas for inclusion, and will provide further details of test findings on request.	The City Solicitor, supported by the DCE and City Treasurer, will develop guidance on the provision of hospitality. They will also identify a suitable place within the existing guidance framework for this to be published.	Update provided 10 August 2020. The proposal is for the revised Employee Code of Conduct to be put to Full Council in November 2020. This is dependant upon agreement from SMT which is to be sought in September 2020 and the subsequent Personnel Committee where the policy will be ratified. **Internal Audit Opinion**: Partially implemented	**Director:** Fiona Ledden, City Solicitor and Carol Culley, Deputy Chief Executive & City Treasurer **Executive Member:** Councillor Leese **Status:** 19 months overdue **Action:** City Solicitor confirmed with Audit Committee a revised deadline for implementation of 31 July 2020 which

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
					predates the impact of Covid-19 New implementation date of November 2020 proposed based on Committee timescales
ICT Software Licensing 24 July 2018	30 April 2019	The Council should review the need for a business case for dedicated full-time resource and software licensing tools in order to drive a centralised and consistent approach to software licensing management.	ICT will: Carry out a review of roles and Responsibilities within Service Operations to assess the current limitations in terms of software asset management (SAM) skillsets and resource: and Explore other market solutions in conjunction with subject matter experts including Gartner, and present a business case to ICT DLT.	An ICT Business Concept Document has been completed outlining the requirements in this area and the potential solutions identified. The potential cost of the work has been identified, which is forecast to be met from the wider capital allocation for ICT improvement, and the project is included in the Corporate Core project portfolio. However, a full business case is yet to be produced and a formal decision on whether to proceed has not yet been taken. **Internal Audit Opinion**: Not Implemented	**Director:** Carol Culley, Deputy Chief Executive and City Treasurer **Executive Member:** Councillor Murphy **Status:** 16 months overdue **Action:** Update paper to be presented to Audit Committee to explain the barriers to implementation of the recommendation as the procurement is unlikely to proceed.
ICT Software Licensing 24 July 2018	30 April 2019	Software licensing management roles, responsibilities and capability gaps need to be defined, implemented and communicated to ICT and the Directorates. Additionally, both the end users of licenced applications and IT staff who install and maintain the applications should have a clear understanding of the appropriate processes and procedures that limit risk to and ensure compliance.	Following the work done in Recommendation 1, ICT will be in a position to define roles and responsibilities for software asset management (SAM). Beyond this, ICT will devise (as part of another recommendation arising from this audit) policies and procedures to support Council-wide compliance	The finalised software licensing policy includes an appendix detailing the roles and responsibilities of relevant stakeholders in respect of the approval, communication, distribution and enforcement of the policy itself. However, a wider assessment of roles across licence management had not been completed, and capability gaps had not been assessed.	**Director:** Carol Culley, Deputy Chief Executive and City Treasurer **Executive Member:** Councillor Murphy **Status:** 16 months overdue **Action:** Update paper to be presented to Audit Committee to explain the

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		This recommendation should be considered in the wider context of the potential requirement to define roles relating to application ownership across the Council, with a specific focus the specific responsibilities that the role entails.	to a consistent approach to SAM, clearly differentiating between centrally managed licensing and those managed locally within business units.	**Internal Audit Opinion**: Partially Implemented	barriers to implementation of the recommendation.
ICT Software Licensing 24 July 2018	30 April 2019	The current systems used by ICT to support software asset management (SAM) should be reassessed to ensure that they are fit for purpose and possess the capability to process, create and maintain all stores and records for software and related assets. Furthermore, the Council should look to move away from the manually intensive process currently in operation and explore the automation of tasks required to maintain compliance with software licenses and control software spending. The tools available to the Council should provide the functionality to detect and manage all exceptions to SAM policies, processes, and procedures; including license use rights and necessary infrastructure and processes for the effective management, control and protection of the software assets, at all stages of the Software license lifecycle. Once reporting is established then regular validation audits should be completed by the SAM team to	ICT will investigate the work other Council colleagues may be undertaking in relation to the acquisition of tools to manage SAM. ICT will seek to collaborate with such colleagues to ensure best ICT practice implemented and ICT requirements are included in any specifications. If no collaboration opportunities exist, ICT will explore other market solutions and present options to DLT to approve a way forward as part of the business case planned in response to another recommendation arising from this audit.	The commissioning of a licence management tool was being explored as part of the preparation of the business case identified as part of another recommendation arising from this audit. Given that this business case had yet to be formally considered, the Licence Manager was exploring how better use could be made of existing data sets. He had built a basic spreadsheet-based tool to support the identification of significant discrepancies in licence management. However, this tool required further work to confirm the reliability of associated information and to develop expectations around its use. **Internal Audit opinion:** Partially implemented	**Director:** Carol Culley, Deputy Chief Executive and City Treasurer **Executive Member:** Councillor Murphy **Status:** 16 months overdue **Action:** Update paper to be presented to Audit Committee to explain the barriers to implementation of the recommendation as the procurement of a tool to support is now unlikely to proceed.

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		ensure that the reported position is accurate.			
Adult Services Management Oversight and Supervision 5 April 2019	31 May 2019	The Assistant Director of Adult Services should establish a central means of monitoring the actual frequency of supervisions. Accuracy of this central record should be confirmed as part of the QA process (see recommendation 4.1). The results in terms of frequency and quality should be audited, analysed, and reported annually.	Audit process to be agreed within the Supervision Task & Finish Group. Process will be embedded into the final Supervision Policy. Additional Resources Required for implementation: Yes – Support from the Reform and Innovation Team secured.	Management reported to Audit Committee in December 2019 that a google form had been developed for supervisors to record the dates of completed supervisions. The requirements for completing this form and how to do it would be communicated to staff at a series of supervisions workshops. The responsibility for collating these forms and then distributing the results to the Service Managers would be with the Business Improvement Team. Service Managers would then be required to report this into the Adults Performance Board. **Internal Audit Opinion**: Not Implemented	**Director:** Bernadette Enright, Executive Director of Adult Social Services **Executive Member:** Councillor Craig **Status:** 14 months overdue **Action:** Internal Audit to complete a follow up audit to confirm compliance.
Children Services: Management Oversight and Supervision 9 May 2019	31 July 2019	The Deputy Director, Children's Services should ensure that Locality Heads of Service complete file audits in conjunction with the requirements of the policy.	To be included within guidance.	Management confirmed that they will reintroduce the file audit process from November 2019. No further follow up with the Business due to COVID19 **Internal audit opinion:** Not Implemented	**Director:** Paul Marshall, Strategic Director of Children's Services **Executive Member:** Councillor Bridges **Status:** 12 months overdue **Action:** Re-engage with management to review and report on progress made. A full audit of Children's Services Management oversight and supervisions is

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
					included on the current year audit plan.
Mental Health Casework Compliance 5 April 2019	30 June 2019	The Director of Adult Services should seek assurance from the Trust over consistency in recording safeguarding investigation activities, including whether the new case management system, Paris, can enforce correct procedures via system workflows. This may involve strengthening timely management oversight on case work and enhanced training for all case workers to ensure that procedures are understood.	Greater Manchester Mental Health Trust and Council to jointly establish a 'Task & Finish' group to investigate, work to resolve, and report progress back to the Director of Adult Services.	Management reported to Audit Committee that safeguarding training to reflect expected standards would be completed by 31 December 2019; appropriate staff would be trained by 31 March 2020; and an audit tool revised to monitor compliance by 31 December 2020. They also reported that it was likely to be December 2020 before practice changes were fully embedded and fully demonstrable in activity. Management also confirmed that they would be providing additional support to Greater Manchester Mental Health Trust through workshops to support their understanding of Adult Social Care statutory functions particularly in reference to safeguarding and annual reviews. Therefore we agreed to complete a full audit early in 2021. **Internal Audit Opinion:** Not Implemented	**Director:** Bernadette Enright, Executive Director of Adult Social Services **Executive Member:** Councillor Craig **Status:** 13 months overdue **Action:** Full audit included on 2020/21 audit plan to be completed early in 2021.
Mental Health Casework Compliance 5 April 2019	30 June 2019	The Director of Adult Services should seek assurance from the Trust in regard to whether Paris, the new case management system, offers improved controls over the initial response to safeguarding concerns, such as requiring management sign-	Greater Manchester Mental Health Trust and Council to jointly establish a 'Task & Finish' group to investigate, work to resolve, and report progress back to the	Management reported to Audit Committee that safeguarding training to reflect expected standards would be completed by 31 December 2019, appropriate staff would be trained by 31 March 2020 and an audit tool revised to monitor compliance by 31	**Director:** Bernadette Enright, Executive Director of Adult Social Services **Executive Member:** Councillor Craig

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		off within 24 hours of receipt of the referral.	Director of Adult Services.	December 2020. They also reported that it was likely to be December 2020 before practice changes were fully embedded and fully demonstrable in activity. Management also confirmed that they would be providing additional support to Greater Manchester Mental Health Trust through workshops to support their understanding of Adult Social Care statutory functions particularly in reference to safeguarding and annual reviews. Therefore we agreed to complete a full audit early in 2021. **Internal Audit opinion**: Partially implemented.	**Status:** 13 months overdue **Action:** Full audit included on 2020/21 audit plan to be completed early in 2021.
Mental Health Casework Compliance 5 April 2019	30 June 2019	The Director of Adult Services should seek assurance from the Trust that manager approval is actively monitored to ensure compliance with quality and time standards.	Greater Manchester Mental Health Trust and Council to jointly establish a 'Task & Finish' group to investigate, work to resolve, and report progress back to the Director of Adult Services.	Management reported to Audit Committee that safeguarding training to reflect expected standards would be completed by 31 December 2019, appropriate staff would be trained by 31 March 2020 and an audit tool revised to monitor compliance by 31 December 2020. They also reported that it was likely to be December 2020 before practice changes were fully embedded and fully demonstrable in activity. Management also confirmed that they would be providing additional support to Greater Manchester Mental Health Trust through	**Director:** Bernadette Enright, Executive Director of Adult Social Services **Executive Member:** Councillor Craig **Status:** 13 months overdue **Action:** Full audit included on 2020/21 audit plan to be completed early in 2021.

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
				workshops to support their understanding of Adult Social Care statutory functions particularly in reference to safeguarding and annual reviews Therefore we agreed to complete a full audit early in 2021. **Internal Audit Opinion:** Partially implemented	
Mental Health Casework Compliance 5 April 2019	30 June 2019	The Director of Adult Services should seek assurance from the Trust over how the timely and appropriate conclusion of investigations can be better managed and monitored – for example, system workflows to ensure adherence to procedure, and system generated reports of open investigations for which no recent activity has been logged.	Greater Manchester Mental Health Trust (GMMHT) and Council to jointly establish a 'Task & Finish' group to investigate, work to resolve, and report progress back to the Director of Adult Services.	Management reported to Audit Committee in December 2019 that performance management during implementation of the improvement agenda would include performance metrics being agreed with Greater Manchester Mental Health Trust management. We have not seen evidence that this has been implemented at this stage. **Internal Audit Opinion:** Not Implemented	**Director:** Bernadette Enright, Executive Director of Adult Social Services **Executive Member:** Councillor Craig **Status:** Six months overdue **Action:** Full audit included on 2020/21 audit plan to be completed early in 2021.
Mental Health Casework Compliance 5 April 2019	30 Sept 2019	The Director of Adult Services should ensure that a formal process is agreed and established with the Trust for a monthly reconciliation between safeguarding referrals sent and received. Trust and Council staff should work together to ensure that the new case management systems in each organisation – Paris and Liquid Logic, respectively – consistently record outcomes of safeguarding referrals, so that these can more easily be transferred across systems	It is accepted that safeguarding outcomes need to be recorded in MiCare (Liquid Logic in future). Quality and Performance group will consider options to ensure this can be done efficiently and effectively.	Management reported to Audit Committee in December 2019 that it was likely to be December 2020 before practice changes were fully embedded and fully demonstrable in operational activities. Therefore it is unlikely that this recommendation will be actioned until practice changes are fully implemented. **Internal Audit Opinion:** Not Implemented	**Director:** Bernadette Enright, Executive Director of Adult Social Services **Executive Member:** Councillor Craig **Status:** 10 months overdue **Action:** Full audit included in 2020/21 audit plan, to be completed early in 2021.

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		to ensure completeness of Council records and ability to monitor outcomes.			
Mental Health Casework Compliance 5 April 2019	30 June 2019	The Mental Health Commissioning Manager should undertake a review of performance reporting against the agreed KPIs to ensure that performance is being reported accurately and consistently in line with the Section 75 agreement.	The Quality & Performance group is working on improvements to the current performance reporting arrangements; changes are planned for the new financial year (from April 2019 onwards), including addition of commentary.	Management reported to Audit Committee in December that performance management during implementation of the improvement agenda would include performance metrics being agreed with Greater Manchester Mental Health Trust management. We have not seen evidence that this has been implemented at this stage. **Internal Audit Opinion**: Partially implemented	**Direct Director:** Bernadette Enright, Executive Director of Adult Social Services **Executive Member:** Councillor Craig **Status:** 13 months overdue **Action:** Full audit included in 2020/21 audit plan, to be completed early in 2021.
Assessed and Supported Year in Employment 21 May 2019	30 June 2019	The Workforce Learning and Development Manager should ensure that Social Work (SW) Managers are reminded of their role in supporting delivery of the ASYE programme. In particular, SW Managers should be required to provide confirmation to the Social Work Consultants on the completion of key milestones, including at a minimum the learning agreement, direct observations, and the six- and twelve-month reviews.	A google sheet has been circulated by the Workforce Learning and Development Manager to the North, South and Central Service Leads. Managers with responsibilities for Newly Qualified SWs can update their records each month over the 12 month programme and progress will be RAG rated. This will allow the SW Consultant to provide additional support to those NQSWs that fall into an amber or red position. The Google sheet will be used to capture all the key milestones of the ASYE	Internal Audit confirmed that a google sheet of all NQSWs on the ASYE programme had been adapted to include the key milestones and had been circulated to all team managers to use to record when key milestones are completed. However, review of these confirmed that team managers were not completing it as required. Therefore, while the mechanism for monitoring progress is now in place, data is not being input as required to allow the Social Work Consultant to identify and escalate issues where needed. Further action needs to be taken to ensure that team managers are populating the sheets as required and evidence of this has not yet been received to confirm implementation.	**Director:** Paul Marshall, Strategic Director of Children's Services **Executive Member:** Councillor Bridges **Status: 13** months overdue **Action:** Re-engage with management to review and report on progress made.

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
			programme up to completion by the service.	Internal Audit Opinion: Partially implemented	
Assessed and Supported Year in Employment 21 May 2019	30 Sept 2019	The Social Work Consultant should ensure that reconciliations of expected income against actual receipts are undertaken regularly (possibly in-line with the quarterly reporting). This may be done by creating additional columns in the tracker and using the notification of payments from Skills for Care to confirm receipt of payment.	Workforce Learning and Development Manager to have greater oversight into the reconciliations and payments from Skills for Care. Monthly review of spreadsheet and viewing payment when available from Skills for Care. *Please note* Skills for Care close for 5 months for online payment so systems will be in place to monitor this and claim when online system is closed from April 2019 – September 2019. Support from finance has been sought who now are in communication with Skills for Care to ensure we are clear on claims received.	The Social Work Consultant has previously stated that she was not receiving detailed remittances and the payment notifications from the Department for Education and Skills for Care were still being received as block payments with no detail to allow for a reconciliation to be performed. Subsequent review of the trackers identified that the dates that payments have been received are now being recorded against each social worker, indicating that this information is now available. Internal Audit have requested confirmation of this. No further follow up with the Business due to COVID19 **Internal Audit Opinion**: Partially Implemented	**Director:** Paul Marshall, Strategic Director of Children's Services **Executive Member:** Councillor Bridges **Status:** 13 month overdue **Action**: Re-engage with management to review and report on progress made.

Appendix 3 – Recommendations 6-9 Months Overdue

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
Adult Services Management Oversight and Supervision 5 April 2019	30 Nov 2019	The Assistant Director of Adult Services should ensure that a programme of supervision training is developed, and that this training is offered to and completed by all social work supervisors.	Training plan to be agreed and implemented via the Supervision Task & Finish Group. Training will be provided to new starters in a pilot phase before being rolled out to existing staff.	An update on progress on this action has been requested. Full follow up audit was planned for May 2020, delayed due to COVID19 **Internal Audit Opinion:** Not Implemented	**Direct Director:** Bernadette Enright, Executive Director of Adult Social Services **Executive Member:** Councillor Craig **Status:** Eight months overdue **Action:** Follow Up Audit to be completed later in the 2020/21 audit year.
Social Value 21 February 2019	31 December 2019	The Contract and Commissioning Leads within each directorate should work with contract managers to ensure that suitable social value KPI's are in place where possible and are being actively managed as part of contract monitoring arrangements. They should also ensure that escalation processes exist in instances where they are not being achieved. The Head of Integrated Commissioning and the Head of Corporate Procurement should enable access to template documents for monitoring social	a) Directorate Leads run training for contract managers to ensure that suitable social value KPI's are in place and are being actively managed as part of contract monitoring arrangements. b) Directorate leads should also ensure that escalation processes exist in instances where KPIs are not being achieved. c) DMTs assure (a) and (b) through standard quarterly contract overview d) Integrated Commissioning enable access to template documents for monitoring social value.	We confirmed that a number of actions driven by the Integrated Commissioning and Procurement Team have been undertaken to address the risks identified during our review. Members and officers had recognised there was a need for social value KPIs alongside a broader qualitative assessment of the impact of social value through stories and testimonials from those helped through the Council's approach. As such a longer timescale was required for the full implementation of this recommendation.	**Director:** Carol Culley Deputy Chief Executive and City Treasurer **Executive Member:** Sir Richard Leese **Status:** Seven months overdue **Action:** Monitor

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		value. Longer term thought should be given as to how benchmarking could be undertaken to enable the value obtained through social value to be determined.	e) Integrated Commissioning consider options for benchmarking the value obtained through social value	**Internal Audit Opinion**: Partially implemented	
Prevention and Detection of Procurement Fraud 6 June 2019	31 December 2019	The Director of Capital Programmes with the Frameworks Lead (NWCH) should develop a method for monitoring bid patterns across this and other frameworks to ensure transparency and inform any actions required to stimulate greater competition. Consideration could be given to the development of a periodic report outlining engagement with the framework, supplier success rates (and any reasons for higher than expected success) and any concerns raised by suppliers over the tender process (whether via a opt out response or through feedback to the framework team). This report should also review lack of engagement by individual suppliers and the reasons for this in order to provide assurance to Senior Management that the framework continues to provide value.	The list of commissions is reviewed each quarter with a finance review undertaken to track fees and Social Value outcomes collected. A Capital Programmes (CAPPS) framework has predominantly been used for Council commissions and as such over the 4 years since launch the reliance on the Council to use the framework has diminished as recruitment has taken place. The NWCH team will add to the quarterly review bid patterns and list any suppliers who have consistently not returned mini competitions. It is noted that the hourly rates originally tendered and the further availability of other frameworks in the market makes CAPPS less attractive to the market than originally envisaged.	A log is maintained of those suppliers who have returned tenders. It was proposed that those who have not returned tenders will be recorded moving forward however we have not yet received evidence to confirm this. **Internal Audit Opinion**: Partially implemented	**Director:** Carol Culley Deputy Chief Executive and City Treasurer **Executive Member:** Sir Richard Leese **Status**: Seven months overdue **Action:** Request evidence to demonstrate that proposals are now operational
Children's Services: Penalty Notices for	31 Dec 2019	The Strategic Lead for School Attendance & Education Other Than at School should continue to monitor the cost of operating the	Regular termly meetings will be held with finance to monitor and review the revenue from monies collected from the paid penalty	No progress reported on this recommendation. Further delays anticipated in relation to COVID19.	**Director:** Paul Marshall, Strategic Director of Children's Services

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
Unauthorised Absences 1 February 2019		penalty notice service compared to the income received, to ensure that this remains cost neutral as required by legislation and the Protocol. A summary report on income and expenditure relating to the penalty notice scheme should be included in the annual Attendance report to Senior Management and to the Children and Young People Scrutiny Committee.	notices. A summary on the income and expenditure will be included in a report to senior management and to the Children and Young People Scrutiny Committee on an annual basis.	**Internal Audit Opinion:** Not implemented	**Executive Member:** Councillor Bridges **Status:** Eight months overdue **Action:** Re-engage with management to review and report on progress made.
Procurement in Schools 12 July 2019	30 Nov 2019	Director of Education to consider arranging procurement workshops for Governors, Head Teachers and Business support staff. These sessions should be used to highlight the risks and issues as identified during this audit along with guidance, support and templates where necessary to address these issues and risks. These forums can also be used to re-promote the DfE schools buying hub. We are happy to support this work however consideration should be given to involving Head Teachers and Business Managers from schools where procurement practices are strong in sharing their knowledge and expertise with their peers. Internal Audit propose issuing a circular to all schools following this work around areas where	Joint workshops for stakeholders to be facilitated by representatives from Procurement, Schools Finance and Audit. The focus will be on an overview of procurement risk and processes, access to and understanding of national and Council guidance, relevant procurement and finance regulations and reasons why they must be followed.	There has been no progress on this proposal which has now been further delayed by Covid19. An update on progress on this action has been requested. **Internal Audit Opinion:** Not implemented	**Director:** Paul Marshall, Strategic Director of Children's Services **Executive Member:** Councillor Bridges **Status:** Eight months overdue **Action:** Internal Audit to re-engage with management to review and assess next steps.

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		improvements are required. This circular will include a tool for schools to self-assess their own procurement practice ahead of the proposed workshops.			
Floating Support - Support to Homeless Citizens in Temporary (Dispersed) Accommodation 29 May 2019	30 October 2019	The Strategic Lead - Homelessness and Migration should ensure that documentation requirements for case activity are confirmed for all key tasks. Representatives from the business should then be identified to engage with Liquid Logic to establish what has been designed and whether it meets the needs of the Service. Ideally this would develop formal workflows that will ensure: • All key records to be retained in a consistent format that also enables management sign off (if required), case prioritisation and review as well as alerts where key actions have not been completed. • Management information can be produced directly from the system (such as last visit date). Consideration should also be given to embedding of key documents for example sign up paperwork.	Meetings with Liquid Logic have already taken place since the initial findings of the audit report to make the new system fit for purpose for the homeless service. Initial discussions show this will not be possible until phase 2 of the roll out. In the meantime, officers will meet with the Liquid Logic team, to see what can be best utilised from the system as it stands to better support the floating support case management and supervision.	Proposed completion by the end of October 2019 was not met as it was to form part of phase 2 developments for Liquid Logic and a new date of October 2020 was set. We note that Liquid Logic is being used as far as possible in its current form to support operational activities. However, the changes needed to make it fully effective cannot be made until phase 2 project development. The business has confirmed it is now working to a deadline of October 2020. **Internal Audit Opinion:** Partially implemented	**Director:** Mike Wright, Director of Homelessness **Executive Member:** Councillor Craig **Status:** Nine months overdue **Action:** Internal Audit to continue to liaise with management to seek updates on progress.

Appendix 4 – Recommendations 1-6 Months Overdue

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
Prevention and Detection of Procurement Fraud 6 June 2019	30 June 2020	The Head of Integrated Commissioning and Procurement should produce / commission an annual review of bid information held in the Chest. This should be done to allow for further investigation of bid patterns if issues are identified. This analysis should include: - Supplier Success Rates. - Single Bidder Activities. - Projects with multiple ITT stages. - Reasons for opt outs. In order to aid in the running of the above the ways of working with the system should be reviewed with the system supplier (as part of the development discussions recommended at 2 above) to ensure that: - the use of multiple ITT stages is avoided unless necessary and that the way the system records these is fully understood. - discontinued activities are marked as such in a way which can be identified within both detailed and summary reports.	An annual report will be produced to consider the procurement activity over the previous financial year.	An update on progress on this action has been requested. We were informed Corporate Procurement will pick up on this action and check what data is available from the Chest. **Internal Audit Opinion:** Not implemented	**Director:** Carol Culley Deputy Chief Executive and City Treasurer **Executive Member:** Sir Richard Leese **Status**: One month overdue **Action:** Monitor
Contract Spend Review 10 December 2019	31 March 2020	Work should be undertaken to identify the Council's main strategic suppliers. The information contained within contract registers could facilitate this and help to identify those suppliers whether this	Agree with some comments. Directorates do have some arrangements in place for strategic suppliers. A one size fits all approach is unlikely to work but the Team can develop	An update on progress on this action has been requested. **Internal Audit Opinion:** Not Implemented	**Director:** Carol Culley Deputy Chief Executive and City Treasurer **Executive Member:** Sir Richard Leese

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		be by number or value of contracts, or service dependency. A plan for how these contracts should be monitored along with any central oversight to be put in place should then be developed to ensure that the Council can take suitable action if becoming aware of any warnings indicating supplier failure.	guidelines and key principles. The management of strategic suppliers will also require work between DMTs and key partners, particularly in health.		**Status**: Four months overdue **Action:** Monitor
Capital Frameworks – Call off Selection and Award 19 February 2020	30 June 2020	The fee process should be reviewed, where possible the ability to recharge the management fee should be brought forward to ensure it happens as close to the tender activity as possible, or the potential for staging the management fee so that a proportion is paid on the completion of the tender activity should be considered. The team may also wish to consider reviewing the fee charges to include a small 'aborted tenders' allowance so that the costs of such incidents are covered where no recharge is to be made directly to the client or contractor. Consideration of whether a "cancellation fee" should be charged to the client where a full tender activity has been undertaken but the project is cancelled prior to any work taking place should be given as part of the review of the fee process.	There is currently a process in place for collecting abortive fees from main contractors should projects not go ahead. This is currently being reviewed together with a proposal to charge 'upfront fees' from contractors early in the second stage of the tender process. This will be discussed at board level and with the Managing Directors of our Contractor Partners.	The Framework Team confirmed a proposal regarding an upfront fee has been sent to the Hub Board for comment. The outcome of this proposal will be followed up at the NWCH Board Meeting in September 2020 attended by managing directors from framework contractors where this will be discussed. **Internal Audit Opinion**: Partially implemented	**Director:** Carol Culley Deputy Chief Executive and City Treasurer **Executive Member:** Sir Richard Leese **Status**: One month overdue **Action:** Monitor

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		Thought should also be given as to how information on the current contractual status of the call offs can be collected promptly and efficiently to ensure that fees are not missed due to the team not being informed that the contract has been signed.			
GDPR Post Implementation Review 20 June 2019	30 April 2020	The Council's Corporate Records Manager working with its Data Protection Officer (DPO) and the Information Steering Group (reporting to CIARG) should develop a corporate action plan to prioritise and agree actions to improve data retention and disposal arrangements. We are aware that the DPO intends to undertake a risk assessment of all service areas which will be presented to CIARG, this will highlight areas of priority to be included in the plan.	It is accepted that a corporate action plan should be developed to improve data retention and disposal arrangements and build this into the Information Governance Risk Register. The Corporate Records Manager will work with the Deputy Senior Information Risk Officers to assess records management maturity in their areas and develop standardised locally owned action plans for development of records management best practice.	The Corporate Records Manager has been working with other stakeholders to improve corporate data retention arrangements, focusing on the forthcoming Microsoft 365 system. Some assessment of local records management maturity has also been undertaken but this was interrupted by the COVID pandemic. **Internal Audit Opinion:** Partially Implemented	**Director:** Fiona Ledden City Solicitor **Executive Member:** Councillor Sir Richard Leese **Status:** Four months overdue **Action:** Continue to monitor
GDPR Data Privacy Impact Assessments (DPIA) 1 November 2019	30 April 2020	The Data Protection Officer, with support from Corporate Communications, should ensure that the data protection communications plan includes messages to address the awareness gaps identified in our audit. The messages should be presented to CIARG for review and approval.	Accepted	The Council has implemented a new system for management of information-related requests, which will be extended to provide DPIA-related functionality. The recommended communications plan will be developed and enacted alongside this rollout. **Internal Audit Opinion:** Not Implemented	**Director:** Fiona Ledden City Solicitor **Executive Member:** Councillor Sir Richard Leese **Status:** 4 months overdue **Action:** Follow up audit in this area to be scheduled.

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
GDPR DPIA 1 November 2019	30 April 2020	The Data Protection Officer should contact the managers identified in our sample, to confirm the completion of a DPIA for each project.	Accepted	The Data Protection Officer has contacted the relevant managers for updates, while seeking assurance over the extent of completion of DPIAs across subsequent corporate projects. **Internal Audit Opinion:** Partially Implemented	**Director:** Fiona Ledden City Solicitor **Executive Member:** Councillor Sir Richard Leese **Status:** 4 months overdue **Action:** Follow up audit in this area to be scheduled.
GDPR DPIA 1 November 2019	30 April 2020	The Data Protection Officer, with support from the Directorate Senior Information Risk Owners, should establish arrangements for the periodic monitoring of compliance with DPIA requirements.	Accepted	A new ICT system is proposed to be used to support compliance monitoring in this area. In addition, the Data Protection Officer has sought opportunities to build in communication of the DPIA completion requirement earlier in the process, for example as part of the "Checkpoint" process before financial approval is granted. **Internal Audit Opinion:** Partially Implemented	**Director:** Fiona Ledden City Solicitor **Executive Member:** Councillor Sir Richard Leese **Status:** 4 months overdue **Action:** Follow up audit in this area to be scheduled.
Adults Improvement Plan Governance 9 January 2020	31 March 2020	The Strategic Lead Business Change should re-evaluate the 'action type' categories and how these can be clarified and simplified. For example, each action could be assigned a priority level (1/2/3) to indicate whether it is currently an area of active focus. We recommend that the workstream leads include an update on each	As part of a 12 month stock-take of the Improvement Programme the action plans are being refreshed, which will include clearer indication of priority level and milestones/sequencing which will flow through into highlight reporting.	The recommendations fell due for implementation during the COVID19 lockdown. We have not received confirmation of implementation from management at this stage and will seek an update based on the refresh of the Plan currently underway which may change the way in which the Plan is monitored.	**Direct Director:** Bernadette Enright, Executive Director of Adult Social Services **Executive Member:** Councillor Craig **Status:** Four months overdue

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		action of the highest priority level in the highlight reports		**Internal Audit opinion:** Not implemented	**Action:** Follow Up Audit to be completed later in the 2020/21 audit year.
Adults Improvement Plan Governance 9 January 2020	30 April 2020	The workstream lead for Provider Services and the Improvement Board should collectively agree on a manageable number of improvement actions, ensuring that these align with the Risk Register and agreed areas of focus. These could be either cross-cutting, specific to individual services, or a combination of both. This should be of a size to allow the entire workstream or thereabouts to be reviewed at a workstream meeting, and updates on all of the highest priority actions should be reported onwards to the Improvement Board, which would better enable oversight and focus on key priorities.	As part of a 12 month stock-take of the Improvement Programme the action plans are being refreshed. For the Provider Services workstream this will mean a streamlining of actions included in the ongoing core Improvement Programme with some actions moving into the new programme of work to review Provider Services (across Health & Social Care).	The recommendations fell due for implementation during the COVID19 lockdown. We have not received confirmation of implementation from management at this stage and will seek an update as the Plan is stepped back up and reassessed. **Internal Audit opinion:** Not implemented	**Direct Director:** Bernadette Enright, Executive Director of Adult Social Services **Executive Member:** Councillor Craig **Status:** Three months overdue **Action:** Follow Up Audit to be completed later in the 2020/21 audit year.
Adults Improvement Plan Governance 9 January 2020	30 April 2020	The Technology Enabled Care (TEC) and Workforce workstream plans should be refreshed using the standard template, which allows for increased clarity over action owners, target timescales, and updates on current status. The workstream leads should ensure these are regularly reviewed and kept up to date and use these to inform the highlight reports.	As part of a 12 month stock-take of the Improvement Programme the action plans are being refreshed. This has already taken place for the Workforce workstream. The TEC workstream is being considered as part of the wider MLCO portfolio with a clear action plan to be finalised by April 2020.	The recommendations fell due for implementation during the COVID19 lockdown. We have not received confirmation of implementation from management at this stage and will seek an update as the Plan is stepped back up and reassessed. **Internal Audit opinion:** Not implemented	**Direct Director:** Bernadette Enright, Executive Director of Adult Social Services **Executive Member:** Councillor Craig **Status:** Three months overdue **Action:** Follow Up Audit to be completed later in the 2020/21 audit year.

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
Planning for Permanence	1 April 2020	Locality Managers should confirm which staff in their locality have not received any training or briefings on the policy and consideration should be given to running some additional events for those who have not yet been trained.	This will be addressed by continuing to run additional training events to ensure all staff have receive required training and by refresh of the induction process to include reference to awareness of the revised policy.	The recommendations fell due for implementation during the COVID19 lockdown. We have not received confirmation of implementation from management at this stage and will seek an update. **Internal Audit opinion:** Not implemented	**Director:** Paul Marshall, Strategic Director of Children's Services **Executive Member:** Councillor Bridges **Status:** Four months overdue **Action:** Internal Audit to re-engage with management to review and assess next steps
Planning for Permanence	1 April 2020	The Permanence Improvement Board should review the impact of the initial roll out of the policy and to address any key issues, such as those identified in our review. In particular, focus should be given to Permanence Planning Meetings (PPM) and how arrangements can be revised to make them more achievable. Requirements of PPM should be included, where applicable, in the Children's QA framework to ensure a level of consistency across each locality.	Senior Management will continue to raise awareness of the importance of the PPM process and engagement of social workers in this process.	The recommendations fell due for implementation during the COVID19 lockdown. We have not received confirmation of implementation from management at this stage and will seek an update. **Internal Audit opinion:** Not implemented	**Director:** Paul Marshall, Strategic Director of Children's Services **Executive Member:** Councillor Bridges **Status:** Eight months overdue **Action:** Internal Audit to re-engage with management to review and assess next steps
Planning for Permanence	1 April 2020	Further performance measures should be developed to assess the effectiveness of permanence planning and then incorporate these in the Permanence score card.	Performance Improvement Board will continue to review performance monitoring to ensure continuous improvement and in considering the effectiveness of the permanence scorecard.	The recommendations fell due for implementation during the COVID19 lockdown. We have not received confirmation of implementation from management at this stage and will seek an update.	**Director:** Paul Marshall, Strategic Director of Children's Services **Executive Member:** Councillor Bridges

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
				Internal Audit opinion: Not implemented	**Status:** Four months overdue **Action:** Internal Audit to re-engage with management to review and assess next steps
Early Help and Troubled Families	30 July 2020	The Strategic Head of Early Help should reinforce with all Early Help staff the importance of confirming that the family have consented to the referral before any action is taken, and that, once a referral has been accepted, a written record of this consent is obtained from all relevant family members and uploaded before information is shared with partner agencies.	Agreed, ensuring families read, or are made aware of, the Early Help Privacy Notice continues to be an important part of the offer of early help from referral through to intervention. We accept the findings and will monitor and challenge non-compliance by: • updating the Early Help Process and Practise Standards to provide clearer guidance for practitioners. New GDPR legislation has changed the language on 'consent' which should now be considered within the remit of the Early Help Privacy Notice. • monitoring and challenging compliance through our existing audit cycle and ensuring regular reporting back to senior management.	We have not received an update on progress at this stage due to business priorities and will now seek evidence of implementation. **Internal Audit opinion:** Not implemented	**Director:** Paul Marshall, Strategic Director of Children's Services **Executive Member:** Councillor Bridges **Status:** One month overdue **Action:** Internal Audit to re-engage with management to review and assess next steps

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
Early Help and Troubled Families	30 July 2020	The Strategic Head of Early Help should develop a means of improving compliance with the requirement to create or update a child impact chronology at the start of the Early Help offer. Compliance should be monitored, either on a whole population or sample basis, and the results should be reported to senior management and fed back to individual team leaders.	We accept the findings in relation to chronologies. The importance of chronologies and requirements for completing them will be included in the new process and practice guidance.	We have not received an update on progress at this stage due to business priorities and will now seek evidence of implementation. **Internal Audit opinion:** Not implemented	**Director:** Paul Marshall, Strategic Director of Children's Services **Executive Member:** Councillor Bridges **Status:** One month overdue **Action:** Internal Audit to re-engage with management to review and assess next steps

By virtue of paragraph(s) 2, 7 of Part 1 of Schedule 12A
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