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MANCHESTER CITY COUNCIL

Audit Committee

Date: Tuesday, 11 February 2020
Time: 10.00 am
Venue: Level 2, Town Hall Extension

Everyone is welcome to attend this committee meeting.

There will be a private meeting for Members only at 9.30am in Committee Room 6 (Room 2006), 2nd Floor of Town Hall Extension. A Town Hall pass is needed to reach this room.

Access to the Council Antechamber

Public access to the Council Antechamber is on Level 2 of the Town Hall Extension, using the lift or stairs in the lobby of the Mount Street entrance to the Extension. That lobby can also be reached from the St. Peter's Square entrance and from Library Walk. **There is no public access from the Lloyd Street entrances of the Extension.**

Filming and broadcast of the meeting

Meetings of the Audit Committee are 'webcast'. These meetings are filmed and broadcast live on the Internet. If you attend this meeting you should be aware that you might be filmed and included in that transmission.

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

1. Urgent Business
To consider any items which the Chair has agreed to have submitted as urgent.

2. Appeals
To consider any appeals from the public against refusal to allow inspection of background documents and/or the inclusion of items in the confidential part of the agenda.

3. Interests
To allow Members an opportunity to [a] declare any personal, prejudicial or disclosable pecuniary interests they might have in any items which appear on this agenda; and [b] record any items from which they are precluded from voting as a result of Council Tax/Council rent arrears; [c] the existence and nature of party whipping arrangements in respect of any item to be considered at this meeting. Members with a personal interest should declare that at the start of the item under consideration. If Members also have a prejudicial or disclosable pecuniary interest they must withdraw from the meeting during the consideration of the item.

4. Minutes 5 - 12
To approve as a correct record the minutes of the meeting held on 10 December 2019.

5. Internal Audit Assurance Report 2019/20 13 - 76
The report of the Deputy Chief Executive and City Treasurer / Head of Internal Audit and Risk Management is enclosed.

6. Outstanding Audit Recommendations 77 - 130
The report of the Deputy Chief Executive and City Treasurer / Head of Audit and Risk Management is enclosed.

7. Audit Strategy Memorandum 131 - 164
A copy of the Audit Strategy Memorandum from the Council's external auditors (Mazars) is enclosed.

8. Committee Work Programme 165 - 172
A copy of the Committee Work Programme and Recommendations Monitor is enclosed.

Information about the Committee

The Committee is responsible for approving the Council's statement of accounts; considering the Audit Commission's Annual Audit and Inspection Letter and monitoring the Council's response to individual issues of concern identified in it. The Committee also considers the Council's annual review of the effectiveness of its systems of internal control and assurance over the Council's corporate governance and risk management arrangements, and engages with the external auditor and external inspection agencies to ensure that there are effective relationships between external and internal audit.

The Council is concerned to ensure that its meetings are as open as possible and confidential business is kept to the strict minimum. When confidential items are involved these are considered at the end of the meeting at which point members of the public are asked to leave.

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Agenda, reports and minutes of all Council Committees can be found on the Council's website www.manchester.gov.uk.

Smoking is not allowed in Council buildings.

Joanne Roney OBE
Chief Executive
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Further Information

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

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

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Audit Committee

Minutes of the meeting held on 10 December 2019

Present:
Councillor Ahmed Ali - In the Chair
Councillors Clay, Lanchbury, Russell, Stanton and Watson

Independent Co-opted member: Dr S Downs

Also Present:
Councillor Craig Executive Member Adult Health and Wellbeing
Councillor Bridges Executive Member Children and Schools
Stephen Nixon, Mazars

Apologies: Dr D Barker (Co-opted member)

AC/19/59 Minutes

Decision

To approve the minutes of the meeting held on 12 November 2019 as a correct record.

AC/19/60 Transitions – Children's to Adult Services

The Committee considered the report of the Executive Director of Adult Social Services and the Strategic Director of Children and Education Services which provided Members with an assurance update on the progress made in responding to outstanding issues arising from the Internal Audit report on the Transition Service.

The Executive Member - Adult Health and Wellbeing and the Executive Member - Children and Schools attended the meeting and addressed the Committee. Also present at the meeting were Tracy Cullen - Assistant Director Adult Services and Julie Hicklin Special Educational Disability Lead – Children's Services.

The report explained that two of the five recommendations agreed had been implemented and provided progress on the three remaining recommendations. The remaining recommendations related to:

- The development of a transitions strategy;
- The implementation of a plan within six months for the delivery of the revised transitions offer in line with the agreed strategy and vision.
- The introduction of Key Performance Indicators to support day to day performance management.

The chair invited questions from the Committee.

A member referred to the revised framework and asked where young do people with a disability, requiring support and in the process of transition to adult services, fit within the current framework. Officers were also asked to respond to the reference made in the consultation feedback regarding the Transition Team being seen as the "Mental Capacity Act assessment team".

It was reported that the Transition Board had been reconfigured and now included representation from across service providers and the Parent/Carer Forum. The Transition Board will discuss 'Transition' as a themed approach to the issue for the reason that it was recognised that there is not a clear point of transition from children to adult services and work was required to co-ordinate the various services concerned in order to address policy processes and practices. It was reported that the consultation feedback received referred to the Mental Capacity Act, as it applies to young people as they approach 16 years old and the need for Children's Services and Adult Services to work together in supporting young people on decisions to be made about their future during the process of transition.

The Executive Members (Adult Health and Wellbeing) and (Children and Schools) informed that a meeting that Manchester Health and Care Commissioning Board had already considered the theme of Transition across related services and this will help to inform the Transition Board when it discusses the theme.

A member referred to the period of time between the audit recommendations in 2018 and the target date of completion in 2020 and asked what arrangements had put in place for young people in the process of transition to adult services. Reference was also made to the introduction of Liquid Logic in July 2019 and officers were asked if all children's details had been migrated onto the new system and how this is maintained.

The Executive Member - Adult Health and Wellbeing gave an assurance that the outstanding recommendations would be completed by February 2020. The point was made that the recommendations related to strategic planning, a draft transition policy and a transitional training plan as part of the development of a strategic overview for the service. The transition and care arrangements of young people in transition had not been affected and every young person had received a service and has access to support during this period. The Committee was also informed that details of children in a category of "known to Social Care" had been moved onto Liquid Logic system. The migration of children from the education database had started as part of a seventy-week work process and would include children with an Education Health Care Plan or a disability.

The Head of Internal Audit and Risk Management reported that a position statement on the outstanding recommendations would be provided to the Committee in February and would be referred to again within the Annual Opinion to be submitted to the Committee in March 2020.

The Chair noted the work that has been undertaken and yet to be completed to achieve clear outcomes. In noting the assurance given through the report the Committee thanked The Executive Members and officers for the information provided and responses to questions.

Decision

To note the report and the comments received.

AC/19/61 Adult Social Care – Improvement Programme

The Committee considered the report of the Executive Director Adult Social Services which provided an overview of current work to improve the core delivery of adult social care services through improvements in process, systems, practice and culture.

The report provided an update on work to integrate adult social care into Manchester Local Care Organisation, including the mobilisation of the Integrated Neighbourhood Teams.

The committee had previously considered a report in October 2019 and a diagnostic piece of work was undertaken that identified challenges on Adult Services such as:

- An increase in in safeguarding enquiries;
- Increase in deprivation of liberty safeguards referrals;
- Challenges in maintaining low lists for assessments and reviews.

The chair invited questions from the Committee.

A member asked officers if they considered the targets set had been over ambitious, in view that some were not going to be delivered on target and the degree of priority given to the targets by those officers responding to the findings. Officers were also asked to give an update on the progress of the implementation of the improvement plan.

The Executive Director - Adult Social Services stated that the input of internal audit is valued as a means to improving services. The aim of the service is to improve at pace however, this is being done in competition with other challenges on the service, such as the integration agenda, staff recruitment and other significant key pieces of work arising during this period.

The Executive Member - Adult Health and Wellbeing referred to the improvement plan and explained that in the process of delivering the plan there had been a series of challenges such as a significant rise on service demand impacting on staff caseloads and other issues that required action to be taken at once. The improvement plan has helped to deal with those unanticipated issues but has also ensured the safe delivery of services to Manchester residents.

Decision

To note the report submitted and the comments made.

AC/19/62 Adult Services Outstanding Audit Recommendations

The Committee considered the report of the Head of Internal Audit and the Executive Director of Adult Social Services. The report provided an overview of the ongoing programme of improvement work for the Audit Committee, in particular to highlight that work to respond to risks confirmed through internal audits undertaken in recent years and now forms part of a wider programme.

The chair invited questions from the Committee.

A member referred to the setup of performance metrics to monitor performance during the implementation of the action plan, to be agreed with GM Mental Health Trust Management (GMMH), and questioned officers on the use of metrics and the length of time monitoring has taken place. Officers were also asked what metrics are in place to measure success in respect of the work on transitions and what percentage of managers had completed supervision training.

It was reported that GMMH have been providing a service for almost two years however, statutory governance monitoring has been provided through Manchester Health and Care Commissioning. The purpose of the recommendation was to dig deeper as part of the Council's statutory duties under the Care Act and its delivery and to work closer with GMMH. In addition, it was reported that the Assistant Director Adult Services acts as link to the GMMH and provides support to the professional lead. The Executive Director Adult Social Services undertook to circulate to members of the committee, for information, performances metrics in respect of GMMH and Transition work and details on the uptake of supervision training by managers.

The Committee discussed the writing and contents of audit reports and, in particular, the language used to present of information. The point acknowledged that phrasing used within reports could sometimes be difficult put into context if the reader was not directly involved with an issue.

Decisions

1. To note the report and the comments made.

2. To circulate to members of the committee, for information, details of performance metrics in respect of Greater Manchester Mental Health Trust to identify measures of success and information on the take up and completion of supervisory training by mangers.

3. To note the comments made regarding the phrasing used within the executive summaries or audit reports.

4. To request an update to be provided to members of the committee on the completion date in respect of the Deprivation of Liberty Safeguards (DoLS) recommendations.

AC/19/63 External Audit - Update

The Committee heard from Stephen Nixon, Mazars the Council's External Auditors.

The committee was informed that the Audit Plan will be submitted to the next meeting.

Decision

To note the report.

AC/19/64 Draft Code of Governance

The Committee considered the report of the Deputy Chief Executive and City Treasurer which presented a revised draft Code of Corporate Governance. The revised Code of Governance will be submitted to the meeting of Council on 27 January 2020.

The chair invited questions from the Committee.

Reference was made the process of engagement with the public and how this takes place. Officers were asked for evidence of community engagement through ward co-ordination and its effectiveness which varied across the city in terms of the role of elected members and the support/development/training they receive in comparison to officers which should be reflected in the Annual Governance Statement.

It was reported that the process of engagement will be spread across the Council and this will set out within the Annual Governance Statement. The process of consultation and how it could be improved had been considered at a scrutiny meeting. The engagement of communities through ward co-ordination does take place but work was needed to assess how effect this is. The point raised on member training and support was noted and would be taken up through member services. In addition, the Equality Team would be contacted regarding the inclusion of staff and elected members to better reflect diversity of those people contacted for engagement purposes and to address the wording used in the Code, in light of the comments received.

Decision/s

1. To note the report submitted.

2. To note the comments made in respect of:
    - The wording of the Code of Governance document
    - Elected member training and support arrangements
    - The inclusion of staff and elected members to reflect diversity of the city to improve the level of effective engagement.

3. To recommend to Council that the revised Code of Corporate Governance be incorporated into the Council's Constitution, subject to the comments received.

AC/19/65 Annual Audit Plan – Horizon Scanning Report

The Committee considered the report of the Head of Audit and Risk Management which set out areas of potential risk and focus for 2020/21 and future years' internal audit planning. The Committee also received a presentation that set out the context of the plan and identified potential areas of future risk within each area of council service.

The chair invited questions from the Committee.

In noting the areas of risk across the Council's directorates, members referred to the resources available to undertake audit work and underlined the importance of focusing on areas that have most impact on the public in particular prioritising the welfare of people before other areas of services that are not frontline. Officers were referred to the issue of risk management and were requested to define what internal audit perceive as being a key risk. The point was also made that the lists shown in the report could be considered as being prioritised.

The Committee was informed that frontline services to residents is at the forefront of the audit plan, although it is necessary to balance this across areas such as the needs of residents, welfare and statutory requirements. Therefore, the audit of key systems of control, are in place to oversee these to ensure their governance is robust and working effectively. Members were informed that the lists in the report were not prioritised or in any order. The Corporate Risk Register will be refreshed and will be submitted to Audit Committee on 11 February 2020. The Annual Audit Plan will be submitted the following month and will include topics from the Risk Register as well as other issues.

A member referred to future changes in areas such as IT and new technology and officers were asked what preparations are in place to ensure there are resources with the right knowledge skills mix to meet new challenges.

The Committee was informed that investment is being made into increasing skills capacity in areas including data information systems, ICT and data analytics to identify patterns and improve efficiency. Staff training is in place to increase in-house skills and knowledge to meet new challenges. IT and new technology is recognised as a key growth area for audit and in some cases it may be necessary to procure external expertise when a particular skill mix is not available internally.

Members referred to the non-completion of the previous audit plans due to a lack of resources and asked officers how many staff vacancies are in Internal Audit and what preparations were in place to fill them. Also officers were asked if there are any areas that have not been identified as a priority that should be.

It was reported that there are currently three vacancies and interest is being sought to fill the vacancies, however the staffing arrangements may change and temporary resources may be brought in to ensure the audit work plan is achieved. A service review is ongoing and this will provide an assurance that resources will be available over the year to fulfil work demands.

In response to the issue of audit planning for the unknown, it was reported that essential areas such as statutory roles are monitored through key processes and

systems to identify changes or the emergence of patterns. Changes in systems could include overspends or a rise in the number of complaints received in an area of service as well as intelligence gathered from internal and external sources.

A member referred to the role of audit teams from other GM Authorities and asked if consideration had been given to individual authorities leading or specialising in a particular area or skill set.

It was reported that discussion has taken place with the other GM Authorities to co-ordinate working in collaboration and the sharing of resources for pieces of work. This collaborative approach is already taking place with audit work and audit colleagues in the health service.

Decision

To note the report and the comments received.

AC/19/66 The Committee's Work Programme

Decisions

1. To note the Work Programme.

2. To note that he meeting of the Committee on 14 January 2020 has been cancelled.

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Manchester City Council
Report for Information

Report to: Audit Committee - 11 February 2020

Subject: Internal Audit Assurance Report 2019/20

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 a summary of the audit work undertaken and opinions issued in the period April to December 2019.

Recommendations

Audit Committee is requested to:

1 Consider and comment on the Internal Audit Assurance Progress Report to 31 December 2019.

2. Confirm and approve the proposed changes to the Internal Audit Plan 2019/20.

Wards Affected: All

Contact Officers:

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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.

- Internal Audit Plan 2019/20 (April 2019)
- Outstanding Audit Recommendations Report (12 November 2019)
- Internal Audit Progress Report (12 November 2019).

1. Introduction

1.1 This report provides a summary of the work of the Internal Audit Section from April to December 2019 including progress towards delivery of the annual audit plan; a summary of assurance opinions on completed audits; and a summary position on the implementation of Internal Audit recommendations. Focus is on the work produced in the third quarter of the year October to December. The opinions and statistics have been shared with Directorate senior managers for discussion; to agree actions; and will be used to inform an overall annual assurance opinion in March 2020.

1.2 Appended to this report are:

- Appendix One: The full delivery status of the annual audit plan
- Appendix Two: Executive summaries from 2019/20 audit opinion reports issued as final in the quarter
- Appendix Three: Basis of Audit Assessments (Opinion/Priority/Impact)

2. Audit Programme Delivery

2.1 The following table is a summary of the outturn against the audit plan to date.

Audit Status	**2018/19 Brought Forward**	**2019/20 Audit Plan Status At Q2**	**2019/20 Audit Plan Status At Q3**
Final Report	24	28	51
Draft Report	1	2	3
Fieldwork Completed		4	3
Fieldwork Started		10	16
Planning		7	13
Not started		38	15
Totals	**25**	**89**	**101**
Cancelled / Deferred / Re-scoped		14	20

2.2 Outputs include audit reports, management letters and advice and guidance as well as support to management on service improvement. The analysis does not include most of the advice and guidance provided to the business through involvement in working groups and projects across the Council as these are not usually captured in formal reports.

2.3 The table includes corporate counter fraud investigations where there is a proactive report issued but does not include all casework outcomes. The key focus of corporate fraud and investigation work is summarised in section nine for information however details and outturn is reported in more detail in an annual fraud report and the last report for 2018/19 was presented to Audit Committee in September 2019. This is due to the confidential nature of case work and the status of case activity.

2.4 The annual plan assumed 103 outputs in the year. As reported to Audit Committee at the end of quarter two this was revised to a plan of 89 outputs based on work cancelled, deferred or rescoped. At the end of quarter three the number of planned outputs has increased to 101. This is as result of:

- Seven additional audits added to the plan to respond to current risks and issues; offset by six audits proposed for cancellation, deferral or rescoping. A net increase of one audit.
- Increase in planned outputs as the blocks of audit time assigned to areas of risk including the Our Town Hall Project and Schools Financial Health Checks have since been broken down to assignment level in line with plans.

2.5 Progress on delivery of the 2019/20 annual audit plan has been impacted by a number of factors as follows:

- Resource and timing requirements to complete a number of audits from the 2018/19 audit plan which were beyond assumptions made in the development of the 2019/20 plan. 25 audits from 2018/19 plan were finalised in the year to date.
- Requests for additional audit support on specific unplanned areas.
- Reduction in resourcing including two recent resignations at senior auditor grade which impacts on staff days available to year end. These posts are not planned to be filled with permanent postholders immediately as a service restructure is underway and permanent recruitment will therefore be made once this new structure is in place in quarter one 2020/21. This remains a key risk and focus for the Service.

2.6 Completion of the 2019/20 plan was therefore lower than expected at 49% at the end of the period (against a quarter three target of 70%) calculated using the original planned outcomes target of 103 against current delivered work of 51 final reports. There has been a further review of risk and resourcing to consider how to address the delivery gap. An additional temporary resource at senior auditor level has now been appointed to support delivery throughout quarter four.

2.7 It was agreed at Audit Committee in November 2019 that a number of audits would be cancelled, deferred or re-scoped particularly where there are alternative means of gaining assurance or there was a reasonable request from management to delay audit to a more appropriate time. The audit plan has been updated to reflect those agreed changes as a result. Some further changes have been proposed based on requests from the business and partners and these will be taken into account as part of a refresh of the audit plan. In particular, it should be noted that the following changes have been proposed:

2.8 **Defer. Joint audit of Manchester Health and Care Commissioning (MHCC) Commissioning Decisions.** At a joint audit planning session, management outlined progress being made by Manchester Clinical Commissioning Group (MCCG) and the Council in aligning the approaches to commissioning and decision making as part of MHCC. In their view joint audit work now would add less value because there are system and process

changes in progress that will need to embed; and there would be minimal value added from auditing a system that is in the process of being changed. It is proposed to complete the audit once these are fully operational. Details of the ongoing work will be provided by MHCC to allow Internal Audit to take interim assurance over progress made. We will then develop a scope of work with the newly appointed Deputy Director of Adult Social Services and MHCC audit colleagues for the 2020/21 audit plan.

2.9 **Defer. Integrated Delivery Teams and Adults Management Oversight / Supervision.** Due to limited resources and new priority work around Disability Supported Accommodation assigned in quarter four we propose to defer this audit to quarter one of 2020/21.

2.10 **New**. **Disability Supported Accommodation Service.** At the request of the Deputy Chief Executive and City Treasurer assurance work is being carried out over the effectiveness of control within the Disability Supported Accommodation Service to identify any areas for improvement. The work will consider the management and control over workforce spend where there is a forecast overspend of £3m (27% of the budget) in 2019/20.

2.11 The sections below describe the progress and overall summaries of assurances provided in this quarter against the agreed annual audit plan.

2.12 There are three limited assurance opinions arising from work in quarter three. Two of these relate to schools and are considered low risk/impact to the Council. The other relates to Data Privacy Impact Assessments which is considered by Internal Audit to be high risk/impact. Whilst the Accountable Officer for this audit is the City Solicitor as the Council's Senior Information Risk Officer, the issues relate to activity required across all directorates and will be overseen by the Corporate Information and Assurance Risk Group (CIARG). The City Solicitor will attend Audit Committee to explain actions being taken to respond to the issues raised through the audit.

3 Adult Services

3.1 **MHCC Financial Framework Compliance (Appendix 2 ES1).** Internal Audit provided substantial assurance overall and raised only one moderate recommendation regarding the content of the financial reports which go to the MHCC Finance Committee and MHCC Board to ensure that they include all of the information which the Framework defined as 'integral' to reporting requirements.

3.2 **Adults Improvement Plan Governance (ES2).** Reasonable assurance was provided that the governance, monitoring and challenge arrangements in place can effectively support delivery of the Adults Improvement Plan. The framework for governance had been appropriately designed, including an Improvement Board that maintained oversight of progress and individual workstreams responsible for delivering elements of the plan. Three significant recommendations were made seeking to strengthen and ensure consistency across each of the workstreams delivering the Improvement Plan. These

related to the need to further clarify and simplify the types of actions included within the plan, to refine the provider services workstream into a more manageable number of clear actions and to refresh the Technology Enabled Care and workforce workstream plans using the standard template.

4 Children's Services

4.1 **Planning for Permanence (ES3).** Reasonable assurance was provided over the implementation of the system for Planning for Permanence in line with legislation and policy. The revised policy was clear and articulated the steps required to ensure appropriate permanence planning. The policy had been cascaded to each of the localities and there was evidence that the policy and the expectations of staff were understood. However, we were unable to provide higher assurance because elements of the policy, in particular the Permanence Planning Meetings (PPM), were not all being undertaken in line with requirements and there was limited evidence recorded of these meetings taking place.

5 Education and Schools

5.1 **Primary School Financial Healthcheck Audits (ES4 and ES5)** Internal Audit provided limited assurance to St Margaret's Primary School and made five significant risk recommendations and one critical risk recommendation to strengthen controls around expenditure and income. We raised concerns about the effectiveness of the School's compliance with the requirements of Schools Financial Regulations and Scheme of Financial Delegation in relation to purchasing. We provided reasonable assurance to Ringway Primary School and raised two significant recommendations, both relating to strengthening the School's procurement controls. When the audit work is completed for all the planned schools we will issue a summary report to bring together and assess key themes arising from the audits and lessons learned. Outcomes will be shared with all schools for information as necessary.

6 Corporate Core

6.1 **GDPR Data Protection Impact Assessments (DPIAs) (ES6).** Internal Audit provided limited assurance over the Council's arrangements for the production of DPIAs. We were satisfied that sufficient guidance was available to managers and staff to support them in completing consistent and complete DPIAs. However, wider awareness of the requirements in this area was low, and arrangements to monitor compliance in this area were informal. We therefore made suggestions to improve awareness and the assessment of potential privacy risks through the Council's network of Senior Information Risk Officers within directorates.

6.2 **Recruitment and Selection (ES7).** Internal Audit provided a reasonable assurance opinion and no significant recommendations for improvement were identified. We were satisfied that the recruitment exercises reviewed were carried out in line with expectations and our recommendations were primarily

centred on the effectiveness of retention of associated documentation to ensure transparency of evidence to demonstrate decision making.

6.3 **Making Tax Digital.** We issued a briefing note outlining the progress made to support the Council's compliance with Making Tax Digital. We were pleased to note that compliance with the 2019/20 requirements was achieved and that there was a structured and proportionate plan for working towards the October 2020 requirements.

6.4 **Core Systems: Payroll Continuous Auditing (Q3).** We finalised our regular quarterly review of payroll data. We identified a small number of errors in processing which were rectified by payroll officers and there were no significant issues arising from the work.

7 Neighbourhoods and Growth and Development

7.1 **Section 106 (Planning Obligations) (ES8)** Over the last 12 months, there have been a number of development actions to provide improvements over the management of s106 agreements. Whilst these development actions were not fully implemented at the time of our fieldwork, we provided a reasonable assurance opinion on the overall systems of governance and control. We acknowledge that the planned improvements should significantly enhance the arrangements in place to monitor and deliver future s106 agreements.

7.2 **New. Local Growth Fund – Grant Certification.** Internal Audit certified grant totalling £5.97m received in respect of highways maintenance and improvement activities. In carrying out the certification we made recommendations (which did not affect the certification itself) around action to enhance record keeping and reconciliations which support spend which were accepted by management. None of those recommendations were assessed as critical or significant.

8 Procurement, Contracts and Commissioning (PCC)

8.1 **Contract Spend Review (ES9).** Internal Audit provided a reasonable level of assurance over the controls in place over contract related spend. We took assurance from the results of a questionnaire to contract managers that appropriate monitoring checks were taking place at individual contract level however we were less assured that there were controls in place to review contract performance at a corporate level. There was positive direction of travel in the number of contracts and level of information recorded on contract registers since our last review two years ago and evidence indicated that there was a greater alignment between forecast contract values and actual spend. This suggests that the increase in data and information is having a positive impact on control of spend however there is further work to be done to increase the accuracy and completeness of those records. We made a number of recommendations which when actioned should help to address risks around the links between contracts and spend, the management of

strategic suppliers and the accuracy and completeness of data within directorate contract registers.

8.2 **Modern Slavery: Safeguards within Contracts**. Internal Audit carried out a review to better understand the arrangements in place to safeguard against modern slavery risks within Council contracts. The outcome of this was reported as a briefing note to management. This assessment was based on a desktop review of key documents, responses received in a questionnaire to contract managers and clarification or further detail from key officers where relevant. Progress had been made in developing the Council's overarching framework and principles to address increased risks around modern slavery. In order to ensure that safeguards are sufficiently robust and to support development we made a number of suggestions specifically around leadership; improved access to strategy and policy; enhanced guidance for supplier checks; and sharing of initiatives and best practice to ensure appropriate steps are taken to prevent and detect modern slavery risks. We acknowledged that modern slavery risks are not limited solely to activity covered by contracts and supply chains and will assess areas for future assurance work in this area.

8.3 **Contracts Performance Management: Key Performance Measures.** We issued a briefing note which provided an overview of the current arrangements in place in relation to the setting and monitoring of key performance measures within Council contracts. This work was largely informed by the results of a contract manager questionnaire. Overall we took assurance from the results obtained and the level of guidance available to promote good contract performance management. However, there is more work to be done particularly for those contracts which do not have clearly defined key performance indicators (KPIs) and for contracts where KPIs were being not reviewed as a matter of routine.

9 Counter-Fraud and Investigations

9.1 Counter fraud work continued through a programme of proactive and reactive activity in line with the annual plan and as referrals were received. As previously reported the details are usually provided in the Annual Counter Fraud report. A summary of key activity is as follows.

Proactive

9.2 The external firm commissioned to review potential duplicate payments, VAT coding errors and unrecovered credit balances with suppliers has concluded the work with a total of £443k identified from review of five years of standard supplier payments undertaken over the last two years. An additional piece of work focused on telecommunications payments has now been commissioned.

9.3 The National Fraud Initiative continued with Internal Audit supporting progress on investigation of data matches with colleagues in various business areas. While data matches do not always indicate fraud or error this work enables an

assessment of risk and improved data quality where appropriate and there is continued value in the national exercise.

Reactive

9.4 Internal Audit continued to address reported allegations of fraud or wrongdoing following risk assessment and consideration of appropriate action in line with the agreed policy and procedures. Steps to investigate were taken by Internal Audit, service management or through the application of other policies, such as corporate complaints or dispute resolution, as appropriate. In all cases Internal Audit retained an overview of the approach and outcome of investigations. The two main areas of casework and key issues arising in the period are set out below.

Corporate Cases

9.5 Internal Audit has received 54 referrals of potential corporate fraud, theft or other irregularity in the year to date of which 11 were considered whistleblowing allegations made either anonymously or from a named source and were handled under the Council's Whistleblowing Policy and Procedure.

9.6 The nature of investigation work remained consistent including concerns raised in respect of a number of key risk areas including: staff conduct; contractor conduct and contract compliance; ethics and behaviours; employee compliance with procedures and thefts from schools.

Council Tax Reduction Scheme, Housing Tenancy and Right to Buy

9.7 A total of 38 new referrals of fraud and irregularity in relation to Council Tax Support, Council Tax Discount, Housing Tenancy Fraud and Right to Buy application fraud were received in the period making a total of 147 referrals in the year to date. The service took steps to recover £25k of Council Tax Reduction overpayments and £239k of fraud has been prevented or detected where benefits accrue to the wider public sector such as the Department for Work and Pensions or housing providers.

9.8 Outcomes reported in the period include:

- A right to buy application (for a discount of £37,500) was successfully prosecuted at Magistrates Court in October 2019. This fraud by misrepresentation led to a sentence of 16 weeks custody suspended for 12 months, 150 hours unpaid work and costs awarded of £1k.
- An investigation into allegations of social housing tenancy fraud involving subletting and a fraudulent housing application led to a guilty verdict at Magistrates Court in January 2020 and a sentence of 80 hours community punishment order and costs of £3k. An appeal has been made on this case.

9.9 As reported in the 2018/19 Annual Fraud Report, the Revenues and Benefits Service commissioned a third party provider to undertake a proactive data matching exercise to identify potential cases of Small Business Rate Relief

(SBRR) fraud within the City. This resulted in 40 cases being passed to Internal Audit for investigation. As a result of this work during 2019/20, retrospective changes to liability has resulted in an additional £142k being recovered and an increase in ongoing liability of £75k. One case is being progressed as a joint prosecution with another GM Authority.

10 Recommendation Implementation

10.1 Internal Audit continued to monitor implementation of recommendations, engaging with managers to assess exposure to risk in areas where actions remained outstanding and to explore options for mitigation of risk. Overdue recommendations are reported in more detail to Strategic Directors and Executive Members at six and nine months overdue. A separate report to Audit Committee February 2020 provides details of the progress and actions to implement overdue high priority recommendations.

10.2 The number of critical, major or significant priority recommendations fully implemented was 68%. This was slightly below the target of 70% but 10% higher than in the last period. A further 15% of recommendations were partially implemented at the time of assessment.

10.3 Outstanding recommendations fell from 32% to 17% however some of those recommendations are more than 12 months past the agreed due dates. Where there are significant issues in meeting deadlines and reducing exposure to risk those issues have been reported to Audit Committee for review. Some solutions in a number of cases are acknowledged to be complex linked to actions being progressed as part of wider service improvement programmes. These matters will remain under review. A separate report to Audit Committee provides further details.

Critical, Major or Significant Priority Recommendations by Directorate

Directorate	Number Due	Implemented	Partially Implemented	Referred Back to the Business	Outstanding
Corporate Core	18	13	3	0	2
Children's Services	16	12	1	0	3
Adult Services	25	11	6	0	8
Growth & Dvt and Neighbourhoods	16	15	1	0	0
Total	**75**	**51**	**11**	**0**	**13**
		68%	**15%**	**0**	**17%**

11. Recommendation

11.1 Audit Committee is requested to:

- Consider and comment on the Internal Audit Assurance Progress Report to 31 December 2019.
- Confirm and approve the proposed changes to the Internal Audit Plan 2019/20.

Appendix One: Audit Status, Opinions and Business Impact

Audit Area	Audit Status	Assurance Opinion	Business Impact
Children's and Families 2018/19 Brought Forward Work			
Assessed and Supported Year in Employment (AYSE) 21.05.19	Delivered	Moderate	Not Set – 2018/19 audits
Schools Procurement (Thematic) 12.07.19	Delivered	Moderate	
Children's Services – Management Oversight and Supervisions 09.05.19	Delivered	Moderate	
Deprivation of Liberty Safeguards (DoLS) 03.05.19	Delivered	Limited	
Floating Support - Support to Homeless Citizens in Temporary (Dispersed) Accommodation 29.05.19	Delivered	Limited	
Adults Services – Management Oversight and Supervisions 05.04.19	Delivered	Limited	
Mental Health Casework Compliance 05.04.19	Delivered	Limited	
St Matthew's RC High School 03.05.19	Delivered	Limited	
Off Rolling of Pupils 06.06.19	Delivered	Moderate	
Manley Park Primary School 09.05.19	Delivered	Moderate	
Ofsted Improvement Plan 17.10.19	Delivered	Moderate	
Planning for Permanence 20.12.19	Delivered	Reasonable	
Manchester Local Care Organisation – Governance 11.09.19	Delivered	Limited	
Manchester Heath Care Commissioning – Financial Framework Compliance 17.10.19	Delivered	Substantial	
Children's and Education Services 2019/20			
St Peter's Catholic Primary School, Financial Health Check 05.09.19	Delivered	Substantial	Low
St Luke's C of E Primary School, Financial Health Check 11.10.19	Delivered	Substantial	Low
Ringway Primary School 18.11.19	Delivered	Reasonable	Low
St Margaret's Primary School 20.12.19	Delivered	Limited	Low
Free Early Education Entitlement (FEEE)	Fieldwork	Set at draft	High

Audit Area	Audit Status	Assurance Opinion	Business Impact
Early Help Delivery	complete		High
Schools Assurance Framework (Assurance Mapping)	Fieldwork	Set at draft	Medium
Adoptions Policy and Procedure	Planning		High
Children's Services: Quality Assurance Framework and Safeguarding and Improvement Unit			High
Schools Quality Assurance Framework			High
Safer Recruitment	Not started		High
Special Educational Needs (SEND)			High
SATs Quality Assurance Framework	Defer to Quarter 1 2020/21		
Post Ofsted Plan Monitoring	Cancelled Consider for 2020/21 audit planning		
Children's Services – Supervisions and Management Oversight – Follow Up	Re-scoped Included in recommendation monitoring		
Adult Services, including MHCC and MLCO 2019/20			
Adults Improvement Plan Governance 09.01.20	Delivered	Reasonable	High
Mental Health Casework – Follow Up	Draft	Set at Final	High
MHCC – Financial Sustainability Plan	Draft		High
Deprivation of Liberties – Follow Up	Fieldwork	Set at Draft	High
Manchester Services for Independent Living (MSIL)			High
Adults Social Work Casework Compliance			High
New: Supported Accommodation High Needs Decision Making			High
MHCC Governance Follow Up	Planning		High
Strength Based Approach (Adults Improvement Plan block)	Not started		High
Mental Health Panels			High
Health and Social Care Assurance Framework			High
MHCC Commissioning Decisions	Defer		High
Adults Services – Management Oversight and Supervisions – Follow Up	Defer		High
Integrated Delivery Teams	Defer		High
Corporate Services Brought Forward Work 2018/19			
Core Systems: Payments (SAP) 09.05.19	Delivered	Not set	Not set 2018/19

Audit Area	Audit Status	Assurance Opinion	Business Impact
Core Systems: Revenue Budget Monitoring 14.05.19	Delivered	Substantial	audits
Our Manchester VCS Grants – Outcome Monitoring 20.06.19	Delivered	Moderate	
GDPR – Post Implementation Review 20.06.19	Delivered	Substantial	
Risk Governance Assurance 24.05.19	Delivered	Substantial	
Data Centre Replacement 25.07.19	Delivered	Briefing note	
Our Manchester – Performance Management Framework	Delivered	Briefing note	
Corporate Services 2019/20			
Our Town Hall: Allocation of Work Packages 28.05.19	Delivered	Substantial	Assurance Review
Grant Certification: Greater Manchester Pension Fund 03.05.19	Delivered	Not applicable – non opinion audit work	
Core Systems: Payroll Continuous Audit (Q1) 12.07.19	Delivered		
Grant Certification: Carbon Reduction Commitment 26.07.19	Delivered	Grant Cert	Medium
Core Systems: Treasury Management 30.07.19	Delivered	Substantial	Medium
Grant Certification: Interreg ABCitiEs 31.7.19	Delivered	Not Applicable – non opinion audit work	
GSuite: Application Audit 10.09.19	Delivered	Reasonable	High
Core Systems: Payroll Continuous Audit (Q2) 9.10.19	Delivered	Not applicable – non opinion audit work Not set	
Cyber Security 18.10.19	Delivered	Not disclosed	High
Liquidlogic: Access Control 30.07.19	Delivered	Advice and Guidance	
Software Licensing: Follow up 11.10.19	Delivered	Follow Up Audit	
Data Protection Impact Assessments 1.11.19	Delivered	Limited	Medium
Recruitment and Selection 10.1.20	Delivered	Reasonable	Medium
Core Systems: Payroll Continuous Audit (Q3) 18.12.19	Delivered	Not applicable – no opinion audit work	

Audit Area	Audit Status	Assurance Opinion	Business Impact
Making Tax Digital 5.12.19	Delivered		
Core Financial Systems: Assurance Framework	Fieldwork	Set at Draft	Low
Digital Experience Programme (Block) Civica Pay Implementation			Medium
Grant Certification: URBACT C-Change			Low
Grant Certification: Interreg ABCitiEs (Jan 202))			Low
Our Town Hall: Cost Surety of Work Packages Construction Budget			High
Annual Governance Statement		Advice and Guidance	
Corporate Core Transformation	Planning	Set at Draft	Low
Core Systems: Income (SAP)			Medium
User Experience Programme: Asset Management			Medium
Officer Decision Making: Recording			High
Core Systems: Payroll Continuous Audit (Q4)		Not Set	Medium
ICT Assurance Framework	Not Started	Not Set	Medium
Capital Project Management	Not Started	Discovery Review	
Our Town Hall: Incentive Model	Cancelled		High
Our Town Hall: Allocation of Work Packages	Defer		High
Capital Strategy: Governance	Re-scoped Included in Capital Programme Management		Medium
Core Systems: Revenue Budget Setting	Cancelled		Medium
Core Systems: Income (Other)			Medium
Core Systems: Council Tax			High
Workforce Development Planning			Medium
Growth and Development and Neighbourhoods Brought Forward Work 2018/19			
Highways Framework Contracts – Award, Payments and Performance 25.04.2019	Delivered	Moderate 🟡	Not set 2018/19 audits
Northwards Capital Project Management 25.06.2019	Delivered	Substantial 🟢	
Governance of City Centre Delivery	Draft	Moderate 🟡	
Growth and Development and Neighbourhoods 2019/20			
Neighbourhood Investment Fund	Delivered	Reasonable	Low

Audit Area	Audit Status	Assurance Opinion	Business Impact
02.09.19		●	
New: MSIRR (Regent Road) 1st Payment Review 15.05.19	Delivered	Briefing Note	High
New: MSIRR (Regent Road) 2nd Payment Review 14.06.19	Delivered	Briefing Note	High
New: MSIRR (Regent Road) 3rd Payment Review 26.07.19	Delivered	Briefing Note	High
New: MSIRR (Regent Road) 4th Payment Review 08.08.19	Delivered	Briefing Note	High
GM Road Activities Permit Scheme (GMRAPS) 15.10.19	Delivered	Reasonable ●	Medium
Section 106 (Planning Obligations) 17.12.19	Delivered	Reasonable ●	Medium
Disabled Facilities (Main) Grant Certification 08.10.19	Delivered	Not applicable – non opinion audit work	
Disabled Facilities (Additional) Grant Certification 08.10.19	Delivered		
Highways – Local Growth Fund Grant Certification	Delivered		
Highways Service: Programme and Project Management Assurance	Fieldwork	Set at Draft	High
New: MSIRR Regent Road Payment Irregularities			High
Leisure Contract – Performance Management Framework			Medium
NCP (Car Parking) Contract Replacement			High
Work and Skills			Medium
Trading Standards	Not started		Medium
Residential Growth Strategy and Affordable Housing			High
Approach to Neighbourhood Delivery: Integrated Neighbourhood Teams			High
Approach to Recycling			High
Planning Applications			Medium
Management of Major Housing Developments within the City			High
New: MSIRR (Regent Road) - Final Payment Review			High
Highways Assurance Framework	Re-scoped		High

Audit Area	Audit Status	Assurance Opinion	Business Impact
Highways Investment Programme Plan	Replaced by Highways Programme and Project Management		High
Highways Service Redesign			Medium
Highways Contracts Financial Due Diligence	Re-scoped Engagement in Task and Finish Working Group		Medium
Casework Management: Flare Upgrade	Cancelled Pending tender exercise for replacement		Medium
Procurement, Commissioning and Contracts (PCC) 2018/19 Brought Forward Work			
Prevention and Detection of Procurement Fraud – Use of System Data 06.06.19	Delivered	Moderate 🟡	Not set 2018/19 audit
Procurement, Commissioning and Contracts (PCC) 2019/20			
PCC Assurance Framework 09.10.19	Delivered	Briefing note	N/A
Public Contracts Regulations Compliance 02.09.19	Delivered	Reasonable 🟡	Medium
Highways Framework Follow Up 17.06.19	Delivered	Implemented 🟢	Medium
Insurance Arrangements in Contracts Follow Up 18.06.19	Delivered	Implemented 🟢	Medium
Taxi Framework: Follow Up 26.09.19	Delivered	Implemented 🟢	Medium
Contractor Whistleblowing Arrangements Follow Up 18.07.19	Delivered	Implemented 🟢	Medium
New: Social Transport Route Allocation Advice 18.09.19	Delivered	Briefing Note	Medium
Contract Spend Review 10.12.19	Delivered	Reasonable 🟡	High
Modern Slavery: Safeguarding in Contracts 10.12.19	Delivered	Not set – Briefing Note	High
Contracts Performance Management Key Performance Indicators 10.12.19	Delivered	Not set – Briefing Note	High
Decommissioning Contracts: Leaving Care	Draft	Not set – Lessons Learnt	Medium
Framework Agreements: Award and Selection	Fieldwork	Set at Draft	High
Contract Management: Adults (Complex Needs)	Planning		Medium

Audit Area	Audit Status	Assurance Opinion	Business Impact
Factory Project			High
Factory Project Grant Certification			
Contract Governance Framework Agreements – Follow Up			
Contract Management: Children's Placements	Deferred for consideration in 2020/21		High
Contract Management: Block	Cancelled		High

Appendix Two: Audit Report Executive Summaries (Opinion Audits)

The following Executive Summaries have been issued for audit opinion reviews finalised in the quarter and are attached below.

Reference in Appendix	Audit Area
ES 1	Manchester Health and Care Commissioning (MHCC): Financial Framework Compliance
ES 2	Adults Directorate: Adults Improvement Plan Governance
ES 3	Children's Services: Planning for Permanence – Progress on Implementation of New Policy
ES 4	School Financial Health Check: St Margaret's C of E Primary School
ES 5	School Financial Health Check: Ringway Primary School
ES 6	General Data Protection Regulations: Data Protection Impact Assessments
ES 7	Corporate Core: Recruitment and Selection
ES 8	Growth and Development Directorate - Planning, Building Control & Licensing: Section 106 Planning Obligations
ES 9	Integrated Commissioning – Corporate Core: Assurance Review - Contract Spend Review

ES1 Internal Audit Report 2019/20 **Manchester Health and Care Commissioning (MHCC): Financial Framework Compliance**

Distribution - This report is confidential for the following recipients	
Rachel Rosewell	Head of Finance, Adult Social Care and Public Health, Responsible Officer
Carol Culley	Deputy Chief Executive and City Treasurer, Accountable Officer
Claire Yarwood	Chief Finance Officer (MHCC)
Joanne Downs	Associate Chief Finance Officer (MHCC)
The final report will also be issued to the following	
Nick Gomm	Director of Corporate Affairs (MHCC)
Louise Cobain	Assistant Director (MIAA)
Ali Hashmi	Audit Manager (MIAA)
Councillor Bev Craig	Executive Member, Adult Services
Joanne Roney	Chief Executive
Janice Gotts	Deputy City Treasurer
Fiona Ledden	City Solicitor
Karen Murray	External Audit (Mazars)

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Draft Report Issued	9 August 2019
Final Report Issued	17 October 2019

Executive Summary

Audit Objective	Assurance Opinion	Business Impact
To provide assurance over compliance with financial framework requirements, specifically in relation to financial monitoring and reporting.	Substantial	Medium

Sub objectives that contribute to overall opinion	Assurance
Timeliness, accuracy and content of financial reporting	Reasonable
Identification and reporting of variances to inform management action	Substantial
Reporting into and out of MCC and MHCC	Substantial

Key Actions	Risk	Priority	Planned Action Date
Any changes agreed that affect the Adult Social Care cashlimit budget in scope for Manchester Local Care Organisation will be highlighted in the monthly report on an exceptional basis. Greater transparency on the gross and net position will be included in future reports.	Moderate	12 months	30/11/19

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 Health and Care Commissioning (MHCC) is responsible for commissioning health, adult social care, and public health services for the City under a single integrated care budget (ICB). MHCC's Financial Framework sets out the detailed financial arrangements for operation of this ICB. We agreed that in the first

full year of its operation, we would provide assurance over compliance with an aspect of the financial framework; we agreed with the Head of Finance, Adult Social Care and Public Health and the Associate Chief Finance Officer (MHCC) that this audit would focus on financial monitoring and reporting.

1.2. Our work considered the production and delivery of the suite of financial monitoring reports for a sample of months in 2018/19, and focused on aspects of the ICB that related to Council duties and accountabilities.

2. Conclusion and Opinion

2.1. Overall we can provide **substantial** assurance over compliance with the financial monitoring and reporting aspects of the Financial Framework. We considered there were strong systems and controls in place within the Council to support timely and accurate delivery of financial reporting to MHCC, with appropriate identification and reporting of variances.

2.2. We have raised one moderate recommendation regarding the content of the financial reports which go to the MHCC Finance Committee and MHCC Board to ensure that they include all of the information which the Framework defined as 'integral' to reporting requirements.

3. Summary of Findings

Key Areas of Strength and Positive Compliance

3.1. Finance Committee and Board meetings were held as expected in line with the Framework's monthly reporting timetable. Each Finance Committee received an Adult Social Care (ASC) finance position report, and a Joint (combined health and social care) finance position report. The Board received only the Joint finance position report, the contents of which differed slightly from the Finance Committee's version in that there was less detail in some areas, plus some additional high level reports, such as the Health Assurance Framework.

3.2. The monthly reporting timetable defined the dates on which financial reports were to be distributed in advance of the meetings. We found that these timescales were for the most part met. Because the Council's production timetable does not align with the Finance Committee schedule, the ASC financial reports were always reported to MHCC one month in arrears.

3.3. We were able to validate the accuracy of a sample of actual spend figures in the ASC finance position report back to the financial accounting system (SAP). Where projected outturn differed significantly from pro-rated actual spend, we were provided with clear and reasonable explanations of how the projections were calculated. It is intended that the implementation of Liquid Logic / ContrOCC, currently in progress, will enable more financial data to flow directly from the system to the reports, with fewer manual adjustments necessary.

3.4. In both the ASC report and the Joint report, variances were a key focus of the narrative discussion. The reports highlighted how the variances had changed from

the previous month's report; that is, whether the year-end overspend had grown or shrunk since the last report. Narrative explanations on the reasons for the changes were provided where known.

3.5. The ASC finance position report, which was submitted to MHCC Finance Committee each month and which fed into the Joint report, was also routinely shared with the Council's Adults Management Team, and in summary form to Executive. The year-end (period 12) report was properly reported to Audit Committee and Resources and Governance Scrutiny.

3.6. Both MHCC Finance Committee and MHCC Board included representatives from the Council. The minutes evidenced that a discussion of the financial position took place at each meeting. This included the reasons for any changes in the overall position month to month, where pressures were arising and agreed actions being taken. The Finance Committee maintained an action log to track and ensure agreed actions were completed.

Key Areas for Development

3.7. We were not able to confirm that all of the reports which the Framework defines as 'integral' were included in the suite of reporting that was presented to the MHCC Finance Committee and Board. In particular, the Framework required that expenditure and income figures and the ratio of income to expenditure where applicable were reported. There was some inconsistency among the four months' reports we sampled: gross, income and net figures were included in the ASC finance position reports for periods 8 and 9, but only net figures were included in periods 10 and 11. None of the Joint finance position reports to Finance Committee and Board included income and expenditure. In addition, changes to the approved budget were not always noted or explained. Although our focus was on the Council-controlled elements of the reporting, we noted that the Joint reports also excluded actual figures, and similarly did not note or explain changes to the annual health budget.

ES2 Internal Audit Report 2019/20
Adults Directorate: Adults Improvement Plan Governance

Distribution - This report is confidential for the following recipients	
Tracy Cullen	Assistant Director – Adult Social Care, Responsible Officer
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Glyn Syson	Assistant Director – Adult Social Care, Responsible Officer
Bernadette Enright	Executive Director of Commissioning & Director of Adult Social Services, Accountable Officer
Keith Darragh	Deputy Director of Adult Social Services
Sarah Broad	Strategic Lead Business Change
Karen Crier	Strategic Programme Lead, Health and Social Care Integration
Kath Smythe	Social Care Workforce Transformation Lead
Councillor Craig	Executive Member, Adult Services
Joanne Roney	Chief Executive
Carol Culley	Deputy Chief Executive and City Treasurer
Fiona Ledden	City Solicitor
Karen Murray	External Audit (Mazars)
Tim Griffiths	Assistant Director Corporate Affairs, MLCO

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Draft Report Issued	21 November 2019
Final Report Issued	9 January 2020

Executive Summary

Audit Objective	**Assurance Opinion**	**Business Impact**
To provide assurance that the governance, monitoring and challenge arrangements can effectively support delivery of the Adults Improvement Plan.	Reasonable	High

Sub objectives that contribute to overall opinion	**Assurance**
The framework for governance is appropriately designed to support delivery of the plan	Substantial
Roles and responsibilities are clearly defined, understood and discharged in line with expectations	Reasonable
Progress is being accurately and sufficiently monitored and challenged, leading to risk-based prioritisation and decision	Reasonable

making	

Key Actions	Risk	Priority	Planned Action Date
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 action of the highest priority level in the highlight reports.	Significant	6 months	31 March 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.	Significant	6 months	30 April 2020
The 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.	Significant	6 months	30 April 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 Adult Social Care has been experiencing long-standing challenges associated with increase in demand across all services and a number of fundamental service provision concerns have come under significant scrutiny. The Adult Social Care Improvement Plan was established in October 2018 to address these challenges by ensuring that the basics are in place to deliver high quality services while adapting to a broader health and social care reform programme.

1.2 As such, successful delivery of the Improvement Plan is critical for the success of the health and social care reform and integration efforts, and is reliant on there being robust governance, monitoring and challenge arrangements in place.

1.3 Due to the Improvement Plan's links to the Council's delivery of statutory duties, which impacts on control and management of significant corporate risks, this programme of work is considered to be high impact. The agreed audit focused on the governance framework arrangements in place to enable delivery and did not include assessment of specific deliverables.

2 Conclusion and Opinion

2.1 Overall, we can provide **reasonable** assurance that the governance, monitoring and challenge arrangements in place can effectively support delivery of the Adults Improvement Plan.

2.2 The framework for governance had been appropriately designed, including an Improvement Board that maintained oversight of progress. There were a number of workstreams underpinning delivery with assigned workstream leads whose role was to oversee key elements of the plan and to drive individual actions forward. The Improvement Board reported on progress against the agreed aims of the Improvement Plan both internally to Senior Management Team (SMT) and externally to MHCC and MLCO, as well as to the Health and Wellbeing Board and Health Scrutiny Committee.

2.3 Roles and responsibilities had been clearly defined for the Improvement Board and it was appropriately constituted with individuals empowered to take actions or seek support for action. Roles and responsibilities were less formally defined for the workstreams but we found that they were clearly understood in practice.

2.4 Action plans were in place for each workstream as expected however there were some issues with the content, completeness, and accuracy of some of the plans. They did not always identify responsible owners and/or timescales and priority levels for individual actions, and some were overly complicated or appeared to be out of date and in need of refresh. Updates on progress were not consistently recorded for all actions, although overall we found that actual progress was further advanced than the information recorded.

2.5 We reviewed the workstreams that were fully operational at the time of our fieldwork, specifically: the Assessment Function; Safeguarding and Quality

Assurance (QA); Provider Services; Technology Enabled Care (TEC); and the Workforce. The Plan has continued to grow and evolve since its inception, and two newer workstreams, on the Front Door, and Commissioning and Contracting, were in early stages of development and so were not considered in our work.

3 Summary of Findings

Key Areas of Strength and Positive Compliance

3.1 There was a timetable for each workstream to provide a 'highlight' report to the Improvement Board, and our review confirmed that these had been produced and reviewed in line with the schedule. There are no documented minutes of Improvement Board meetings, but a log is kept of actions and decisions, with all actions assigned owners and timescales which are monitored until complete. We attended one Improvement Board meeting and considered there was an atmosphere of honest dialogue wherein challenges and sticking points were properly scrutinised openly and productively, whilst also recognising achievements and milestones delivered.

3.2 Interviews with each of the workstream leads confirmed that each was confident in their role, understanding expectations of them and their teams. Some leads had set up the workstream groups more formally with terms of reference, agendas and minutes, which added clarity, and some had sub-groups within the overall workstream to drive actions forward. Each lead chaired a regular meeting of the workstream group and attendance at each group was stable but also flexible in response to need.

3.3 Methodologies for documenting planned actions, responsibility and timescales, and updates on progress varied significantly between workstreams. These were more robust and comprehensive for the two workstream groups which received more direct support from the Business Change Team: Assessment Function, and Safeguarding and Quality Assurance.

3.4 We attended one meeting of the Assessment Function workstream and could see links between the action plan, discussion and decisions that took place at the meeting, and the contents of the next highlight report to the Improvement Board. We could also readily align the Safeguarding and QA workstream's highlight reports with the workstream plan, including identification of specific actions that were 'not on track' or 'partly on track'. This provided assurance that the Improvement Board was sighted on progress and challenges of the agreed actions.

3.5 There were clear links between the Adults' Risk Register and the Improvement Plan, indicating that improvement actions were being focused on the areas of greatest risk as identified collaboratively with the Council's Risk Team.

3.6 Progress on the delivery of the Improvement Plan was effectively reported to stakeholder organisations on both a routine and ad hoc basis. To minimise the demands on staff time in creating those reports, the Strategic Lead Business Change had devised an effective system to create summary reports from the most recent set of highlight reports, and to re-purpose existing reports for different

audiences. A forward plan had recently been developed pick up on all anticipated information requests to reduce the demand on staff time in producing ad hoc reports on short-notice. We support this action.

Key Areas for Development

3.7 Each action on the Plan was given an 'action type' which could be either 'priority', 'longer term' or 'evidence gathering'. Discussion with each of the workstream leads identified that there was an inconsistent understanding of 'priority' versus 'longer term' and whether and how these related to target completion dates. We have recommended that this rating system should be clarified and that updates on each action of the highest priority level are included in the workstream highlight reports to ensure the Improvement Board have consistent oversight of the highest priority actions.

3.8 The Provider Services workstream was in our view ambitiously scoped with over 250 improvement actions identified across multiple service areas. Each Service Lead was tasked with identifying improvement actions and managing delivery of these within a linked service area plan. Some service areas' plans were complete and up-to-date, but overall there were many gaps in the detail of individual actions in terms of responsible owners, timescales and priority levels, and lack of updates on progress. The workstream lead acknowledged that finding sufficient time to review the plan was a challenge given its size. Although it was clear that lots of improvement work was going on in this area, we found it difficult to see the connection between what was being reported in the highlight reports and what was on the Improvement Plan. To enable greater focus on key deliverables we have recommended that the workstream lead and Improvement Board collectively agree on a manageable number of improvement actions to better enable oversight and maintain focus on key priorities.

3.9 Both the TEC and Workforce workstreams had departed from the standard template for setting and monitoring individual actions. Those workstreams were supported by project managers from the Transformation Team, and had adopted differing methodologies. Both workstreams were more formally governed with set agendas and minutes, and the TEC workstream had a number of sub-groups that reported up into it. However, the documented workstream action plans did not reflect the current positions and both were in fact much further advanced than the plans had suggested. Both workstream leads produced thorough and regular highlight reports, but as with the Provider Services workstream, we could not confirm that what was being reported was in line with expectations because it was difficult to see the links back to the Improvement Plan. We have recommended that both of these workstream plans be refreshed using the standard template to improve clarity and ease of oversight.

ES3 Internal Audit Report 2018/19

Children's Services - Children's Social Care

Planning for Permanence – Progress on Implementation of New Policy

Distribution - This report is confidential for the following recipients	
Name	**Title**
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Sean Walsh	Head of Locality (North)
Kim Scraggs	Head of Locality (Central)
Abu Siddique	Head of Locality (South)
Paul Marshall	Director of Children's Services
Councillor Bridges	Executive / Cabinet Member
Joanne Roney	Chief Executive
Carol Culley	Deputy Chief Executive and City Treasurer
Janice Gotts	Deputy City Treasurer
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Report Authors		
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Draft Report Issued	08 October 2019
Final Report Issued	20 December 2019

Executive Summary

Audit Objective	**Assurance Opinion**	**Business Impact**
To provide assurance over the implementation of the system for Planning for Permanence in line with legislation and policy.	Reasonable	High

System / Risk Sub Objectives	**Assurance**
Strategy, Governance and Oversight arrangements are appropriate.	Substantial
Plans and processes are in place to enable the new approach to be embedded.	Reasonable
There is compliance with procedures including that roles and responsibilities are being discharged consistently.	Reasonable

Management information systems are in place to support monitoring, challenge and decision making and inform performance management and reflective learning.	Reasonable

Key Actions	Risk	Priority	Planned Action Date
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.	Significant	6 months	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 Quality Assurance framework to ensure a level of consistency across each locality.	Significant	6 months	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.	Significant	6 months	1 April 2020

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 City Council has a legal duty to develop a 'Plan for Permanence' for all looked after children (LAC) within its care. The revised policy, implemented in November 2018, outlines the process and timescales required to ensure compliance with national guidelines and the Children and Social Work Act 2017.

1.2 We agreed with management that, given the policy is relatively new and is still embedding across the service, that a developing system audit would be helpful in

providing assurance over the developing arrangements whilst also providing actions, where necessary, to further embed arrangements.

2. Conclusion and Opinion

2.1 Overall, we can provide **reasonable** assurance over the implementation of the system for planning for permanence in line with legislation and policy. The revised policy itself is clear and articulates the steps required to ensure appropriate permanence planning. The policy has been cascaded to each of the localities and there is evidence that the policy is understood, as are the expectations of staff. Elements of the policy, such as the tracker meetings, are becoming embedded in operational arrangements at each locality and from discussions with staff there was a growing awareness of the importance of prioritising permanence from the outset.

2.2 However we are unable to provide higher assurance at this stage given that elements of the policy, in particular the Permanence Planning Meetings (PPM), are not all being undertaken in line with the requirements of the policy. For the sample of cases we reviewed there was limited evidence of these meetings taking place in line with the policy. Interviews with staff confirmed that they were struggling to find the time and resources to plan, hold and document these meetings. However this was not representative across all localities in that it was evident that PPMs are well embedded in some localities in comparison to others.

2.3 Engaging with other services such as the Fostering Service, who are required to attend these meetings is proving difficult due to limited resources and busy schedules. Whilst we accept that supervision meetings were being used to facilitate some of these discussions, these do not achieve the multi-agency input which the PPMs were designed to achieve.

3. Summary of Findings

Key Areas of Strength and Positive Compliance

3.1 The planning for permanence policy is clear and concise and is readily available to staff. Interviews and questionnaires demonstrated that there are positive levels of policy awareness amongst staff, key elements are understood, as are its principles and objectives. It was also clear that staff recognise the importance of the new approach and the benefits for children if permanence planning is undertaken correctly.

3.2 Testing confirmed compliance across a number of key requirements, in particular permanence plans were being developed, reviewed and retained and the tracker meetings were taking place. Tracker meetings are chaired by senior management and we found timely management oversight and challenge of individual cases. Google sheets retained to support these tracker meetings demonstrate this oversight and challenge. Staff interviewed also talked positively about the usefulness of tracker meetings.

Key Areas for Development

3.3 Work needs to be completed to ensure staff, particularly new staff, across all three localities have been fully briefed to support the continued roll out of the new permanence planning policy.

3.4 Our sample testing of cases identified some inconsistencies regarding the maturity and embedding of new arrangements around the Permanence Planning Meetings (PPMs). Records did not show these meetings taking place in line with the policy requirements and some staff confirmed in interviews that they really struggled to arrange, hold and document them given the competing priorities for themselves and partners. These meetings and their proposed agendas are a key element of the new permanence planning arrangements. We recommend that the Permanency Improvement Board review the impact of the initial roll out of the policy and address any key issues identified. Particular focus should be given to Permanence Planning
3.5 Meetings (PPM) and ensuring all staff are fully conversant with the aims and objectives of these meetings and can create the conditions for better practice in this area.

3.6 Planning for Permanence does have a ‘permanence scorecard’ in place that reports activity across the permanence service but does not include targets. The Permanence Lead should work with PRI to develop performance indicators and enable Liquid Logic to provide a platform to record them. In terms of key performance indicators the only one used in relation to permanence planning is that ‘each child is to have a Permanence Plan in place by the second LAC Review’. This KPI is now at 100%. Consideration should be given to developing more performance measures around permanence planning to enable management to assess whether new arrangements are having the desired impact on service delivery and outcomes for children and to assess the overall effectiveness of permanence planning arrangements.

ES4 Internal Audit Report 2019/20
School Financial Health Check
St Margaret's C of E Primary School

Distribution - This report is confidential for the following recipients	
Alison White	Head Teacher, Responsible Officer
Mark Slater	Chair of Governors, Accountable Officer
Jennifer Miller	School Business Manager
Councillor Bridges	Executive Member for Children and Schools
Joanne Roney	Chief Executive
Carol Culley	Deputy Chief Executive and City Treasurer
Fiona Ledden	City Solicitor
Paul Marshall	Strategic Director, Children's and Education Services
Amanda Corcoran	Director of Education & Skills
Reena Kohli	Directorate Finance Lead, Children's Finance
Isobel Booler	Strategic Head of Schools QA & SEND
Karen Murray	External Audit (Mazars)

Report Authors		
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Draft Report Issued	15 November 2019
Final Report Issued	20 December 2019

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.	Reasonable
Expenditure, specifically purchasing and payroll.	Limited
Income collection and recording.	Limited

Key Actions	Risk	Priority	Planned Action Date
The governing body should ensure that its meetings are scheduled to coincide with key milestones in the annual financial management cycle, such as approving the budget plan.	Significant	6 months	Full GB Mtg. – 9 Dec 2019
The Head Teacher and governing body 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 3 years.	Significant	6 months	3 April 2020
The Scheme of Financial Delegation should be clarified in regards to thresholds and approval procedures for budget changes above the Head Teacher's current limit of £20k. We recommend that all budget changes 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. The School Business Manager should ensure that any proposed budget changes have been authorised in line with the Scheme prior to being input into the financial management system.	Significant	6 months	Gov. Finance Committee 22 Jan 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 prior to commitment to purchase being made with the supplier (any ongoing issues should be escalated to the Head Teacher to address with members of staff directly). • Delivery notes or invoices should be clearly annotated to confirm satisfactory receipt of the goods or services. • There is separation of duties between the individuals approving purchases, certifying receipt, and	Significant	6 months	20 Dec 2019

Key Actions	Risk	Priority	Planned Action Date
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 will help to ensure that quotation or tendering exercises can be 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, such as the Educational Psychologist, governors should agree a frequency for periodically market testing the service (for example every three years).	Critical	3 months	Gov. Finance Committee 22 Jan 2020
The Head Teacher and School Business Manager should consider the options for ensuring that there are robust source records of all cash income. We recommend reducing cash transactions by promoting or requiring use of the cashless payment system. For remaining cash income, we recommend use of a drop-box. The School Business Manager should ensure that the source records are checked against the total amounts prepared for banking and this check should be clearly evidenced (sign and date).	Significant	6 months	3 April 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 St Margaret's C of E Primary School in our audit programme due to the length of time elapsed since the previous audit (2011).

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.

2.2 Although we are satisfied that some of the key financial controls are operating effectively, we identified one critical and five significant areas of risk, which prevent us from providing a higher assurance opinion at this time. The Scheme of Financial Delegation and Financial Procedures Manual document key financial controls, delegations and approvals. We are satisfied with the Head Teacher's and governing body's involvement in the financial management of the school. We provide reasonable assurance overall for three of the five areas tested and have identified a number of areas of good practice.

2.3 However, we offer limited assurance over controls around expenditure and income, and in particular have concerns over the school's compliance with Schools Financial Regulations and the school's own procedures and Scheme of Financial Delegation in relation to purchasing. We have raised one critical and two significant risk recommendations in these areas. We were particularly concerned over the degree to which purchases were not being raised on the school's Financial Management System (FMS) prior to the invoice being received from the supplier, and the lack of quotations / competitive tendering for high value purchases.

2.4 We recommend immediate improvements over cash receipting to ensure a robust record of all cash income is maintained, sufficiently detailed to enable an independent reconciliation to the amounts banked.

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 We were satisfied that there was a robust level of financial scrutiny by the Finance Committee. We could see that the Head Teacher reviewed financial information regularly, but records to evidence this were informal, so we have suggested these checks are signed and dated.

3.3 Bank reconciliations were performed in a timely manner and had been reviewed by the Head Teacher. All sampled payroll amendments and additional hours claims were accurate.

3.4 Controls over the use of debit cards were robust. We have recommended including the supporting documentation with the bank reconciliations to improve oversight.

3.5 Cash receipts for dinner money were logged and reconciled to the weekly banking records. We have made a suggestion to improve the efficiency of how dinner money receipts are recorded.

Key Areas for Development

3.6 We have made one critical and five significant risk recommendations. Three relate to improving high level governance of the school, specifically:

- ensuring governing body meetings align to key financial milestones;
- the need for a three-year School Development Plan which links to the three-year budget; and
- changes to the budget have the necessary oversight and approval.

3.7 Two recommendations relate to procurement; we were concerned over the lack of compliance with procurement procedures. Too frequently, staff were arranging supplies and services directly with suppliers, meaning that orders were not subject to formal written advance authorisation. This increases the risk of inappropriate purchases, poor value for money, and loss of budgetary control due to over-commitments. In addition, none of our sample of five high value purchases were supported by alternative quotes or tendering exercises as required. Too many contracts and SLAs had been allowed to roll over year on year without market testing to confirm value for money.

3.8 Finally, we were concerned over the lack of robust source records for cash receipts other than for dinner money. The school has a cashless payment system but still accepts a significant amount of cash at the start of the year for after school clubs and milk. We were unable to confirm that the money was banked in full, as the source records were incomplete. This leaves the school vulnerable to loss of income, and also exposes staff to allegations of wrongdoing.

ES5 Internal Audit Report 2019/20
Schools Financial Health Checks
Ringway Primary School

Distribution - This report is confidential for the following recipients	
Name	**Title**
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Pam Thompson	School Business Manager
Councillor Bridges	Executive Member for Children and Schools
Joanne Roney	Chief Executive
Carol Culley	Deputy Chief Executive and City Treasurer
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Report Authors		
Lead Auditor	Emma Maddocks	234 5269
Audit Manager	Kathryn Fyfe	234 5271

Draft Report Issued	29 October 2019
Final Report Issued	18 November 2019

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	Substantial
Key financial reconciliations	Substantial
Expenditure, specifically purchasing and payroll	Limited
Income collection and recording	Substantial

Key Actions	Risk	Priority	Planned Action Date
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 prior to commitment to purchase being made with the supplier; • All orders, unless there is any case of dispute, are paid within 30 days of the invoice date; and • If the invoice is for a higher value than the order, any additional expenditure should be signed off by an authorised signatory prior to payment being made.	Significant	6 months	31/12/2019
The Head Teacher should ensure that for all higher value purchases where the school does not obtain the requisite number of quotations that the reason for this is reported to the Governing Body. Any reasons for not obtaining the necessary quotations should be in line with the exceptions outlined in Schools Financial Regulations. The Head Teacher should ensure that where a decision is taken to raise call off orders for small packages of work within a larger annual package that this is competitively tendered at the start of the year. In the current year, once the total value of the existing call off order for the plumbing and building supplier has been reached, a competitive exercise should be completed for any further work.	Significant	6 months	31/3/2020

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 includes an allocation of time to complete financial health checks at a sample of Local Authority maintained schools. We agreed to include Ringway Primary School in our audit programme due to the length of time elapsed since the previous audit.

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 Ringway Primary School.

2.2 Overall, we are satisfied that the majority of key financial controls have been well designed and are operating effectively. The scheme of delegation and financial procedures clearly document key financial controls, delegations and approvals and overall we are satisfied with the Head Teacher's and Governing Body's involvement in the financial management of the School. We have provided substantial assurance overall for four of the five areas tested and have identified a number of areas of good practice.

2.3 However, we are only able to provide limited assurance over expenditure and in particular have concerns over the schools purchasing arrangements. We have raised two significant risk recommendations in this area and this has prevented us from providing higher overall assurance at this stage. We are concerned that for half of the sample of purchases tested the order has not been raised on the FMS system prior to the invoice being received from the supplier. We also consider that the controls over high value procurement could be improved to demonstrate best value and to show compliance with the Schools Financial Regulations.

3. Summary of Findings

Key Areas of Strength and Positive Compliance

3.1 The Scheme of Financial Delegation and financial procedures clearly documented key financial controls, approvals and delegation limits, and these were in line with actual practice. The current year School Development Plan clearly linked to the budget. There was evidence of Governing Body involvement on a timely basis in approving key documents and overseeing budget setting and monitoring.

3.2 We were satisfied with controls in operation over key reconciliations, including bank, payroll and income reconciliations. Separation of duties across key financial systems was sufficient. Purchases were approved in line with delegated limits in the Scheme of Financial Delegation.

3.3 There was very little cash income received, and where cash was received, controls were generally sound with appropriate separation of duties and documentation to support banking.

Key Areas for Development

3.4 We have made two significant risk recommendations, both relating to the schools purchasing and procurement arrangements. We are concerned that half of the sample of ten purchases tested had been raised as confirmation orders once the invoice had been received from the supplier. This meant that the commitment to spend had not been approved or been input to the school's financial management system prior to the purchase being made with the supplier in line with procedure.

3.5 We have also raised concerns over aspects of the school's approach to higher value purchasing. Three quotations were not obtained for any of the five higher value purchases we tested, as required by Schools Financial Regulations. For three of the purchases, we were satisfied with the reasons for not obtaining three quotations, however we would expect any such exceptions to be reported to and approved by the Governing Body and this had not happened. For the remaining two purchases, we do not consider sufficient procurement exercises had been undertaken. For one, only two quotations had been received. For the other, the school raised a call-off order with a supplier for various works at the school over the year and we confirmed that both the individual purchase and the overall order were above the higher value threshold. The school had not undertaken any kind of competitive tendering or comparison of costs with other suppliers in appointing this supplier.

3.6 We make a number of moderate and minor risk recommendations to address individual instances of non-compliance and to help strengthen existing controls.

ES6 Internal Audit Report: 2019/20
Corporate Core: Legal Services
General Data Protection Regulation – Data Protection Impact Assessments

Distribution - This report is confidential for the following recipients	
Name	**Title**
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Michael Seal	Data Protection Officer
Stephen Hollard	Group Manager, Democratic and Statutory Services
Sir Richard Leese	Executive Member
Joanne Roney	Chief Executive
Carol Culley	Deputy Chief Executive and City Treasurer
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Report Authors		
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Draft Report Issued	16 October 2019
Final Report Issued	1 November 2019

Executive Summary

Audit Objective	**Assurance Opinion**	**Business Impact**
To provide assurance over the Council's arrangements for the production of DPIAs.	Limited	High

System/Risk Objectives	**Assurance**
Council systems support the proactive identification of the requirement for a DPIA to be undertaken.	Reasonable
Operational working practices support the consistent and complete production of DPIAs, in line with Council policy.	Reasonable

DPIAs are produced and agreed on a timely basis, supported by relevant sources of information.	Limited
Management information supports the active management of compliance with DPIA legislation.	Limited

Key Actions	Risk	Priority	Planned Action Date
Ensure that the data protection communications plan includes messages to address the awareness gaps identified in our audit. The plan should be presented to CIARG for review and approval.	Significant	6 months	30 April 2020
Provide support to facilitate the completion of a DPIA for each project included in the audit.	Significant	6 months	30 April 2020
Establish arrangements for the periodic monitoring of compliance with DPIA requirements.	Significant	6 months	30 April 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 General Data Protection Regulations (GDPR) came into effect on 25 May 2018. The Data Protection Impact Assessment (DPIA) is one of the specific processes mandated by GDPR – organisations must carry out a DPIA where a planned or existing processing operation "is likely to result in a high risk to the rights and freedoms of individuals". The failure to carry out a DPIA when required or to consult the Information Commissioner's Office (ICO) when necessary, can lead to the Council facing enforcement action with the maximum financial penalty of 10 million euros.

Examples of processing that normally require the completion of a DPIA are:

Type of processing	Example
Innovative technology	Artificial intelligence and machine learning
Denial of service	Mortgage or insurance applications
Large-scale profiling	Social-media networks

Biometric data	Facial recognition systems
Genetic data	DNA testing
Data matching	Direct marketing
Invisible processing	Online tracking by third parties
Tracking	Data processing at the workplace
Risk of physical harm	Social care records

1.2 Following the introduction of GDPR, we agreed with managers to carry out a series of reviews over time, focusing on specific aspects of compliance with GDPR. If the Council is unable to demonstrate a robust approach to the assessment of privacy risks, there are significant associated financial and reputational risks.

1.3 We selected DPIAs as an area for review in recognition of the critical role they fulfil in demonstrating that significant changes to policy and working practice are designed to mitigate privacy-related risks at the earliest stages.

2. Conclusion and Opinion

2.1 As a result of the audit work that we have carried out we can only provide limited assurance over the Council's arrangements for the production of DPIAs. From the managers we interviewed, awareness of DPIA requirements was low. We reviewed ten decisions from the Register of Key Decisions and Forward Plan) where we would expect the requirement for a detailed DPIA to have been actively considered. Only two assessments had been completed.

2.2 We discussed with managers how they had assessed data protection risks in each instance. Only half the managers were aware of DPIAs. None of these had completed the screening assessment to confirm whether a DPIA was required for their project, except the two who had completed DPIAs.

2.3 We accept that some large projects may have started before the legal requirement for DPIAs was introduced. However, given the scale of projects we reviewed, and the good practice advice issued by the ICO before this time, we would expect some formal assessment of data protection and privacy related risk to have been undertaken.

2.4 We were further concerned that corporate monitoring arrangements were not sufficiently developed to highlight non-compliance in this area, and we consider that further work is necessary to support the Data Protection Officer in this respect.

2.5 The guidance produced for completion of DPIAs was clear and comprehensive, and had been embedded in the Council's contracting process. Our key recommendation relates to more effective communications so all officers know how to assess the risk of processing activities impacting data subjects.

3. Summary of Findings

Key Areas of Strength and Positive Compliance

3.1 We were assured that steps had been taken to embed DPIA guidance in the procurement process. We also noted that existing sources of best practice in relation to information governance had been updated to refer specifically to DPIA requirements. To further improve arrangements, we consider that a signpost to the guidance should also be provided in respect of areas added to the Council's Register of Key Decisions.

3.2 A screening template, developed by Legal Services, was available on the intranet. It consisted of a series of questions to support managers in deciding whether a full DPIA was required. Further guidance for the production of DPIAs was also available, which supported the inclusion of consistent information and a standard structured approach. The templates were accessible to all, and support was available to managers when completing the assessment. The guidance could be further enhanced by referencing the need (and associated timescale) for retention of the screening assessment and formal DPIA document.

Key Areas for Development

3.3 Despite the positive efforts to embed standard DPIA practice into the Council's ways of working, managers we spoke to generally seemed unaware of the GDPR requirements in this area. Only two of the areas we reviewed had completed DPIAs in relation to their projects. In our opinion, the remaining eight projects require a formal DPIA.

3.4 For those areas where a DPIA had not been completed, managers were able to discuss potential data protection risks arising from their projects, and to describe actions they had taken to mitigate these. However, none had adopted either the prescribed formal approach, or an alternative, to assess these risks and to document their findings. If a data breach were to occur, and the ICO were to investigate, a key mitigation would be demonstrable evidence that data risk had been assessed and that appropriate action was planned or taken.

3.5 We support the view of Legal Services that some dedicated communications in this area is required to boost awareness of the specific requirements of GDPR. This has been included on the relevant GDPR action plan but has not yet been delivered.

3.6 The size and delivery timetable of projects we tested differed. Some projects we reviewed predated the introduction of GDPR and therefore had not benefitted from updated guidance which is now available. However, other project managers considered their projects were not sufficiently advanced to complete the DPIA. We appreciate that it is not appropriate to be overly prescriptive as to when a DPIA should be completed, particularly as the consideration of data processing risk should be subject to ongoing assessment. However, our findings indicate that this area could usefully be included in communications.

3.7 We are aware that compliance with GDPR has only been a legal requirement since May 2018, and that some of the areas we reviewed have been in progress since before that time. With this in mind, the risk of legal non-compliance in these areas is low and will reduce further over time as ongoing projects conclude.

However, given the high profile of the areas we reviewed (all of which merited inclusion on the corporate Register of Key Decisions), we consider that completion of DPIAs in these areas would demonstrate a positive and active commitment to the principle of protection of personal data, and provide a baseline for future development.

3.8 With regard to management information, there was no structured active scrutiny of information to provide assurance that the requirement for DPIA completion was being addressed. There were a number of existing corporate information sources that could provide the basis for an assurance framework in this area, including dashboards tracking delivery of capital projects and the aforementioned Register of Key Decisions. Further work in this area is required to support the Data Protection Officer in discharging his responsibility for monitoring corporate compliance with this element of the GDPR.

ES7 Internal Audit Report 2019/20
Corporate Core, HROD
Recruitment and Selection

Distribution - This report is confidential for the following recipients	
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Report Authors		
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Lead Auditor	Kate Walter	35292
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Draft Report Issued	15 November 2019
Final Report Issued	10 January 2020

Executive Summary

Audit Objective	**Assurance Opinion**	**Business Impact**
To provide assurance that there are effective arrangements for the recruitment and selection of appropriate individuals to advertised Council vacancies.	Reasonable	Medium

Sub objectives that contribute to overall opinion	**Assurance**
Policies and procedures are in place to support a timely recruitment process, and assist both recruiting managers and officers in HROD.	Substantial
Documentation supporting recruitment decisions is created and retained in line with requirements, including data protection.	Reasonable
There is a clear, demonstrable and fair evaluation and feedback to candidates.	Reasonable

Pre-Employment Verification checks are undertaken prior to an offer of employment.	Substantial

Key Actions	Risk	Priority	Planned Action Date
None	n/a	n/a	n/a

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 workforce plays an integral part in achieving the Council's vision and delivering the city's strategy. It is essential that the process for recruitment of new employees is fair, transparent and enables applicants to demonstrate the behaviours, attitudes and skills required to deliver the Council's aspirations. There were approximately 1,000 fixed term or permanent vacancies approved in the last 12 months. Where recruitment processes do not succeed this can result in excessive costs and can compromise services' ability to deliver to expectations.

1.2. Recruitment processes and applications are considered in all directorates of the Council and are supported by HROD. In order to facilitate the recruitment process, the Council uses a Greater Manchester wide resourcing system, Application Tracking System (ATS), to help manage the process.

1.3. We are aware of a number of other corporate reviews underway which are expected to impact on the future design and operation of the recruitment process. With this in mind we agreed with managers that this work would focus on the operation of the current process between from when an internal vacancy has been approved for advertisement to the pre-employment checks completed prior to starting. The timescales agreed for implementation of our specific recommendations should support managers in considering these actions in context of the outcomes of the other reviews, and moving forward in a co-ordinated and holistic manner.

2. Conclusion and Opinion

2.1. We can provide a **reasonable** level of assurance over the arrangements for the recruitment and selection of appropriate individuals to Council vacancies. From our testing it was clear that recruiting managers were aware of the processes and their responsibilities. Where recruiting documentation was available it demonstrated there was a clear rationale behind recruiting decisions, with multiple officers involved

in the decision. Pre-employment checks were undertaken on external candidates (and internal candidates where appropriate) before a final offer of employment.

2.2. We identified two key issues in the audit. Firstly, the absence of information regarding recruiting decisions after six months, and secondly limitations in the functionality to record on the ATS system.

2.3. We acknowledge that there will always be a tension between data retention requirements for personal data and the ability to demonstrate fair and equitable decisions in longitudinal analysis. However, the risk to the council is that there is a time limit for discrimination claims of six months (less one day), the Council would have up to 3 months (for complicated allegations) to respond to a formal 'letter before claim' from the applicant and as such, in our opinion, documents could be required for 9 months. Where the case proceeded to court, documents would need to be retained subject to the outcome of any court decision and/or appeal.

2.4. A Greater Manchester-wide review of recruitment processes is being undertaken in order to align working practices across the different organisations. Once this review has been completed the intention is to procure a shared recruitment system with improved consistency in use. Accordingly, any recommendations and decisions based on the ATS system itself should be used to inform the future specification for this. Any changes that could be reasonably made in the ATS system must be balanced against the possibility that there are likely to be further changes to the process, and possibly the system, in the medium term.

3. Summary of Findings

Key Areas of Strength and Positive Compliance

3.1. Recruitment policies had been updated in June 2018, and a timetable for periodic reviews was in place. It had also been documented that the policy would be reviewed earlier to reflect legislative changes where this was necessary. There were also a number of additional guidance notes, for example in relation to Equality in Recruitment which included potential adjustments that might be supported to remove barriers to applicants with disabilities.

3.2. The guidance provided in relation to the shortlisting process contained standard documentation that was available to support the recording of interview notes, a panel scoring matrix, and the record of the panel selection decision.

3.3. In order to support a fair and unbiased assessment to determine the shortlist for interview, the information provided to recruiting managers withheld personal information from the application form. However, it was impossible to remove these details if the applicant had included them in the supporting evidence.

3.4. We reviewed 8 recruitment exercises for 30 vacancies, covering 219 candidates. In each case there was clear communication to candidates throughout the process; from the initial advert and role profile, through shortlisting and interviews, to requests for references and/or evidence of qualifications for successful

candidates. This was supported by the ATS system which was used to generate communications to candidates.

3.5. We interviewed six recruiting managers as part of our audit, along with officers from the Resourcing Team in HROD. Five of the managers had undertaken the Council's Recruitment and Selection training, as mandated by the policy before access to the ATS system was granted by the Resourcing Team. In discussion it was clear that managers understood this training, and this was supported by our testing. One of the managers had been granted access to ATS system but had not yet undertaken the Recruitment and Selection training. This manager had undertaken similar training and had used ATS in their previous role in another authority. They had recently been reminded via email of the need to undertake this training.

3.6. Shortlisting was undertaken on the basis of the role profile advertised. In all cases, interviews were undertaken by a panel consisting of either two or three officers. We identified three different approaches to the use of written assessments dependent upon the role, two of which were standalone exercises and the third was a basis for part of the interview.

3.7. A number of clear pre-established criteria had been set and were included in the guidance for shortlisting, examples include the requirement to interview any identified looked after children who met the shortlist criteria, and to only interview candidates who live in Manchester for vacancies below grade 3. Our testing identified that where these conditions had been met the appropriate process had been followed.

Key Areas for Development

3.8. The ATS system (as configured) did not have anywhere to explicitly record the results and outcomes from interviews and assessments, other than through attachments. Interview documentation was not always provided to the Resourcing Team to be attached, and there has been an inconsistent approach by managers attaching the documents themselves, with some records not being attached.

3.9. Where documentation had been attached these were deleted after six months in line with the agreed retention period as had the paper records retained by the Resourcing Team. However, we identified three instances where paper records of applications and interview records had been retained by the recruiting manager, and had not been destroyed in line with policy after six months. In each case the recruiting manager was unaware of the need to destroy the records.

3.10. The absence of records for recruitment exercises beyond six months makes it more challenging to demonstrate the basis for decisions taken following the evaluation of candidates. Given the potential requirement for documentation for up to nine months based on the timescales detailed in the practice guidance of the Equalities Act 2010 we would expect records to support recruiting decisions to be retained in line with this. We would not expect full records to be retained beyond this except where a claim was being made as this could be considered excessive under GDPR.

3.11. There was also an absence of documented shortlisting, assessment or interview criteria. In discussion, managers were able to explain the criteria they had used, however this had not been documented for any of the exercises in our sample.

3.12. During the course of our testing in ATS, and through discussions with recruiting managers, it was clear that there were a number of other issues with the ATS System; there were limitations in the functionality, the user interface was considered awkward, and it did not integrate with other Council systems and processes. The following issues should be explored with the current provider and considered as part of any future tendering exercise.

- The user interface was described as ‘clunky’ and not intuitive or user friendly.
- We were advised that ATS would sometimes freeze or go slow (although we are aware that this may be due to wider ICT issues).
- There was no integration with other Council systems and processes, for example SAP or DBS. (We understand that elements of this are being considered as part of Our Transformation with regard to the Joiners, Movers and Leavers processes).
- ATS was not supportive of direct input of interviews or assessments, instead documentation had to be produced outside of the system and attached.

3.13. Although the general recruitment training was clear and well understood there was no structured formal training in relation to ATS. The ATS guidance that was available was sufficient to explain the process for setting up a recruitment exercise, but did not have sufficient information to ensure a consistent approach to recording results. Examples of this included the lack of recorded appointment criteria, the absence of records in the system, and the length of time records retained. In our opinion both training and guidance should be strengthened.

3.14. There were two consistent messages from recruiting managers regarding interactions with the HROD Resourcing Team where their user experience was not ideal:

- It was felt that activity on progressing recruitment only progressed when the managers chased the Resourcing Team. Given the limitations of the scope of our audit this was most obvious in the pre-employment verification checks undertaken, with some services setting up their own processes outside of the system to ensure these were undertaken.
- Linked to this was the absence of consistent communication from the Resourcing Team, with claims that letters had not been issued in line with agreed timescales, resource panels not meeting or not making decisions regarding vacancies, and conflicting information regarding the receipt of documentation.
- This feedback was discussed with the HR Operations Lead, who acknowledged that they were already aware of these issues and that they were working on solutions which would be included in their response to our action plan.

ES8 Internal Audit Report 2019/20
Growth and Development Directorate - Planning, Building Control & Licensing
Section 106 Planning Obligations

Distribution - This report is confidential for the following recipients	
Name	**Title**
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Joanne Roney	Chief Executive
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Draft Report Issued	7 November 2019
Final Report Issued	17 December 2019

Executive Summary

Audit Objective	**Assurance Opinion**	**Business Impact**
To provide assurance that an effective system is in place to ensure that planning obligations agreed under S106 are delivered as intended.	Reasonable	Low

Sub objectives that contribute to overall opinion	**Assurance**
Arrangements are in place to identify and monitor all obligations.	Reasonable
Non-financial obligations are delivered as outlined within the obligation and within agreed timescales.	Reasonable
Financial obligations are collected on time, followed up and accounted for.	Substantial
Monies are used in good time to deliver the agreed outcomes.	Limited
Management information is sufficient; reported and supports	Limited

effective delivery of agreements.	

Key Actions	Risk	Priority	Planned Action Date
Formalise and update the resources and team structure, finalise policies and procedures and formalise governance proposals.	Significant	Within 6 months	31 May 2020
Reconcile the new database to the various records held across the Council and update the database to ensure details of all 106 agreements are recorded in a single place.	Significant	Within 6 months	31 May 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 process of collection and monitoring of s106 obligations contains several key risks, for example that the Council could fail to ensure money due is collected and discharged as intended. There was a new system under development for the monitoring of all obligations and as we had not reviewed this area in over five years we agreed with the Strategic Director, who inherited this service in July 2018, to include this area on the 2019/20 audit plan.

2. Conclusion and Opinion

2.1 Over the last 12 months, there have been a number of development actions to provide improvements over the management of s106 agreements. The key advances have included;

- The development of a database that will enable records and information to be consolidated,
- The development of improved governance processes, and
- The establishment of a revised staffing structure that will provide the capacity to manage all s106 agreements.

2.2 Whilst these development actions were not fully implemented at the time of our fieldwork, we can provide a **reasonable** assurance opinion on the overall systems of governance and control. We acknowledge that the planned improvements will significantly enhance the arrangements in place to monitor and deliver s106 agreements.

2.3 The newly created database is a valuable tool and once fully populated with up to date information on all agreements will increase the effectiveness over the management of s106 agreements. However, it is essential that alongside this, the key actions are implemented.

2.4 Since the time of our fieldwork the service has taken a number of further actions, including some of the key areas for development identified in this report. It is management's view that a number of these actions are now substantially complete and we will review these as part of our standard follow up process to confirm that the risks have been mitigated.

3. Summary of Findings

Key Areas of Strength and Positive Compliance

3.1 A significant amount of work had gone into the creation of the new database. This database is a clear and comprehensive way to capture the information required that will provide for easy monitoring and reporting once fully reconciled to the various information held across the Council.

3.2 New governance proposals had been developed and were starting to be embedded. These include having a key contact for each relevant Council department attending a s106 Advisory Board (reporting to the Strategic Capital Board), which will be supplemented by a s106 Operations group.

3.3 106 agreements contained obligations that made it clear what is expected from the developer, and placed the onus on the developer to notify the Council of any triggers having been met. Wording of agreements had evolved in a manner that ensured spend can go towards relevant projects / activities and any underspend can be utilised.

3.4 There was an enforcement process for any developments that did not comply with obligations, and in practice this was very rarely required.

3.5 There were appropriate systems in place for collecting, following up and accounting for money once the Council had been notified that a trigger had been met.

3.6 A number of new processes had been designed to improve monitoring of spend going forward, such as a new cover sheet that is populated by the relevant departments. This will supplement the new governance arrangements in ensuring all obligations are being fulfilled in a timely manner.

3.7 A new team structure had been approved which will provide a dedicated section 106 officer, increased capacity to implement the new system and formalised reporting lines. This was in place at the time of our final report.

3.8 An annual report was produced for Members (scrutiny) and new reporting and a viewing portal for Ward Members was under design.

3.9 The new database allowed for updates to be received and updated from host service systems (uniform, SAP) in order that accurate information could be continuously available to Members, Officers, developers and the public.

Key Areas for Development

3.10 At the time of our fieldwork the newly designed database was not fully reconciled to s106 records held in other Council systems. Implementation of the new structure should provide the capacity to complete this and we are told that the majority of these have now been reconciled.

3.11 There has historically been a lack of clarity over the roles and responsibilities of the various interrelated teams involved such as leisure, highways, planning officers and legal. Whilst this will improve with the new governance structures, these roles should be formalised.

3.12 Whilst the onus is on the developer to notify the Council when triggers have been met, there was no formalised proactive monitoring (for example inbuilt triggers and biannual reconciliation of all obligations) to ensure monies were received and obligations fulfilled.

3.13 There appeared to be delays on the spending and movement of monies and there were indications that there may have been a number of unspent historical balances remaining on SAP. We are told a piece of work has been done to identify these and that actions will be put in place.

3.14 More regular management information and performance monitoring should be produced to aid in identifying variances and assessing performance**.**

ES9 Internal Audit Assurance Review Report 2019/20
Integrated Commissioning – Corporate Core
Assurance Review - Contract Spend Review

Distribution - This report is confidential for the following recipients	
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Draft Report Issued	13 November 2019
Final Report Issued	10 December 2019

Executive Summary

Assurance Objective	**Assurance Opinion**	**Business Impact**
To provide assurance over financial monitoring and cost control arrangements for contract related spend.	Reasonable	High

Sub objectives that contribute to overall opinion	**Assurance**
Controls used to determine that contracts are in place for areas of high spend.	Reasonable
Mechanisms for ensuring spend is in line with contract terms and the identification of individual contracts where there are significant variances.	Reasonable
Arrangements for monitoring suppliers with multiple contracts across the Council**.**	Limited

Key Actions	Risk	Priority	Planned Action Date
The Council should build on the work undertaken in the last 18 months to improve the content of contract registers so that strategic suppliers can be identified and monitored.	Significant	6 months	31 March 2020

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

1. Executive Summary

1.1 Directorate contract registers show that the Council currently has approximately 550 contracts with other organisations worth £350 million. In line with Our Manchester, we need to understand how our suppliers are performing and be assured that our contracts deliver on the outcomes suppliers have committed to. A key requirement of the Council's contract procurement rules is for officers to monitor a number of areas during the life of the contract including cost, compliance with specification and contract and any value for money requirements.

1.2 This review seeks to build on our previous work undertaken in 2017/18 which identified gaps in the level of information held about contracts and the related spend which limited the corporate view of how well controlled contract spend was. Since that time the Integrated Commissioning and Procurement Team (ICP) have undertaken a significant amount of work with contract managers across the Council to improve not only the information available corporately but also develop the knowledge of these managers about their role. As part of this work more complete contract registers were created enabling officers to more accurately identify the contracts in place and expected related spend.

1.3 Given the level of expenditure attached to contracts, the risks associated with non performing contracts and the amount of work being undertaken to reform the contract monitoring process we have classified this area as having a high business impact.

1.4 Our review provides a **reasonable** level of assurance over the financial management and cost control procedures in place for contract related spend across the Council. We took assurance from the results of our questionnaire to contract managers that checks were taking place at individual contract level. We were less assured that there were controls in place to review contract performance at a corporate level. There was positive movement in the number of contracts and level of information recorded on contract registers since our last review two years ago.

There is also an indication from our sample of greater alignment between forecast contract values and actual spend. This indicates that the increase in data and information is having a positive impact on control of spend, there is however further work to be done to increase the accuracy and completeness of these records.

2. Introduction and Background

2.1 The Integrated Commissioning and Procurement Team (ICP) continue their work to improve the contract management capabilities of the Council including training plans for contract managers and the ongoing plan for procurement of a contract management system. While each of these is likely to help improve the spend management of contracts the impact of this will take time to push through once the initiatives are live. We consider this review should help to provide some assurance that the steps taken so far have had a positive impact and could help in identifying particular areas of focus in future development work.

2.2 Our review utilised data from 2018/19, the last full financial year of information available at the time of the audit. We used the directorate contract registers held by the ICP Team to compare against the spend information, which was extracted from SAP. This differs from our previous review when we had to focus on information in the Chest (the Council's online procurement system) to provide details of contracts due to an absence of consistent and up to date contract registers being in place across the Council. This is a very positive development over the last 18 months.

2.3 While we have attempted to include all contracts detailed on the register that were active during the 2018/19 financial year we encountered a number of issues that meant this was not possible. As such we have included as many contracts as possible in our review and Appendix 4 outlines the methodology that we used to determine whether or not a contract could be included in our sample.

3 Findings

Progress since last review

3.1 One of the key findings from this review was the increase in the amount of data available on Council contracts. When we undertook a similar review two years ago we were only able to incorporate 153 contracts into our review, with this information being extracted from the Council's electronic procurement system (Chest) as no central registers were in place at the time of the review. For this current exercise we were able to incorporate 320 contracts into the review and the information for these have come from contract registers maintained within individual directorates. The fact that we have more than doubled the number of contracts reviewed shows the work undertaken to improve the systems surrounding contracts is taking hold.

3.2 In using the directorate contract registers as the basis for our contract information we were also able to provide further detailed breakdown of performance by directorate. This allowed us to reflect on the varying levels of adoption of the new contract practices across the different directorates. Appendix 2, table 1 shows some

of the indicators of this by measuring the number of contracts on each register that have either a named contract manager or SRO and whether the criticality tool has been applied to the contract. From this we can see that the new tools seem to have been fully adopted within the Neighbourhoods, Strategic Development and Highways services but that there is more work to be done across the other areas of the Council though it is acknowledged that work is in progress in other areas with both Adults and Children's in the process of reviewing the criticality of their contracts. While this is broadly in line with the views that ICP officers had of how their work was being adopted this review demonstrates the level of compliance with the contract management standards and the progress being made is worthy of note.

3.3 In assessing spend against contract information we were able to calculate an aggregate position for the Council which showed contracts overall as being underspent (9%). While this incorporates some much larger over and under spends on individual contracts it again reflects a better position than our previous review which showed contracts as being on average 13% overspent. We acknowledge that the change in value may be due to the contracts being considered in each of the reviews. Nonetheless the table below shows that the level of change is significant and as such consider this is as a result of the work undertaken to increase the knowledge and awareness of contract managers that has taken place over the last two years. The table below compares the headline results for this review compared to the one two years ago.

	2018/19	**2016/17**	**% Increase**
Number of contracts examined	323	153	111%
Total Contract Value	£255,454k	£94,636k	169%
Total Spend	£232,328k	£107,319k	116%
Total Variation	-£23,126k	£12,683k	-182%

3.4 In conducting the above comparison we did note that the number of capital contracts contained within the registers had dropped compared to the previous reviews with large value capital contracts not being included on the directorate registers (e.g. North West Construction Hub, CAPPS, Factory and Our Town Hall). We confirmed that while a register had been put in place for 2019/20 it was not in place for the previous year and as such would not be helpful for our review. As such we have not attempted to include these contracts and acknowledge that their absence is a limitation of the review.

Spend Analysis

3.5 We determined the spend position for 323 contracts against the contract registers (Appendix 2 table 2 provides a breakdown by directorate of contracts).

3.6 While the overall position was broadly in line with the contract value (an underspend of 9%), this masks some of the individual contract variances. The table below provides details of the number and value of contracts that were overspent, underspent or on target (within 10% of contract value). From this it can be seen that

the majority of contracts were overspent though there are number of high value contracts which are underspent which skew the overall totals.

Status	Number of contracts	Total Annual Value	Total variation from contract value	Average Contract value	Average Variation
Underspent	122	£162,672k	(£55,029k) -34%	£1,333k	£451k
On track (those within 10% of contract value)	36	£4,800k	£208k +4%	£133k	£6k
Overspent	165	£87,982k	£31,695k +36%	£533k	£192k
Total	323	£255,454k	£23,126k -9%	£791k	£72k

3.7 We examined some of the highest overspent contracts (by percentage of contract value) to understand why the contracts were overspent. The results of this as recorded in table 5 of Appendix 2 outline that there were additional purchasing arrangements in place with contract suppliers which were not covered by the actual contracts listed on the registers. We suggest that further investigation may be required to determine if this was due to additional contracts being in place which were not included on the register or non contractual spend which potentially should have a further agreement in place.

3.8 As part of the checks that we undertook on some of the overspent contracts we were able to identify that the annual values entered for some significant, high value contracts had been entered incorrectly into the contract registers. While we have asked staff to make corrections where we have identified these issues we did not confirm the accuracy of all contracts, as such the accuracy of our findings are limited to the accuracy of the data contained in the contract registers.

3.9 As part of the matching exercise we attempted to link all of the suppliers on contract registers to SAP suppliers (noting that some contracts are awarded to multiple suppliers, e.g. frameworks so there are more suppliers than contracts). We were able to link 73% of suppliers a slight increase on our previous review (table below shows comparison). Again while this is a positive step there is still no clear link between contracts and SAP and 80 contracts remained where it did not suggest that a supplier had been set up on SAP. While this may be linked to payments made through other systems which are then interfaced into SAP there is no reference that can be easily checked to confirm if this is the case.

	2018/19	2016/17
Number of suppliers	703	386
Number matched to SAP	516	275

Number not matched	187	111
% not matched	27%	29%

3.10 We also used the contract data available to determine any strategic suppliers for the Council, i.e. those suppliers who have a large number of contracts, high value contracts, or contracts critical to the operations of the Council. As the completion of the criticality of contracts on the register was patchy we were unable to incorporate the criticality of contracts in the review.

3.11 The suppliers with the most contracts and those with the highest value are recorded in tables 3 and 4 of Appendix 2. We reviewed this information to try and determine the Council's strategic suppliers. From this we note that suppliers with the most contracts generally held lower value contracts with only four exceeding a total value of £1million. The highest value contracts ranged from £5million to £20million. Only one supplier appeared on both lists – this was Manchester University NHS Foundation Trust. There will be other suppliers who will be critical to the Council's success however it was not possible from the information held in the registers to identify these. We made enquiries to determine if there were any processes in place to determine the strategic suppliers for the Council, however no work was currently underway to progress this or to define any additional monitoring or scrutiny required for those suppliers.

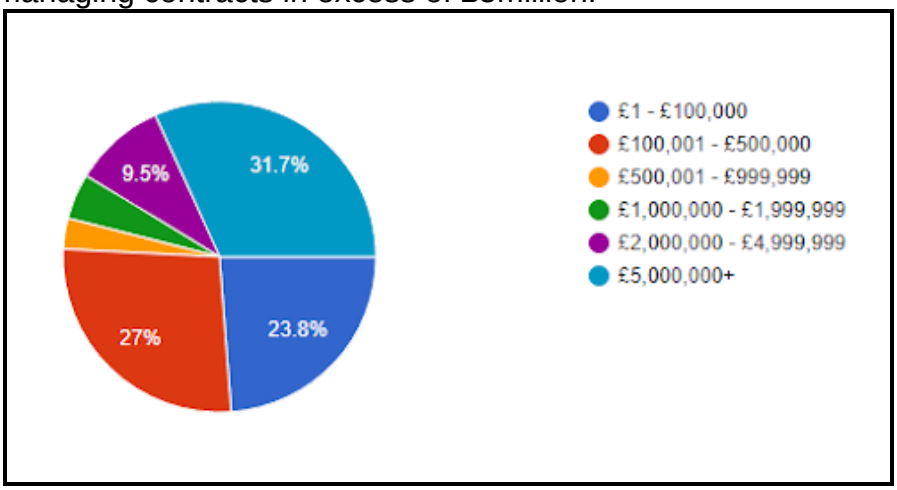
3.12 We identified the top 20 suppliers by spend and attempted to match these to contract registers to ensure that agreements were in place. We were only able to match six of the top 20 suppliers to the directorate registers. When we checked the remaining suppliers against information held within the Chest we were able to match a further five suppliers. We made enquiries into the remaining nine and confirmed:

- Four related to Housing Investment Fund loans paid across on behalf of the Greater Manchester Combined Authority.
- One related to a PFI agreement that was not included on the register.
- One was the Councils Arm's Length Housing Operator, Northwards.
- One was Manchester International Festival (MIF), linked to grant and The Factory project.
- One was confirmed to be a strategic loan agreed by the Council; and
- One was NHS Central Manchester CCG with whom the Council is working in partnership to redesign the Health offer across Manchester.
- As such we were assured that appropriate agreements were in place with the suppliers with whom the Council has the highest levels of spend.

Questionnaire

3.13 We issued an anonymous questionnaire to 251 individuals identified as having a role in contracts and commissioning. Of these 87 responded (35%). Due to the variety of roles related to contracting and commissioning across the Council our first question asked for the number of contracts that the respondent managed. If the respondent answered 0 then no further questions were asked. Following this we had 63 respondents who answered our detailed questions.

3.14 We asked a number of background questions which established that respondents were split across the three directorates, mainly managed revenue contracts and in the majority worked with other officers to manage their contracts (Appendix 3 shows details of responses). We also asked the respondents to estimate the total value of the contracts that they managed. The chart below shows the results of this and illustrated that almost half of the respondents were managing contracts in excess of £500,000, with the biggest proportion of respondents (31.7%) managing contracts in excess of £5million.



3.15 The majority of respondents confirmed that they were, at least in part, responsible for checking the calculations of payments for their contracts. Of those not involved in checking payments to the supplier 5/8 were able to confirm that another officer undertook these checks and 2/8 were unsure if someone else undertook the checks (and had confirmed that others were involved in the contract). Only one confirmed that they were the only one involved in the contract and did not check payments. This respondent had identified that they managed contracts up to the value of £100,000.

3.16 The number of respondents who were able to positively confirm that they were involved in the payment process and the checks that they were undertaking provides positive assurance that spend is considered a key part of the contract monitoring process. We were also assured that the majority of respondents (59/63) confirmed that either they or another member of their team were monitoring actual costs against the expected annual value of the contract.

3.17 The majority of respondents considered that their contract spend was in line with the expected value (65%). This does not align with our findings which showed only 11% of the contracts examined were within 10% of approved value. However given that the responses were anonymous we could not match the responses to the payment analysis and it may be that the contract managers for those contracts which were on track were the ones that responded to the questionnaire.

4 Conclusions

4.1 Our testing has shown that the Council has taken significant steps to improve both the visibility and financial management of contracts, however the journey is not yet complete and further work is needed.

4.2 While contract registers have been incorporated into corporate Council standards they are clearly more embedded in some areas than others and our work did identify some gaps and errors. As such further work is needed to improve the accuracy and completeness of these registers.

4.3 The links between contracts and SAP is still unclear. Whilst we were able to match more suppliers to SAP records as part of this exercise this was only a marginal increase (albeit with a much bigger sample size).

4.4 The Council did not yet have any clear procedures to identify and oversee its strategic suppliers (those suppliers with high number, high value contracts or contracts which are critical to the Council's operations). Work is underway to identify the criticality of contracts and information within registers already allows some aggregation of the number and value of contracts if the information were to be merged and summarised across registers this would help to determine those strategic suppliers. Given the recent high profile liquidations of a number of key suppliers to the public sector it is important that the Council recognises and monitors those suppliers on whom it places a level of reliance. In doing this the Council can then look to mitigate any risks that may appear should the supplier enter a period of crisis.

4.5 While the overall contract position shows an underspend this hides a number of overspends which as identified above may relate to either additional contract spend or additional agreements not included on the contract registers. Work may be needed to identify and address these as they may place the Council at risk of challenge, either through a challenge that the original tender value was incorrect, or because additional spend has not been appropriately procured. Both of which would likely result in a financial loss for the Council (at the least in defending the claim) and potentially an inability to provide services if contracts were suspended while the claim investigated.

4.6 Taking all of this into consideration and as a result of this review we can provide reasonable assurance over the Council's financial management of contracts and a positive assurance over the current direction of travel.

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 - 11 February 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.

Recommendation

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 12 November 2019
- Adult Social Care Improvement Programme Report to Audit Committee 15 October 2019

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.

1.2 Details of progress on all individual outstanding recommendations are shared with Strategic Management Team, Executive Members and Audit Committee to enable oversight of progress to address exposure to risk. From 2019/20 there are four categories of recommendation priority: critical, significant, moderate and minor assigned based on risk. High priority are those recommendations classified by Internal Audit as critical or significant and deadlines for action are agreed with the business at the time of the audit.

1.3 This report provides the details of progress to address outstanding recommendations in the High Priority categories.

1.4 This report focuses solely on Internal Audit recommendations, as there are currently no High Priority External Audit recommendations currently outstanding. There are two medium priority recommendations as noted in the November 2019 update to Audit Committee where assurance over progress will be requested and shared with the External Auditor as part of their audit review process.

2 Process

2.1 Internal Audit follows up management actions on high priority recommendations formally at least quarterly, to provide independent 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. The results are summarised in the Council's Annual Governance Statement.

3 Current Implementation Position

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

3.2 Since the last formal update in November 2019 Internal Audit has confirmed that there has been action completed to address 24 high priority recommendations in ten audits which have been implemented as follows:

- Framework Agreements – Contract Governance (2)
- Highways Framework Contracts – Award of Work, Monitoring of Payments and Performance (3)
- Northwards Capital Project Management (1)
- Our Manchester Voluntary and Community Grant (1)
- Children Missing from Home (3)
- Adult Services Management Oversight and Supervision (1)
- Mental Health Casework Compliance (2)
- Assessed and Supported Year in Employment (1)
- Management Oversight and Supervision – Children's (8)
- Floating Support (2)

Outstanding Recommendations

3.3 There are currently 30 recommendations, from 18 audit reports that are overdue past the agreed implementation dates. These are being monitored and can be summarised as:

- Six over 12 months overdue.
- Four between six to nine months overdue.
- 20 recommendations between one and six months overdue.

3.4 The 30 overdue recommendations comprise of actions that remain fully outstanding (16) or partially implemented (14). Actions to address them continue to progress and an update summarising this is provided below.

3.5 The six recommendations outstanding over 12 months all relate to Adults Services and or where there are complex changes required to strategies, systems policy and guidance.

3.6 Internal Audit have provided updates on the status of all recommendations in the latest DMT assurance reports and continue to liaise with management to establish progress and evidence of implementation and means to support action to address risk.

Overdue More than Nine Months (Appendix 2)

3.7 There are six recommendations which have been outstanding over 12 months in three audits. Audit Committee received an update on progress from the

Executive Director of Adult Social Services and Executive Member, Adults Health and Wellbeing on 15 October 2019 on Transitions and Disability Supported Accommodation Services and from the City Solicitor in regard to Purchase Card guidance. Internal Audit will continue to monitor progress and Directors will be asked to attend Audit Committee for further updates if implementation has not been achieved.

- Disability Supported Accommodation Services (2 recommendations)
- Transition to Adults (3 recommendations, 2 of which partially implemented)
- Purchase Cards (1 partially implemented recommendation)

3.8 A follow up audit for Disability Supported Accommodation Services quality assurance framework was undertaken and concluded that the recommendations remain outstanding. A workshop was held to assist development of the audit tool and the new moderation process. However, more work is needed to embed this and demonstrate consistency of approach before the recommendation can be confirmed as implemented. Internal Audit will remain engaged with Adults Services in monitoring progress in this area.

3.9 Transitions is a key area of focus in the Adults Improvement Plan and this remains a high priority. As reported to Audit Committee in previous reports there is still work to do to mitigate risk and recommendations remain significantly overdue. Planned actions include a review of vision and strategy, which will inform the basis of the new service.

3.10 A recommendation relating to the use of Purchase Cards remains partially implemented. The City Solicitor attended Audit Committee to update on progress and agreed a new implementation deadline, allowing time to embed the changes. The recommendation is related to the need to clarify guidance and expectations in respect of provision of gifts and hospitality. Action is underway to review Member Code and the Employee Code to incorporate requirements and will be completed by July 2020 as part of a wider review of the Codes. In the short term, amendments to the Purchase Card guidance have included the requirement for hospitality expenditure to be approved by the Strategic Director prior to provision, which should reduce the risks regarding hospitality paid for via purchase cards.

Overdue for 6 – 9 months (Appendix 3)

3.11 Four recommendations have been overdue for between six and nine months, from two audit reports. 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.

- Adult Services Management Oversight and Supervisions (1 recommendation)
- ICT Software Licensing (3 of which 2 partially implemented)

Overdue less than 6 months (Appendix 4)

3.12 There are 20 recommendations which have been overdue for between one and six months in 13 audit reports. Some of these reports also include

additional recommendations which have not yet fallen due and/or moderate risk recommendations. Three recommendations have due dates that fall at the end of January 2020.

3.13 Internal Audit will continue to monitor these as part of an active programme of review and as part of scheduled follow up audits. The recommendations are shown in appendix four and relate to the following:

- Mental Health Casework (6 recommendations of which 2 partially implemented)
- Assessed and Supported Year in Employment (2 recommendations of which 1 partially implemented)
- Management Oversight and Supervisions - Children's (1 recommendation)
- Penalty Notices (1 recommendation)
- Framework Agreements - Contract Governance (3 recommendations of which 2 partially implemented
- Social Value (1 partially implemented)
- Prevention and Detection of Procurement Fraud (1 partially implemented)
- Neighbourhood Investment Fund (1 partially implemented)
- Adult Services Management Oversight and Supervisions (1 recommendation)
- Procurement in Schools (1 recommendation)
- Deprivation of Liberty Safeguards (1 recommendation)
- Floating Support – Support to Homeless Citizens in Temporary (Dispersed) Accommodation (1 partially implemented)

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 December 2019	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.	- Corporate Procurement 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. Legal issue clear guidance that Framework Managers should not make decisions on re-evaluation of ranking or suspension of allocations against a framework without advice from Legal and Corporate Procurement Integrated Commissioning and Corporate Procurement incorporate changes into guidance -Integrated Commissioning and Corporate Procurement incorporate into training materials - Corporate Procurement communicate widely, including to senior managers	We have reviewed a number of new framework contracts (NWCH and Small Works) which confirmed the wording in the standard framework documentation has been improved such that it would be easier to suspend a supplier from the framework for non-compliance. **Internal Audit Opinion**: Implemented	**No further action required**

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
			and SROs whose responsibility it is to oversee these contracts - Directorate contract leads ensure application of selection, suspension and allocation rules in their framework contracts. Seek advice from Legal and Corp Procurement if required.		
Framework Agreements – Contract Governance 21 January 2019	31 December 2019	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.	- Corporate Procurement will check and if necessary clarify existing guidance on procuring framework contracts, to reinforce the point that the method for selecting suppliers must be agreed and clear in the framework - Legal and Corporate Procurement will amend current protocol for contract finalisation to emphasise this must be in place prior to contract completion - Legal and Corporate Procurement will communicate the guidance and protocol to all Framework	Tender templates for frameworks provide a section for procurement officers to include the method by which suppliers will be selected. This also requires the rules of the framework to be included in the report. Additionally, a framework pack is produced by procurement colleagues for the framework managers which should help to clarify the basis of selection on an individual framework basis. This topic was discussed at the Contract and Commissioning Managers meeting in September 2019 and the correct process to be followed was communicated.	**No further action required**

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
			Managers and Directorate Contract leads. - Directorate contract leads should ensure that selection method is in place and recorded in their framework contracts.	**Internal Audit Opinion**: Implemented	
Our Manchester Voluntary and Community Sector Grants – Monitoring 20 June 2019	30 August 2019	The Programme Lead – Our Manchester Funds should develop minimum expectations for Liaison Officers in relation to frequency and extent of contact made with funded organisations. This could be informed by a risk assessment of the level of support or input required. Once these expectations have been agreed, they should be communicated to Liaison Officers and compliance with these should be monitored.	Liaison Officer role profile, expectations and handover pack to be developed, issued and monitored by Programme Team.	Copies of the relevant updated documents were provided, and we confirmed that they included the relevant information identified during our work. **Internal Audit Opinion:** Implemented	**No further action required**
Highways Framework Contracts – Award of Work, Monitoring of	31 July 2019	The Contract Manager for TC40 and 41 should ensure that all pre, during, and post works inspections are documented. The pre commencement inspections should document	The scope of the works is given to the contractor via drawings and specification sheets. The drawings show the extent of the works and the carriageway markings that	We have received confirmation of the process as well as a number of completed examples of each required document.	No further Action Required

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
Payments and Performance 25 April 2019		the agreed scope and any additions to the original order. This should be confirmed with the contractor in a works order (and or email). A formal process for agreeing changes to this scope should be agreed with all contractors.	are to be put back after the surfacing work and the Specification sheets detail what the works are. Occasionally there may be alterations made to the scope of the works during the pre-start inspection, but more often than not these are of a minor nature and the documentation isn't amended. If there is significant change then the documents would be amended. There are detailed estimates done for every site and orders raised for the contractors in line with the estimates.	**Internal Audit Opinion:** Implemented	
Highways Framework Contracts – Award of Work, Monitoring of Payments and Performance 25 April 2019	31 July 2019	The quality inspection regime should be formally documented and evidenced for all contracts. For TC944 and TC975 quality checks still need to be evidenced while the clerk of works post is vacant. This could be by means of a simple sheet recording a pass/ fail.	TC 40&41: All sites are now visited after the works have been completed and an inspection sheet is filled in with details of any defects that are evident that need remedial works carrying out and, where necessary, photographic evidence is also recorded. Documentary evidence of this will be kept.	We have received details of the quality inspection regime for each contract as well as a number of completed examples. **Internal Audit Opinion:** Implemented	**No further Action Required**

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
			Q20286: The Post quality inspection sheet has been revised, audits are undertaken each week and all checks are captured on the revised control sheet. We are now achieving 5 % checks on each of the wards. TC 944 & 975: A document has been drafted to catch each quality check carried out. Quality checks and site supervision will improve with the appointment of a dedicated Clerk of Works. On site supervision along with quality checks are currently carried out by one of our in house gully operatives and the Contract Manager. Although there is a quality control process agreed, it is yet to be implemented, pending the start of the Clerk of Works. Currently, random and planned inspections of work are carried out, both during and after work is complete, with photographic records compiled.		

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
Highways Framework Contracts – Award of Work, Monitoring of Payments and Performance 25 April 2019	28 April 2019	The Contract Manager for TC944 (and going forwards invoicing for TC975) should ensure that evidence of a review of a sample of line items on each invoice is maintained. This could include but is not limited to:- • Highlighting line items that have been sampled for accuracy. • Maintaining evidence of any items queried and the outcome of these. • Signing and dating the day the review was carried out. • Printing the reports from Kaarbontech as supporting evidence of review. In addition the contractor invoices should state the dates the work relates to, which will aid comparisons to Kaarbontech.	Invoices are checked against work carried out on TC944 and TC975 and although there were anomalies with the two invoices referenced, there is considerable evidence in email form of invoices that have been charged incorrectly and returned to the contractor in question. The advice offered by the audit team is already in place. Invoices that are checked and confirmed as being accurate are stamped and dated prior to being goods receipted. In addition, a copy of any works order and works variation order confirming when the work was completed is attached to the invoice for reference.	Invoice procedure and invoice file reviewed. Improvements to invoices observed. **Internal Audit Opinion:** Implemented	**No further Action Required**
Northwards Capital Project Management 25 June 2019	30 September 2019	The Head of Housing should seek confirmation from the City Solicitor to confirm that she has sufficient resources to ensure that contracts for Northwards managed projects are able to be signed in a timely manner to	Seek confirmation from the City Solicitor that resources are available to seal contracts promptly and to establish whether any additional information or process needs to be put in place.	The Head of Housing has met with the City Solicitor and Northwards Management team to introduce arrangements to regularly monitor the signing / or sealing of contracts. Regular meetings have been arranged	**No further Action Required**

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		facilitate delivery of this aspect of the Capital programme. Clarification should be provided to Northwards on what information the City Solicitors requires from them, and a process agreed to ensure that signed copies of contracts are provided to Northwards to enable them to manage the contractors and suppliers to deliver the work.		and we can confirm these have taken place and that contracts are being signed with more regularity. **Internal Audit Opinion:** Implemented	
Children Missing from Home 2 July 2018	31 March 2019	The Strategic Head of Early Help should ensure that the functionality of Liquid Logic's MFH workflow enables more effective handling of episodes, preferably with a single point of entry which flows through to SW notification, allocation of the IRI, and recording of the IRI outcome. PRI should confirm reporting requirements can be met from the new workflow in Liquid Logic.	Mapping of missing from home workflow to inform new processes in Liquid Logic and user acceptance testing to be undertaken by MFH workers. In the interim review of current data and spreadsheets to be undertaken to identify some quick wins.	Internal Audit confirmed via demonstration that the new work flow within Liquid Logic is more straightforward and integrated; for example, the IRI is recorded as a form within the missing episode, rather than attached as a separate document, which makes it easier to confirm that an IRI has been completed for each missing episode. **Internal Audit Opinion**: Implemented	**No further action required.**

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
Children Missing from Home 2 July 2018	31 March 2019	The Strategic Head of Early Help should re-emphasise with staff the importance of ensuring the completeness and accuracy of Case History data. To monitor this in the short-term, timeliness and accuracy of MiCare updates should be added to the Return Interview Audit form. Moving forward, the necessity of capturing complete and accurate data for reporting purposes should be considered in the new MFH workflow within Liquid Logic, such that the data is drawn from essential steps rather than from a retrospective step that is not consistently completed.	To be included in the new workflow requirements for Liquid Logic. Dip sampling of missing episodes by the MFH workers and senior social workers to be undertaken to evidence improvements.	Walkthrough of the way missing episodes are recorded in Liquid Logic confirmed that the 'Missing from Home - Case History' episode is no longer in use. Instead, the child's LL page will include a 'missing person records' under the 'Additional' tab, which is a summary of the start and end dates of each previously recorded missing episodes, and drawn directly from the missing episodes themselves, rather than as a separate manually entered step. **Internal Audit Opinion**: Implemented	**No further action required.**
Children Missing from Home 2 July 2018	31 October 2018	The Strategic Head of Early Help and the Performance Manager (People) should ensure that key performance indicators, as described in the Missing from Home and Care Strategy, are agreed and targets defined. Other routine reporting should be reconsidered to ensure that the focus is on key	Development of a fit for purpose dashboard for missing and complex safeguarding services.	There is a GM wide dashboard in place however this does not provide the detail required to monitor operational performance with the Council. A set of key performance indicators has now been developed for inclusion on a dashboard for missing and complex safeguarding services. These were shared with	**No further action required**

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		trends and that it is generated from the most timely and accurate data. The rationale for the reports, including whether they should prompt certain actions (and if so, what and by whom), should be described in the MFH Procedures.		stakeholders at the Complex Safeguarding Executive Partnership Board in December 2019. This Dashboard is not yet operational as continued work is needed with PRI to establish what data will feed into the new dashboard to ensure its completeness and accuracy. This data was not reported on in Micare so work is still needed to ensure required data can be included in reports (including some partners' data). We are satisfied that by developing and agreeing the performance indicators for the dashboard, sufficient action has been taken to report this recommendation as implemented. We will however continue to engage with PRI and management to confirm when the dashboard is operational. **Internal Audit Opinion:** Implemented	

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
Adults Services, Management Oversight and Supervision 5 April 2019	31 May 2019	The Assistant Director of Adult Services should complete a thorough review of the Supervision Guidance document, to ensure that it clearly articulates the actual expected procedures and how these requirements should be documented, particularly in those areas identified in the matters arising.	Review the Supervision Policy and how to embed it within the workforce. Additional Resources Required for implementation: Yes – Support from the Reform and Innovation Team secured.	We confirmed that the Supervision Guidance has been updated, effective November 2019. We reviewed the contents against the previous version and were satisfied that it has been clarified in the areas previous identified. For example, the previous version required that Supervision Agreements be reviewed every 6 months, which testing found was not happening. The revised version still requires Supervisors and Supervisees to sign a Supervision Agreement, but this remains in effect until there is a change in role or extended absence, which we agree is more practical. **Internal audit opinion:** Implemented	**No further action required.**
Mental Health Casework Compliance 5 April 2019	30 June 2019	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	Associate Director of Operations (GMMH Trust) is working to ensure the new system, Paris, which has been in place since December 2018, addresses the audit trail and outcomes	We confirmed that Paris includes an authorisation tick-box, which automatically records the name and date/time of the person ticking this box, and that only a user with 'manager'	**No further action required.**

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		system generated dates to ensure accuracy of reporting.	reporting issues and will report back on progress.	credentials is allowed to authorise a form. **Internal audit opinion:** Implemented	
Mental Health Casework Compliance 5 April 2019	30 Sep 2019	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.	GMMH Trust and MCC have agreed and begun a joint piece of work focussing on outstanding reviews, aiming to reduce the backlog by April 2019. Going forward, a work-stream is providing assurance over annual reviews, with results reported as a quality measure via Q&P. The joint 'Task & Finish' group will pick up any remaining issues. Additionally, the Assistant Director of Adult Services is to form a 'Task & Finish' group focusing on mental health panels, with input from GMMH.	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. **Internal audit opinion:** Implemented	**No further action required.**
Assessed and Supported	30 June 2019	The Social Work (SW) Consultant should produce a report from the tracker every	As discussed above spreadsheets will be circulated with information but	Internal Audit confirmed that a monthly update is now being produced by the Social Work	**No further action required.**

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
Year in Employment 21 May 2019		quarter to provide senior management with information on: • new starters (first half of funding claimed); • Newly Qualified Social Workers (NQSWs) SWs on track with key milestones and those for whom progress is unknown or delayed for a known reason (e.g. change of manager); • NQSWs suspended from the programme (e.g. due to maternity or sickness absence - these should be supported by manager confirmation and expected return date); and, • NQSWs that have successfully completed their ASYE (second half of funding claimed).	a dashboard will be completed with key information identified around, new starters, stages in programme and any challenges.	Consultant showing: the number of NQSWs in each locality and the duration on the ASYE programme; panel outcomes including themes, learning, and actions arising; learning and development sessions held; and reflective supervision sessions held. We also confirmed that the trackers include detail of NQSWs experiencing delays and the reasons why. **Internal Audit Opinion:** Implemented	
Management Oversight and Supervision – Children's 9 May 2019	31 July 2019	The Deputy Director Children's Services should ensure that action is taken to review and update the Supervisions Policy to ensure it is fit for purpose. This should include assigning responsibility for the review and ongoing maintenance and	The Supervision policy will be reviewed by one of the Heads of Locality.	Internal Audit have now had confirmation that management completed a review of the policy in August 2019 and have formally approved this. **Internal Audit Opinion:** Implemented	**No further action required.**

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		setting a date for an annual refresh.			
Management Oversight and Supervision – Children's 9 May 2019	30 June 2019	Consideration could be given to a 'risk based' approach to case review by targeting those cases that are considered to be high risk or have particular issues for in depth discussion at supervisions	The above review will revise the position on each child being discussed in supervision and if required additional direction will be provided.	Internal Audit have confirmed that the revised policy includes a risk approach in terms of dealing with the highest priority cases. **Internal Audit Opinion**: Implemented	**No further action required.**
Management Oversight and Supervision – Children's 9 May 2019	31 July 2019	The Deputy Director Children's Services should ensure that all managers who are responsible for completing supervisions complete supervision training. Consideration should also be given to making more focussed supervision training available to all staff, potentially as part of the induction process to ensure all staff are aware of the importance of supervisions.	Action to be taken: The model delivered to staff in the ILM5 training will be revisited. This may require commissioning the training on this model of supervision.	Internal Audit confirmed that briefings have taken place and the majority of managers have attended these. Further mop-up sessions are ongoing for new and existing staff to ensure that all staff have been involved. **Internal Audit Opinion**: Implemented	**No further action required.**
Management Oversight and Supervision – Children's 9 May 2019	31 July 2019	The Deputy Director Children's Services should ensure that there is greater clarity over requirements to record performance and professional	The supervision template will be reviewed as part of the review of the supervision policy.	Internal Audit confirmed that the revised policy addressed these points, including changes to the template.	**No further action required.**

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		standards feedback consistently. We propose that this could be addressed when the Supervisions Policy is reviewed and built into strengthening the supervision template and the mechanism for tracking development actions.		**Internal Audit Opinion**: Implemented	
Management Oversight and Supervision – Children's 9 May 2019	31 July 2019	The Deputy Director Children's Services should ensure that the policy is clear on requirements for supervision agreements and record retention.	The supervision template will be reviewed as part of the review of the supervision policy.	Internal Audit confirmed that the revised policy addressed the recommendation and the requirements for supervision agreements and record retention are also covered in the staff briefings. **Internal Audit Opinion**: Implemented	No further action required.
Management Oversight and Supervision – Children's 9 May 2019	31 July 2019	The Locality Heads of Service should remind all staff of the importance of completing supervisions on a timely basis and emphasis that they should only be postponed in exceptional circumstances such as staff sickness or holiday and should be rearranged promptly.	The briefings that support the implementation of the revised policy will focus on timely completion of supervision.	Internal Audit have confirmed that the revised policy included reference to ensuring comprehensive compliance and that this was also emphasised in the staff briefings. **Internal Audit Opinion**: Implemented	No further action required.

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
Management Oversight and Supervision – Children's 9 May 2019	31 July 2019	In the case of staff vacancies the Team managers at each Locality should allocate an interim supervisor to fill the resource gap and ensure supervisions are done.	This to be completed in guidance.	Internal Audit confirmed that management have developed a contingency process, effective from November 2019: a google form has been created to schedule all supervisions, flag up any gaps and reallocate these to an interim supervisor or locality manager to ensure the supervision goes ahead as planned. **Internal Audit Opinion**: Implemented	No further action required.
Management Oversight and Supervision – Children's 9 May 2019	31 July 2019	The Deputy Director Children's Services should ensure that arrangements are developed to monitor completion of supervisions in accordance with the supervisions policy. This could be achieved by developing the current monthly report for supervisions to include a clear indication as to where there are clear gaps in timeliness of supervisions both for individual social workers and also for teams/ localities.	Revision of current Google sheet.	Internal Audit have confirmed that the service has introduced a google form to enable monitoring and overview of completion of monthly supervisions, and that a monthly report is produced from this on overall timeliness and by teams / localities. **Internal Audit Opinion**: Implemented.	No further action required.

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
Floating Support – Support to Homeless Citizens in Temporary (Dispersed) Accommodation	31 May 2019	The Strategic Lead - Homelessness and Migration should lead a review of the floating support team services with a view to developing clear and consistent systems and processes across the service to support delivery of agreed procedures. This could be achieved by developing a working group, to be attended by senior management, team leaders and a sample of SWs. The remit of the group should be to map out what are the critical steps that must be taken in supporting citizens in temporary accommodation and agreeing systems and processes which will support consistent delivery in line with statutory duties. Areas of focus for this group could include : • Define a new procedure for allocation of cases. • Define arrangements to ensure equality of caseloads across individual SWs and teams.	Three workshops to be delivered across the floating support service to look at and address the issues raised. This will ensure support worker buy in and consistent approach. Managers improving consistency and putting in place a more robust supervision regime. Senior management analysing and improving management supervision, with ongoing monitoring to be put in place.	Key processes have been remapped and strengthened and an implementation plan is in place to embed changes. There has also been a residents handbook developed to explain what services can be accessed through the floating support team. **Internal Audit Opinion:** Implemented	No further action required

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		• Establishing key expectations for ongoing support. • Determine and agree a critical path of support that must be delivered for all citizens with minimum expectations and clear timescales. • Agree minimum documentation requirements to support casework delivery and review. • Confirm arrangements for supporting and monitoring caseloads through supervisions. • Confirm arrangements to key stakeholders.			
Floating Support – Support to Homeless Citizens in Temporary (Dispersed) Accommodation	June 2019	We recommend that the Strategic Lead - Homelessness and Migration ensures that an appropriate supervisions regime is introduced and complied with which enables timely and systematic case review.	New supervision regime to be introduced and maintained which covers best practice. KPI of 'About You' sessions and 1:1s to be added to the monthly performance clinics.	New supervision regime introduced and operational **Internal Audit Opinion: Implemented**	No further action required

Appendix 2 – Recommendations Over 9 Months Overdue

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
Transition to Adult Services	31 October 2018	The Interim 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 NICE guidance.	Operational Plan in place for delivering the revised transitions offer in line with the agreed strategy and vision	Joint process design sessions were completed with Children's Services in September 2019 and the transitions Board has agreed a number of key priorities. It is planned that by the end of 2019/20 the process design will focus on ensuring there is clarity of process and pathway for young people between Children's and Adults Services. **Internal Audit Opinion:** Partially implemented	**Director:** Bernadette Enright, Executive Director of Adult Social Services **Executive Member:** Councillor Craig **Status:** 14 months overdue **Action:** Internal Audit will continue to engage with management to review and report on progress.
Transition to Adult Services	30 April 2018	The Interim 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	Transitions Strategy and Vision to be developed	There has been considerable slippage in the implementation of this recommendation and significant management change since the recommendation was agree. However, the new management team are now in place and committed to addressing the issues as a matter of priority. Addressing the ongoing issues in relations to the transitions offer is a key	**Director:** Bernadette Enright, Executive Director of Adult Social Services **Executive Member:** Councillor Craig **Status:** 20 months overdue

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		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.		element of the Adults Social Care Improvement Plan. Joint process design sessions have been completed with Children's Services in September and the Transitions Board has agreed a number of key priorities. It is planed that by the end of 2019/20 the process design will focus on ensuring there is clarity of process and pathway for young people between Children's and Adults Services. **Internal Audit Opinion**: Partially Implemented	**Action:** Internal Audit will continue to engage with management to review and report on progress.
Transitions to Adult Services	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.	Key performance Indicators (KPIs) introduced.	Work is on going. Process design will ensure there is clarity of process and a pathway for young people moving between Children's and Adults services and KPIs will be developed to support and assure these arrangements.	**Director:** Bernadette Enright, Executive Director of Adult Social Services **Executive Member:** Councillor Craig **Status:** 18 months overdue

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		A long term solution should be considered and built into Liquid Logic to help identify performance trends and provide assurance to senior management.		**Internal Audit Opinion**: Outstanding	**Action**: Internal Audit will continue to engage with management to review and report on progress.
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 inspections and provide results to the Interim Service Manager (DSAS) and Programme Lead. Accountability for registered managers and support	I agree with the activity identified within recommendation 1. Register of all details including residents; staff and properties to be sent to PRI.	A complete register of all citizens, staff and properties was not created as envisaged in the recommendation. Internal Audit have now seen the 'House File Tracker' for South Locality which was intended to serve as both the register to track Quality Assurance activity, and also enable monitoring of other key activities such as Deprivation of Liberties in a Domestic Setting applications and Social Worker reviews. An 'audit' tab to record activity has been recently added, but was not yet populated. Once fully populated, it is considered that this will satisfy bullet points one, two and four of the recommendation. There remained no system in place to ensure accountability for actions arising from the	**Director:** Bernadette Enright, Executive Director of Adult Social Services **Executive Member:** Councillor Craig **Status:** 16 months overdue **Action:** Follow Up Audit Report September 2019. Internal Audit will continue to engage with management to review and report on progress. Workshop October 2019

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		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 QA Framework, allowing auditors to provide an opinion on these arrangements rather than lower level, task specific compliance.		audits. To resolve this a tracker to monitor the status of actions has been introduced and will be reviewed and discussed every four weeks at the Senior Leadership meeting. Once in place, this process will satisfy the third bullet point of the recommendation. **Internal Audit Opinion:** Outstanding	
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	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 follow-up audit confirmed that workshops took place in March 2019 as planned and our review of the revised audit tool and guidance document confirmed that some changes had been made. However, it was not evidence that the risks previously identified have been satisfactorily addressed, in particular:	**Director:** Bernadette Enright, Executive Director of Adult Social Services **Executive Member:** Councillor Craig **Status:** 16 months overdue **Action:** Follow Up Audit Report September 2019

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		inquiry or inspection of evidence is required for each question/section and QA auditors 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.	The service is a commissioned In House Provider and is regulated and inspected by CQC and is also 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.	The audit tool for citizens was still broad and generically worded. A sample of completed audits demonstrated that questions were being answered inconsistently and not in line with the guidance, and that actions were not always being raised where standards were not met. There was still no moderation process in place. From our review of a sample of completed audits, there was still inconsistency and incompleteness in how questions were answered and the depth to which outcomes were recorded. Management have arranged a workshop with all Support Coordinators in October 2019 to develop and agree an audit moderation process. This will also consider the content and wording of the audit tool following our feedback to determine where further improvements can be made.	Internal Audit will continue to engage with management to review and report on progress. Workshop October 2019

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
				Internal Audit Opinion: Outstanding	
Purchase Cards 19 September 2018	31 Dec 2018	The 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 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.	Purchase card guidance has been updated to clarify the approval process for hospitality. To strengthen the response and ensure alignment with best practice the City Solicitor is developing guidance further part of the employee and member codes of conduct. This is part of a wider update of the Codes and implementation of this recommendation has now been reset with a target of end of July 2020. **Internal Audit Opinion**: Partially Implemented	**Director:** Fiona Ledden, City Solicitor and Carol Culley, Deputy Chief Executive & City Treasurer **Executive Member:** Councillor Leese **Status:** 12 months overdue **Action:** City Solicitor confirmed with Audit Committee revised deadline for implementation of 31 July 2020. Internal Audit will monitor progress in line with this.

Appendix 3 – Recommendations 6-9 Months Overdue

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
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**: Partially implemented	**Director:** Carol Culley, Deputy Chief Executive and City Treasurer **Executive Member:** Councillor Ollerhead **Status:** Eight months overdue **Action:** Deputy Chief Executive and City Treasurer to be advised of request to attend a future Audit Committee to explain the barriers to implementation of the recommendation.
ICT Software Licensing 24 July 2018	30 April 2019	Software licensing management roles, responsibilities and capability gaps need to be defined, implemented and	Following the work done in Recommendation 1, ICT will be in a position to define roles and responsibilities for software asset management	The finalised software licensing policy includes an appendix detailing the roles and responsibilities of relevant stakeholders in respect of the	**Director:** Carol Culley, Deputy Chief Executive and City Treasurer

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		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. 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.	(SAM). Beyond this, ICT will devise (as part of another recommendation arising from this audit) policies and procedures to support Council-wide compliance to a consistent approach to SAM, clearly differentiating between centrally managed licensing and those managed locally within business units.	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. **Internal Audit Opinion**: Outstanding	**Executive Member:** Councillor Ollerhead **Status:** Eight months overdue **Action:** Deputy Chief Executive and City Treasurer to be advised of request to attend a future Audit Committee to explain the 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	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	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	**Director:** Carol Culley, Deputy Chief Executive and City Treasurer **Executive Member:** Councillor Ollerhead

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		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, regular validation audits should	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.	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	**Status:** Eight months overdue **Action:** Deputy Chief Executive and City Treasurer to be advised of request to attend a future Audit Committee to explain the barriers to implementation of the recommendation.

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		be completed by the SAM team to 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.	The new Supervision Guidance makes clear that Supervisors must complete an entry on the Supervisions Google Form following each supervision session to record that it has taken place for central monitoring and oversight. This is clearly defined as the responsibility of the Supervisors and is reiterated at several points within the Guidance. We confirmed that the Supervisions Google Form has been created and that is includes basic details (name of supervisor, name of supervisee, team, date of supervision, date of previous supervision and an explanation for the delay (if any). We have been told that this form will be in use from January 2020, and that the results will be monitored by PRI.	**Director:** Bernadette Enright, Executive Director of Adult Social Services **Executive Member:** Councillor Craig **Status:** Seven months overdue **Action:** Monitor

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
				Internal Audit opinion: Partially implemented	

Appendix 4 – Recommendations 1-6 Months Overdue

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
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.	GMMH Trust and MCC to jointly establish a 'Task & Finish' group to investigate, work to resolve, and report progress back to the Director of Adult Services.	We confirmed that in the new system, 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. However, our testing of a sample of five safeguarding 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. **Internal audit opinion:** Outstanding	**Director:** Bernadette Enright, Executive Director of Adult Social Services **Executive Member:** Councillor Craig **Status:** Six months overdue **Action:** Monitor
Mental Health Casework Compliance	30 June 2019	The Director of Adult Services should seek assurance from the Trust in regard to whether	GMMH Trust and MCC to jointly establish a 'Task & Finish' group to investigate,	Follow up testing identified ongoing issues with a lack of management oversight of the	**Director:** Bernadette Enright, Executive

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
5 April 2019		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.	work to resolve, and report progress back to the Director of Adult Services.	initial decision-making. Recently implemented system changes will prevent some of these issues, such as a worker being able to approve their own decisions, from occurring in future. The Trust now generates a "daily DQ report" from the system, which we confirmed highlights where referral forms have been started but are not yet authorised. However, we remain concerned at the number of referrals remaining unauthorised with an apparent lack of escalation. Our testing also identified one instance where no action was taken in response to a safeguarding referral for nearly two months, and none of the current reports would have picked this up. **Internal Audit Opinion:** Outstanding	Director of Adult Social Services **Executive Member:** Councillor Craig **Status:** Six months overdue **Action:** Monitor

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
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.	GMMH Trust and MCC to jointly establish a 'Task & Finish' group to investigate, work to resolve, and report progress back to the Director of Adult Services.	Follow up testing confirmed that "DQ reports" are now in place. which aim to provide oversight of outstanding work. The daily DQ report shows the number of initial safeguarding referral decisions that were authorised within one day. The weekly DQ report does not directly report on timeliness, but does show where some aspect of a safeguarding investigation remains incomplete or unauthorised. Our review of these reports and additional follow-up testing identified ongoing issues with timeliness of management approval of both the initial decision making and the conclusion of the enquiries. Therefore, while we are satisfied that these reports provide a mechanism for monitoring timeliness and outstanding work, we remain concerned that these reports indicate (and testing confirmed) that there are still unaddressed issues with performance.	**Director:** Bernadette Enright, Executive Director of Adult Social Services **Executive Member:** Councillor Craig **Status:** Six months overdue **Action:** Monitor

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
				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.	We confirmed that 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	**Director:** Bernadette Enright, Executive Director of Adult Social Services **Executive Member:** Councillor Craig **Status:** Six months overdue **Action:** Monitor

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
				that these reports indicate (and testing confirmed) that there are still issues with performance. **Internal Audit Opinion:** Partially implemented	
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 to ensure completeness of Council records and ability to monitor outcomes.	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.	Conversations with colleagues in PRI 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. **Internal Audit Opinion:** Outstanding	**Director:** Bernadette Enright, Executive Director of Adult Social Services **Executive Member:** Councillor Craig **Status:** Three month overdue **Action:** Follow Up Audit

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
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.	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. **Internal Audit Opinion:** Outstanding	**Direct Director:** Bernadette Enright, Executive Director of Adult Social Services **Executive Member:** Councillor Craig **Status:** Six months overdue **Action:** Follow Up Audit
Assessed and Supported Year in Employment 21 May 2019	30 June 2019	The Workforce Learning and Development Manager should ensure that Social Work 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 SW 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 NQSWs 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	We confirmed that a google sheet of all NQSWs on the ASYE programme has 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	**Director:** Paul Marshall, Strategic Director of Children's Services **Executive Member:** Councillor Bridges **Status:** Six months overdue **Action:** Monitor

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
			capture all the key milestones of the ASYE programme up to completion by the service.	escalate issues where needed. Further action needs to be taken to ensure that team managers are populating the sheets as required. **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	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.	**Director:** Paul Marshall, Strategic Director of Children's Services **Executive Member:** Councillor Bridges **Status:** Three month overdue **Action**: Monitor

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
			for Care to ensure we are clear on claims received.	**Internal Audit Opinion:** Outstanding	
Management Oversight and Supervision – Children's 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. **Internal Audit Opinion**: Outstanding	**Director:** Paul Marshall, Strategic Director of Children's Services **Executive Member:** Councillor Bridges **Status:** Five months overdue **Action:** Internal Audit to consider evidence of implementation of the file audit process.
Framework Agreements – Contract Governance 21 January 2019	31 December 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	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	The Integrated Commissioning and Procurement Team have produced a Frameworks guidance pack to address the areas covered in the recommendation. We have reviewed this and shared comments back with colleagues for consideration. Once finalised and published for use by	**Director:** Carol Culley Deputy Chief Executive and City Treasurer **Executive Member:** Councillor Ollerhead **Status:** One month overdue

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		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.	- 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.	contract and commissioning managers we can change the status of the recommendation to implemented. **Internal Audit Opinion**: Partially implemented	**Action:** Monitor
Framework Agreements – Contract Governance	31 December 2019	The Head of Integrated Commissioning should provide guidance for framework managers	Action to be taken - develop, in collaboration with practitioners, guidance for	The Integrated Commissioning and Procurement Team have produced a Frameworks guidance pack to address the	**Director:** Carol Culley Deputy Chief Executive and City Treasurer

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
21 January 2019		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	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 SROs 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	areas covered in the recommendation. We have reviewed this and shared comments back with colleagues for consideration. Once finalised and published for use by contract and commissioning managers we can change the status of the recommendation to implemented. **Internal Audit Opinion:** Partially implemented	**Executive Member:** Councillor Ollerhead **Status:** One month overdue **Action:** Monitor

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		should be incorporated into the framework agreements as framework level KPIs and how the development of such framework KPIs can be developed going forward.	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: - 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 December 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	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,	The draft guidance produced on Frameworks did not include sufficient detail in relation to the recommendation. We have shared some suggested areas for inclusion and if accepted this should address the risks identified. We will continue to monitor this with the Integrated	**Director:** Carol Culley Deputy Chief Executive and City Treasurer **Executive Member:** Councillor Ollerhead **Status:** One month overdue

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		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.	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 SROs 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. Recommend they scrutinise, demand forecasts and reports on performance, spend and compliance, and require explanation of variance and remedial action.	Commissioning and Procurement Team. **Internal Audit Opinion:** Outstanding	**Action:** Monitor

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
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 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. "	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. e) Integrated Commissioning consider options for benchmarking the value obtained through 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. This included raising the requirement for social value KPIs in Commissioning and Contract Management group meetings, the launch of social value e learning and informing officers of this through targeted bulletins. We also confirmed the amendment of the new pre tender forms prompting the inclusion of social value KPIs and defining how these will be monitored. There is also improved accessibility of monitoring templates to facilitate contract managers in their monitoring. Other activity being undertaken to improve social value monitoring included the use of the social value portal by NWCH. There are plans to set up a working group to consider	**Director:** Carol Culley Deputy Chief Executive and City Treasurer **Executive Member:** Councillor Ollerhead **Status:** One month overdue **Action:** Monitor

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
				non achievement of KPIs and consider and share good practice in addressing non performance. We were also informed a further session on social value is planned for the commissioning and contract management group. Whilst some thought has been given to benchmarking and how to enable the value obtained through social value to be determined we were informed a longer timescale is required for this. As such we consider the recommendation to be partially implemented. **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	The list of commissions is reviewed each quarter with a finance review undertaken to track fees and Social Value outcomes collected. CAPPS has predominantly been used for MCC commissions and as such	Due to changes in management there were some delays in work being taken forward in respect of this recommendation. However, we have recently confirmed that the monitoring spreadsheet used by the team has been updated to capture additional	**Director:** Carol Culley Deputy Chief Executive and City Treasurer **Executive Member:** Councillor Ollerhead

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		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."	over the 4 years since launch the reliance on MCC 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.	data to allow monitoring of bidding activity to take place. As this has only recently been introduced no data has been captured as yet, once this is further embedded the status of the recommendation can be reassessed. **Internal Audit Opinion**: Partially implemented	**Status**: One month overdue **Action:** Monitor
Neighbourhood Investment Fund (NIF)	6 Sept 2019	Management should ensure that NIF funding is only be paid where there has been a community group application,	No NIF grant to proceed without written record of decision (email or signature to confirm verbal	The NIF guidance has been updated and includes reference to exemptions to the application process. Internal audit awaiting	**Director:** Fiona Worrall **Executive Member:**

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
2 September 2019		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.	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.	evidence that the guidance has been formally approved and shared across all three neighbourhood teams. **Internal Audit Opinion**: Partially Implemented	**Status:** Three months overdue **Action:** Monitor
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. **Internal Audit Opinion:** Outstanding	**Direct Director:** Bernadette Enright, Executive Director of Adult Social Services **Executive Member:** Councillor Craig **Status:** One month overdue **Action:** Follow Up Audit
Penalty Notices	31 Dec 2019	The Strategic Lead for School Attendance & EOTAS should	Regular termly meetings will be held with finance to	An update on progress on this action has been requested.	**Director:** Paul Marshall, Strategic

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
1 February 2019		continue to monitor the cost of operating the 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.	monitor and review the revenue from monies collected from the paid penalty 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:** Outstanding	Director of Children's Services **Executive Member:** Councillor Bridges **Status:** One month overdue **Action:** Monitor.
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	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.	An update on progress on this action has been requested. **Internal Audit Opinion:** Outstanding	**Director:** Paul Marshall, Strategic Director of Children's Services **Executive Member:** Councillor Bridges **Status:** One month overdue **Action:** Monitor.

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		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 improvements are required. This circular will include a tool for schools to self-assess their own procurement practice ahead of the proposed workshops.			
Deprivation of Liberty Safeguards 03 May 2019	30 Oct 2019	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.	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	Recruitment of additional posts has been undertaken with new officers now in place, and new processes have been introduced so that BIA triage cases as they come in. We have been advised that allocations have been improved	**Direct 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
		We understand that actions are already underway to address the unassigned 'screened' cases. This needs to be done as a matter of urgency so that the Council only migrates those DoLS episodes needed into Liquid Logic.	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 similar occurrence. Cases which do not require assessment will be recorded as such.	and that the number of unallocated outstanding cases has been significantly reduced. However, we are still awaiting evidence of this in order to consider this implemented. Progress for this was initially delayed due to unanticipated impacts of the implementation of Liquid Logic particularly on this area of work. **Internal Audit Opinion**: Partially Implemented	**Status:** Four Months overdue **Action:** A Follow Up Audit is underway and will be reported shortly.
Floating Support	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	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	It was acknowledged in the audit report that whilst this was proposed for completion by the end of October 2019 as part of a phase 2 implementation and this was dependent on the completion of phase 1 of the project to timescales. This has not been possible in part due to slippage in the project implementation. Work has been completed to ensure Liquid Logic I used as far as possible in its current form to	**Director:** Mike Wright, Director of Homelessness **Executive Member:** Councillor Craig **Status:** 2 months overdue **Action:** The Business have confirmed they have a revised planned date for this

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		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.	floating support case management and supervision.	support work. However, the changes needed to make it fully effective cannot be made until phase 2. The timescale for phase 2 and the completion of work to ensure the recommendation can be fully addressed are still to be confirmed but it is currently expected likely to be October 2020. Internal Audit Opinion: Partially implemented	of October 2020. We will continue to liaise with management to seek updates on progress.

Audit Strategy Memorandum

Manchester City Council (and Group)

Year ending 31 March 2020

MANCHESTER CITY COUNCIL

MAZARS

CONTENTS

Mazars LLP

One St Peter's Square

Manchester

M2 3DE

Members of the Audit Committee

Manchester Town Hall

Manchester

M60 2LA

21 January 2020

Dear Members of the Audit Committee

Audit Strategy Memorandum – Year ending 31 March 2020

We are pleased to present our Audit Strategy Memorandum for Manchester City Council for the year ending 31 March 2020.

The purpose of this document is to summarise our audit approach, highlight significant audit risks and areas of key judgements and provide you with the details of our audit team. As it is a fundamental requirement that an auditor is, and is seen to be, independent of its clients, Section 8 of this document also summarises our considerations and conclusions on our independence as auditors.

We consider two-way communication with you to be key to a successful audit and important in:

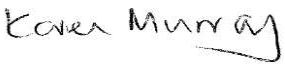
- reaching a mutual understanding of the scope of the audit and the responsibilities of each of us;
- sharing information to assist each of us to fulfil our respective responsibilities;
- providing you with constructive observations arising from the audit process; and
- ensuring that we, as external auditors, gain an understanding of your attitude and views in respect of the internal and external operational, financial, compliance and other risks facing Manchester City Council which may affect the audit, including the likelihood of those risks materialising and how they are monitored and managed.

This document, which has been prepared following our initial planning discussions with management, is the basis for discussion of our audit approach, and any questions or input you may have on our approach or role as auditor.

This document also contains specific appendices that outline our key communications with you during the course of the audit, and forthcoming accounting issues and other issues that may be of interest.

Client service is extremely important to us and we strive to continuously provide technical excellence with the highest level of service quality, together with continuous improvement to exceed your expectations so, if you have any concerns or comments about this document or audit approach, please contact me on 0161 238 9248.

Yours faithfully



Karen Murray

Partner and Engagement Lead

Mazars LLP

1. ENGAGEMENT AND RESPONSIBILITIES SUMMARY

Overview of engagement

We are appointed to perform the external audit of Manchester City Council (the Council) for the year to 31 March 2020. The scope of our engagement is set out in the Statement of Responsibilities of Auditors and Audited Bodies, issued by Public Sector Audit Appointments Ltd (PSAA) available from the PSAA website: https://www.psaa.co.uk/audit-quality/statement-of-responsibilities/

Our responsibilities

Our responsibilities are principally derived from the Local Audit and Accountability Act 2014 (the 2014 Act) and the Code of Audit Practice issued by the National Audit Office (NAO), as outlined below.

Audit opinion

We are responsible for forming and expressing an opinion on the financial statements.

Our audit is planned and performed so to provide reasonable assurance that the financial statements are free from material error and give a true and fair view of the financial performance and position of the Council for the year.

Value for Money

We are required to conclude whether the Council has proper arrangements in place to secure economy, efficiency and effectiveness in it its use of resources. We discuss our approach to Value for Money work further in section 6 of this report.

Reporting to the NAO

We report to the NAO on the consistency of the Council's financial statements with its Whole of Government Accounts (WGA) submission.

Electors' rights

The 2014 Act requires us to give an elector, or any representative of the elector, the opportunity to question us about the accounting records of the Council and consider any objection made to the accounts. We also have a broad range of reporting responsibilities and powers that are unique to the audit of local authorities in the United Kingdom.

1. ENGAGEMENT AND RESPONSIBILITIES SUMMARY

Our audit does not relieve management, as those charged with governance, of their responsibilities. The responsibility for safeguarding assets and for the prevention and detection of fraud, error and non-compliance with law or regulations rests with both those charged with governance and management. In accordance with International Standards on Auditing (UK), we plan and perform our audit so as to obtain reasonable assurance that the financial statements taken as a whole are free from material misstatement, whether caused by fraud or error. However our audit should not be relied upon to identify all such misstatements.

As part of our audit procedures in relation to fraud we are required to enquire of those charged with governance as to their knowledge of instances of fraud, the risk of fraud and their views on management controls that mitigate the fraud risks.

The Council is required to prepare its financial statements on a going concern basis by the Code of Practice on Local Authority Accounting. As auditors, we are required to consider the appropriateness of the use of the going concern assumption in the preparation of the financial statements and the adequacy of disclosures made.

For the purpose of our audit, we have identified the Audit Committee as those charged with governance.

2. YOUR AUDIT ENGAGEMENT TEAM

Karen Murray
Partner and Engagement Lead

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Tel: 0161 238 9248

Stephen Nixon
Senior Manager

Email: Stephen.Nixon@mazars.co.uk

Tel: 0161 238 9233

Simon Livesey
Assistant Manager

Email: simon.livesey@mazars.co.uk

Tel: 0161 238 9240

In addition an engagement quality control reviewer has been appointed for this engagement.

3. AUDIT SCOPE, APPROACH AND TIMELINE

Audit scope

Our audit approach is designed to provide an audit that complies with all professional requirements.

Our audit of the financial statements will be conducted in accordance with International Standards on Auditing (UK), relevant ethical and professional standards, our own audit approach and in accordance with the terms of our engagement. Our work is focused on those aspects of your business which we consider to have a higher risk of material misstatement, such as those affected by management judgement and estimation, application of new accounting standards, changes of accounting policy, changes to operations or areas which have been found to contain material errors in the past.

Audit approach

Our audit approach is a risk-based approach primarily driven by the risks we consider to result in a higher risk of material misstatement of the financial statements. Once we have completed our risk assessment, we develop our audit strategy and design audit procedures in response to this assessment.

If we conclude that appropriately designed controls are in place then we may plan to test and rely upon these controls. If we decide controls are not appropriately designed, or we decide it would be more efficient to do so, we may take a wholly substantive approach to our audit testing. Substantive procedures are audit procedures designed to detect material misstatements at the assertion level and comprise tests of details (of classes of transactions, account balances, and disclosures) and substantive analytical procedures. Irrespective of the assessed risks of material misstatement, which take into account our evaluation of the operating effectiveness of controls, we are required to design and perform substantive procedures for each material class of transactions, account balance, and disclosure. Direct confirmations will be obtained from the Council's bankers and for a sample of investments and borrowings.

Our audit will be planned and performed so as to provide reasonable assurance that the financial statements are free from material misstatement and give a true and fair view. The concept of materiality and how we define a misstatement is explained in more detail in section 4.

The diagram below outlines the procedures we perform at the different stages of the audit.

3. AUDIT SCOPE, APPROACH AND TIMELINE

3. AUDIT SCOPE, APPROACH AND TIMELINE

Internal audit

We take note of the work performed by internal audit to modify the nature, extent and timing of our audit procedures. We will meet regularly with internal audit to discuss the progress and findings of their work prior to the commencement of our controls evaluation procedures. We have held initial discussions with the internal audit team in October 2019.

Management's and our experts

Management makes use of experts in specific areas when preparing the Council's financial statements. We also use experts to assist us to obtain sufficient appropriate audit evidence on specific items of account. We discuss our use of experts further in respect of independence in section 8.

Items of account	Management's expert	Our expert
Defined benefit pension liability valuation and disclosures.	Hymans Robertson – Actuary for the Greater Manchester Pension Fund.	PwC – Consulting actuary appointed by the National Audit Office.
Property valuations: land & buildings owned by the Council and investment properties.	Jacobs Inc. – Valuer for Council owned land, buildings and investment properties and land at Manchester Airport (also Council houses for 19/20).	The local audit team will challenge the key valuation assumptions.
Revaluation of land and buildings owned by third parties for group consolidation purposes on IFRS basis.	Avison Young (Manchester, Stansted and East Midlands Airports, Manchester Convention Complex).	The local audit team will challenge the key valuation assumptions.
Financial instrument disclosures.	Link Asset Services.	We will review Link's methodology to gain assurance that the fair value disclosures of the Council's financial assets and liabilities are materially correct.

3. AUDIT SCOPE, APPROACH AND TIMELINE

Service organisations

International Auditing Standards define service organisations as third party organisations that provide services to the Council that are part of its information systems relevant to financial reporting. We are required to obtain an understanding of the services provided by service organisations as well as evaluating the design and implementation of controls over those services. There are no service organisations used by the Council which impact upon our planned audit approach.

Direct Confirmations

We plan to seek external counterparty confirmations to provide assurance on the following balance sheet areas where appropriate:

- Cash and bank (Barclays and a sample of school banks)
- Investments (Confirmation of material items and a sample of residual year-end balances)
- Borrowings (PWLB and a sample of LOBOs and other long and short term borrowings)

3. AUDIT SCOPE, APPROACH AND TIMELINE

Group audit approach

The Council prepares Group accounts and consolidates the following bodies:

- Manchester Airports Holdings Limited (MAHL) – a joint venture in which the Council owns 35.5%
- Destination Manchester Limited (DML) – a 100% owned subsidiary of the Council.

The approach to the Group audit is set out below:

Entity	Level of response	Risks identified	Planned audit approach
Manchester Airports Holdings Ltd (MAHL)	Comprehensive	Alignment of group accounting policies	Early engagement with the Council's finance team. Early engagement with MAHL auditors (KPMG) to understand their risk identification process. Review the outcome of KPMG's audit and the Council's finance team's consolidation. Review Avison Young valuation of Manchester Airport.
Destination Manchester Ltd (DML)	Analytical	Alignment of group accounting policies	Early engagement with the Council's finance team. Review of the finance team's consolidation process by reference to DML accounts. Review Avison Young valuation of the Convention Centre.

We apply a separate materiality for the audit of the Group accounts as set out in section 4.

The Council also holds investments and interests in other bodies. Management carry out an annual assessment to see if these bodies have become sufficiently material to warrant consolidation into the Group accounts. Northwards Housing Ltd is the next largest body beneath MAHL and DML but was not consolidated in 2018/19 because inclusion would not materially alter the accounts. We will revisit management's assessment of the Group for 2019/20 and ensure the exclusion criteria complies with financial reporting standards.

We have not identified any significant risks for Group accounts purposes in relation to the components. The significant risks and areas of audit focus for the Council as a single-entity are set out in section 5. Based on our initial planning discussions we do not consider these significant risks to be risks for the component subsidiary companies.

4. MATERIALITY AND MISSTATEMENTS

Summary of initial materiality thresholds

Threshold	Initial threshold (£'000s) Council	Initial threshold (£'000s) Group
Overall materiality	£31,489	£36,829
Performance materiality	£22,042	£25,780
Trivial threshold for errors to be reported to the Audit Committee	£945	£1,105

Materiality

Materiality is an expression of the relative significance or importance of a particular matter in the context of financial statements as a whole. Misstatements in financial statements are considered to be material if they, individually or in aggregate, could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

Judgements on materiality are made in light of surrounding circumstances and are affected by the size and nature of a misstatement, or a combination of both. Judgements about materiality are based on consideration of the common financial information needs of users as a group and not on specific individual users.

The assessment of what is material is a matter of professional judgement and is affected by our perception of the financial information needs of the users of the financial statements. In making our assessment we assume that users:

- have a reasonable knowledge of business, economic activities and accounts;
- have a willingness to study the information in the financial statements with reasonable diligence;
- understand that financial statements are prepared, presented and audited to levels of materiality;
- recognise the uncertainties inherent in the measurement of amounts based on the use of estimates, judgement and the consideration of future events; and
- will make reasonable economic decisions on the basis of the information in the financial statements.

4. MATERIALITY AND MISSTATEMENTS

We consider materiality whilst planning and performing our audit based on quantitative and qualitative factors.

Whilst planning, we make judgements about the size of misstatements which we consider to be material and which provides a basis for determining the nature, timing and extent of risk assessment procedures, identifying and assessing the risk of material misstatement and determining the nature, timing and extent of further audit procedures.

The materiality determined at the planning stage does not necessarily establish an amount below which uncorrected misstatements, either individually or in aggregate, will be considered as immaterial.

We revise materiality for the financial statements as our audit progresses should we become aware of information that would have caused us to determine a different amount had we been aware of that information at the planning stage.

Our provisional materiality is set based on a benchmark of gross expenditure at the provision of services. We will identify a figure for materiality but identify separate levels for procedures design to detect individual errors, and also a level above which all identified errors will be reported to the Audit Committee.

We consider that gross expenditure at the provision of services remains the key focus of users of the financial statements and, as such, we base our materiality levels around this benchmark. We also consider qualitative factors when setting the level of materiality including related party transactions, transactions within the group boundary and the source of borrowing.

We expect to set a materiality threshold at 1.75% of gross expenditure at the provision of services.

Based on gross expenditure at the provision of services, we anticipate the overall materiality for the year ending 31st March 2020 to be in the region of £31.5m (£30.3m in the prior year), and for the Group it will be in the region of £36.8m (£35.7m in the prior year). For planning purposes this is based upon 2018/19 gross expenditure. This will be revisited upon receipt of the draft 2019/20 accounts and adjusted if there is a significant variation from the 2018/19 gross expenditure.

Performance Materiality

Performance materiality is the amount or amounts set by the auditor at less than materiality for the financial statements as a whole to reduce, to an appropriately low level, the probability that the aggregate of uncorrected and undetected misstatements exceeds materiality for the financial statements as a whole. Our initial assessment of performance materiality is based on low inherent risk, meaning that we have applied 70% of overall materiality as performance materiality.

4. MATERIALITY AND MISSTATEMENTS

We have also calculated materiality for specific classes of transactions, balances or disclosures where we determine that misstatements of a lesser amount than materiality for the financial statements as a whole, could reasonably be expected to influence the decisions of users taken on the basis of the financial statements. We have set specific materiality for the following items of account:

Item of account	Specific materiality (£'000s)
Senior Employees' Remuneration	£5,000 (reflecting the published salary bandings

After setting initial materiality, we continue to monitor materiality throughout the audit to ensure that it is set at an appropriate level.

Misstatements

We aggregate misstatements identified during the audit that are other than clearly trivial. We set a level of triviality for individual errors identified (a reporting threshold) for reporting to the Audit Committee that is consistent with the level of triviality that we consider would not need to be accumulated because we expect that the accumulation of such amounts would not have a material effect on the financial statements. Based on our preliminary assessment of overall materiality, our proposed triviality threshold is £945k, and £1,105k for the Group, based on 3% of overall materiality. If you have any queries about this please do not hesitate to raise these with Karen Murray.

Reporting to the Audit Committee

To comply with International Standards on Auditing (UK), the following three types of audit differences will be presented to the Audit Committee:

- summary of adjusted audit differences;
- summary of unadjusted audit differences; and
- summary of disclosure differences (adjusted and unadjusted).

5. SIGNIFICANT RISKS, KEY AUDIT MATTERS AND OTHER JUDGEMENTS AND ENHANCED RISKS

Following the risk assessment approach discussed in section 3 of this document, we have identified relevant risks to the audit of financial statements. The risks that we identify are categorised as significant, enhanced or standard, as defined below:

Significant risk

A significant risk is an identified and assessed risk of material misstatement that, in the auditor's judgment, requires special audit consideration. For any significant risk, the auditor shall obtain an understanding of the entity's controls, including control activities relevant to that risk.

Enhanced risk

An enhanced risk is an area of higher assessed risk of material misstatement at audit assertion level other than a significant risk. Enhanced risks incorporate but may not be limited to:

- key areas of management judgement, including accounting estimates which are material but are not considered to give rise to a significant risk of material misstatement; and
- other audit assertion risks arising from significant events or transactions that occurred during the period.

Standard risk

This is related to relatively routine, non-complex transactions that tend to be subject to systematic processing and require little management judgement. Although it is considered that there is a risk of material misstatement, there are no elevated or special factors related to the nature, the likely magnitude of the potential misstatements or the likelihood of the risk occurring.

5. SIGNIFICANT RISKS, KEY AUDIT MATTERS AND OTHER JUDGEMENTS AND ENHANCED RISKS

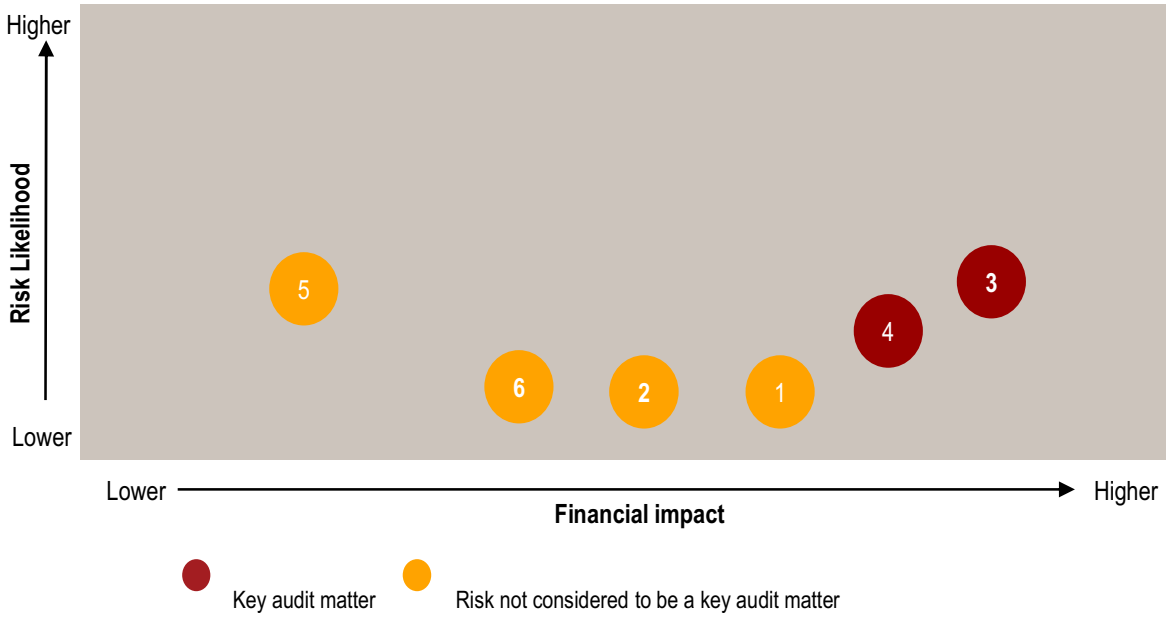
Key audit matters

Key audit matters are defined as those matters that, in our professional judgment, are of most significance in our audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) we identified, including those which had the greatest effect on: the overall audit strategy, the allocation of resources in the audit; and directing the efforts of the engagement team.

It is important that you understand and have opportunity to discuss with us why something is being communicated as a key audit matter and the way this is described. The summary risk assessment, illustrated below, highlights those risks which we deem to be significant, key audit matters and other enhanced risks. Our audit response to each of these risks is outlined on the table on the following page.

An audit is a dynamic process, should we change our view of risk or approach to address the identified risks during the course of our audit, we will report this to the Audit Committee.

The risk matrix below details the risks which are explained on the following pages.



5. SIGNIFICANT RISKS, KEY AUDIT MATTERS AND OTHER JUDGEMENTS AND ENHANCED RISKS

Specific identified audit risks and planned testing strategy

We provide more detail on the identified risks and our testing approach with respect to significant risks in the table below. An audit is a dynamic process, should we change our view of risk or approach to address the identified risks during the course of our audit, we will report this to the Audit Committee.

Significant risks

	Description of risk	Fraud	Error	Judgement	Expected KAM	Planned response
1	**Management override of controls** Management at various levels within a Council are in a unique position to perpetrate fraud because of their ability to manipulate accounting records and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively. Due to the unpredictable way in which such override could occur there is a risk of material misstatement due to fraud on all audits.	●	○	●	○	We plan to address the management override of controls risk through performing audit work over accounting estimates, journal entries and significant transactions outside the normal course of business or otherwise unusual.

5. SIGNIFICANT RISKS, KEY AUDIT MATTERS AND OTHER JUDGEMENTS AND ENHANCED RISKS

Significant risks (continued)

	Description of risk	Fraud	Error	Judgement	Expected KAM	Planned response
2	**Revenue recognition** Our audit methodology incorporates this risk as a significant risk at all audits, although based on circumstances it is rebuttable. Based on our initial planning discussions we have concluded that we can rebut the presumption for the majority of the Council's revenue income and expenditure. The areas where we will carry out further detailed planning work and expect to be able to rebut the risk that relates to income including income categorised as fees & charges and that derived from the Council's subsidiary companies and trading operations etc.	●	●	●	○	We plan to establish, through our obtaining of a detailed understanding of income sources, that we can rebut the significant risk of revenue recognition for all areas of income. Notwithstanding this, our audit approach will however incorporate testing from payments and receipts around the year-end to provide assurance that there are no material unrecorded items of income and expenditure in the 2019/20 accounts.

5. SIGNIFICANT RISKS, KEY AUDIT MATTERS AND OTHER JUDGEMENTS AND ENHANCED RISKS

Significant risks (continued)

	Description of risk	Fraud	Error	Judgement	Expected KAM	Planned response
3	**Valuation of Property, Plant & Equipment (land and buildings including investment properties)** The CIPFA Code requires that where assets are subject to revaluation, their year end carrying value should reflect the fair value at that date. The Council has adopted a five year rolling revaluation model which sees all land and buildings revalued in a five year cycle. Property revaluations do not affect the Council's usable reserves. The valuation of Property, Plant & Equipment involves the use of management experts (the valuers), and incorporates material assumptions and estimates. As a result of the rolling programme of revaluations there is a risk that individual assets not revalued for up to four years are not valued at their materially correct fair value. In addition as the valuations are undertaken through the year there is a risk that the fair value as the assets is materially different at the year end.	○	●	●	●	In relation to the valuation of land and buildings we will: • Assess the skill, competence and experience of Jacobs as the Council's external valuers; • Consider whether the overall revaluation methodology used is in line with industry practice, social housing statutory guidance, the CIPFA Code of Practice and the Council's accounting policies; • Critically assess the appropriateness of the underlying data and the assumptions used in the values' calculations, based on our expectations by reference to sector and local knowledge; • Critically assess the appropriateness of the social housing factor applied to Council Dwellings; • Ensure the in-year valuation movements are consistent with market indices; • Critically assess the approach that the Council adopts to ensure that assets not subject to revaluation in 2019/20 are materially correct; • Test a sample of items of capital expenditure in 2019/20 to confirm that the additions are appropriately valued in the financial statements.

5. SIGNIFICANT RISKS, KEY AUDIT MATTERS AND OTHER JUDGEMENTS AND ENHANCED RISKS

Significant risks (continued)

	Description of risk	Fraud	Error	Judgement	Expected KAM	Planned response
4	**Valuation of Defined Benefit Pension Liability** The net pension liability is a material entry on the Council's balance sheet. The Council is an admitted body of Greater Manchester Pension Fund (GMPF), which had its last triennial valuation 31 March 2019 The valuation of the Local Government Pension Scheme relies on a number of assumptions, most notably around the actuarial assumptions, and actuarial methodology which results in the Council's overall valuation. There are financial assumptions and demographic assumptions used in the calculation, such as the discount rate, inflation rates and mortality rates. The assumptions should also reflect the profile of the Council's employees, and should be based on appropriate data. The basis of the assumptions is derived on a consistent basis year to year, or updated to reflect any changes. There is a risk that the assumptions and methodology used in valuing the Council's pension obligation are not reasonable or appropriate to the Council's circumstances. This could have a material impact to the net pension liability. Pension revaluations do not impact the Council's usable reserves	○	●	●	●	In relation to the valuation of the Council's defined benefit pension liability we will: • Critically assess the competency, objectivity and independence of the GMPF's Actuary, Hymans Robertson; • Liaise with the auditors of GMPF to gain assurance that their controls in place are operating effectively. This will include the processes and controls in place to ensure data provided to the Actuary by GMPF for the purposes of the IAS19 valuation is complete and accurate; • Assess the portion of GMPF total assets and liabilities that are attributable to the Council. • Test payroll transactions at the Council to provide assurance over the pension contributions which are deducted and paid to GMPF; • Review the appropriateness of the Pension Asset and Liability valuation methodologies applied by GMPF Actuary, and the key assumptions included within the valuation. This will include comparing them to expected ranges, utilising information provided by PWC, consulting actuary engaged by the National Audit Office; • Agree the data in the IAS 19 valuation report provided by the Fund Actuary for accounting purposes to the pension accounting entries and disclosures in the Council's financial statements.

5. SIGNIFICANT RISKS, KEY AUDIT MATTERS AND OTHER JUDGEMENTS AND ENHANCED RISKS

Other key areas of management judgement and enhanced risks

Key areas of management judgement include accounting estimates which are material but are not considered to give rise to a significant risk of material misstatement. These areas of management judgement represent other areas of audit emphasis.

	Description of risk	Fraud	Error	Judgement	Expected KAM	Planned response
5	**Group Financial Statements consolidation process** The Council has made judgements around which of its group entities it consolidates into its Group Financial Statements, and how it consolidates the transactions and balances into the Group.	○	●	●	○	Our approach to auditing the Group Financial Statements has been detailed in section 3. We will complement this work by our review of the Council's Group consolidation process. In particular we will review the Council's judgements relating to the entities that are consolidated into the Group Financial Statements, and we will review and test the method of consolidation of those group entities into the Group Financial Statements.

5. SIGNIFICANT RISKS, KEY AUDIT MATTERS AND OTHER JUDGEMENTS AND ENHANCED RISKS

Other key areas of management judgement and enhanced risks (continued)

	Description of risk	Fraud	Error	Judgement	Expected KAM	Planned response
6	**Valuation and ownership of Manchester Airport Land & Buildings for Group consolidation** MAHL's accounts are prepared in accordance with UK GAAP and the land & buildings are valued at 'deemed cost'. This is not on the same basis as the Council's valuations of land & buildings. Consequently, to align the accounting policies for the group consolidation exercise, the Council engages Avison Young as their expert to value the Manchester Airport land & buildings are valued on an IFRS basis (current value or depreciated replacement cost). Most of the airport land is owned by the City Council and the other nine GM Metropolitan Councils which creates a risk of double counting upon consolidation.	○	●	●	○	There is a need for a valuation of the airport land & buildings. We will review the valuation by Avison Young to ensure the land owned by the Council is correctly accounted for. This was an issue which resulted in a material adjustment to the 2018/19 Group Accounts.

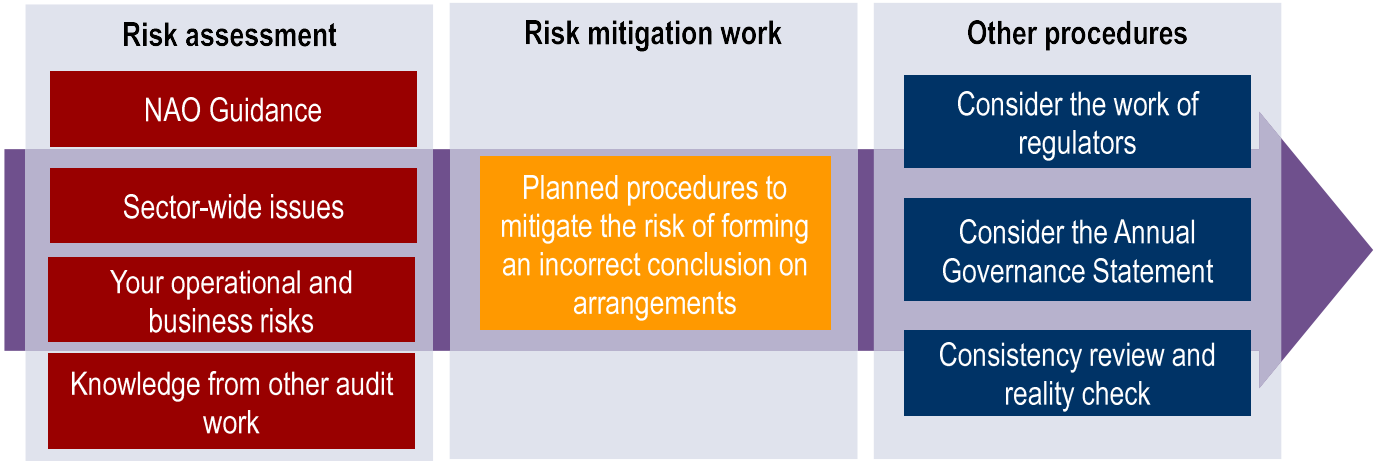
6. VALUE FOR MONEY

Our approach to Value for Money
We are required to form a conclusion as to whether the Council has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The NAO issues guidance to auditors that underpins the work we are required to carry out, and sets out the overall criterion and sub-criteria that we are required to consider.

The overall criterion is that, 'in all significant respects, the Council had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people.'

To assist auditors in reaching a conclusion on this overall criterion, the following sub-criteria are provided set out by the NAO:
- informed decision making;
- sustainable resource deployment; and
- working with partners and other third parties.

A summary of the work we undertake is provided below:



6. VALUE FOR MONEY

Significant Value for Money risks

The NAO's guidance requires us to carry out work at the planning stage to identify whether or not a Value for Money (VFM) exists. Risk, in the context of our VFM work, is the risk that we come to an incorrect conclusion rather than the risk of the arrangements in place at the Council being inadequate. As outlined above, we draw on our deep understanding of the Council and its partners, the local and national economy and wider knowledge of the public sector.

For the 2019/20 financial year, we have identified the following significant risk to our VFM work:

Description of significant risk	Planned response
Financial sustainability 2019/20 is the final year of the Councils three year strategy (2017-20), a period which has seen considerable budget cuts. The 2019/20 budget is balanced following an increase in Council Tax of 3.49% but requires the achievement of £15m savings. The continuing challenges the Council faces are not new and are not unique to Manchester City Council. The challenges do, however, present a significant audit risk in respect of considering the arrangements that the Council has in place to deliver financially sustainability.	We will review the arrangements the Council has in place for ensuring financial resilience, specifically progress in achieving a balanced outturn in 2019/20. We also plan to review the 2020/21 medium term financial plan to ensure it properly reflects factors such as future funding sources, levels of other income, salary and general inflation, and demand pressures.

7. FEES FOR AUDIT AND OTHER SERVICES

Fees for work as the Council's appointed auditor

At this stage of the audit we are not planning any divergence from the scale fees set by PSAA, as communicated in our fee letter of 23 April 2019.

Service	2018/19 fee	2019/20 fee
Code audit work	£161,519*	£159,519

* An additional fee for £2,000 was agreed for further work required regarding the WGA consolidation.

Fees for non-PSAA work

We have not been engaged by the Council to carry out any additional work. If requested to carry out any additional work, and before agreeing to undertake any additional work, we consider whether there are any actual, potential or perceived threats to our independence. Further information about our responsibilities in relation to independence is provided in section 8.

8. OUR COMMITMENT TO INDEPENDENCE

We are committed to independence and are required by the Financial Reporting Council to confirm to you at least annually, in writing, that we comply with the Financial Reporting Council's Ethical Standard. In addition, we communicate any matters or relationship which we believe may have a bearing on our independence or the objectivity of the audit team.

We have not made arrangements for any of our activities as auditor to be conducted by another firm that is not a Mazars' member firm. In section 3 we have outlined the experts that we intend to use as part of our audit. We will write to these experts seeking confirmation of their independence and will report this within our Audit Completion Report.

Based on the information provided by you and our own internal procedures to safeguard our independence as auditors, we confirm that in our professional judgement there are no relationships between us and any of our related or subsidiary entities, and you and your related entities creating any unacceptable threats to our independence within the regulatory or professional requirements governing us as your auditors.

We have policies and procedures in place which are designed to ensure that we carry out our work with integrity, objectivity and independence. These policies include:

- all partners and staff are required to complete an annual independence declaration;
- all new partners and staff are required to complete an independence confirmation and also complete computer-based ethical training;
- rotation policies covering audit engagement partners and other key members of the audit team;
- use by managers and partners of our client and engagement acceptance system which requires all non-audit services to be approved in advance by the audit engagement partner.

We confirm, as at the date of this document, that the engagement team and others in the firm as appropriate, and Mazars LLP are independent and comply with relevant ethical requirements. However, if at any time you have concerns or questions about our integrity, objectivity or independence please discuss these with Karen Murray in the first instance.

Prior to the provision of any non-audit services, Karen Murray will undertake appropriate procedures to consider and fully assess the impact that providing the service may have on our auditor independence. Included in this assessment is consideration of Auditor Guidance Note 01 as issued by the NAO, and the PSAA Terms of Appointment.

No threats to our independence have been identified.

Any emerging independence threats and associated identified safeguards will be communicated in our Audit Completion Report.

APPENDIX A – KEY COMMUNICATION POINTS

ISA (UK) 260 'Communication with Those Charged with Governance', ISA (UK) 265 'Communicating Deficiencies In Internal Control To Those Charged With Governance And Management' and other ISAs (UK) specifically require us to communicate the following:

Required communication	Where addressed
Our responsibilities in relation to the financial statement audit and those of management and those charged with governance	Audit Strategy Memorandum Engagement letter
The planned scope and timing of the audit including any limitations, specifically including with respect to key audit matters	Audit Strategy Memorandum
With respect to misstatements: • Uncorrected misstatements and their effect on our audit opinion; • The effect of uncorrected misstatements related to prior periods; • A request that any uncorrected misstatement is corrected; and • In writing, corrected misstatements that are significant.	Audit Completion Report
With respect to fraud communications: • Enquiries of the audit committee to determine whether they have a knowledge of any actual, suspected or alleged fraud affecting the entity; • Any fraud that we have identified or information we have obtained that indicates that fraud may exist; and • A discussion of any other matters related to fraud.	Audit Completion Report Discussion at Audit Committee Audit planning and clearance meetings
Significant matters arising during the audit in connection with the entity's related parties including, when applicable: • Non-disclosure by management; • Inappropriate authorisation and approval of transactions; • Disagreement over disclosures; • Non-compliance with laws and regulations; and • Difficulty in identifying the party that ultimately controls the entity.	Audit Completion Report
Significant deficiencies in internal controls identified during the audit	Audit Completion Report
Where relevant, any issues identified with respect to authority to obtain external confirmations or inability to obtain relevant and reliable audit evidence from other procedures.	Audit Completion Report
Indication of whether all requested explanations and documents were provided by the entity.	Audit Completion Report

APPENDIX A – KEY COMMUNICATION POINTS

Required communication	Where addressed
Significant findings from the audit including: • Our view about the significant qualitative aspects of accounting practices including accounting policies, accounting estimates and financial statement disclosures; • Significant difficulties, if any, encountered during the audit; • Significant matters, if any, arising from the audit that were discussed with management or were the subject of correspondence with management; • Written representations that we are seeking; • Expected modifications to the audit report; and • Other matters, if any, significant to the oversight of the financial reporting process or otherwise identified in the course of the audit that we believe will be relevant to the Board of Directors or the Audit Committee in the context of fulfilling their responsibilities.	Audit Completion Report
Audit findings regarding non-compliance with laws and regulations where the non-compliance is material and believed to be intentional (subject to compliance with legislation on tipping off) and enquiry of the Audit Committee into possible instances of non-compliance with laws and regulations that may have a material effect on the financial statements and that the Audit Committee may be aware of.	Audit Completion Report Audit Committee meetings
With respect to going concern, events or conditions identified that may cast significant doubt on the entity's ability to continue as a going concern, including: • Whether the events or conditions constitute a material uncertainty; • Whether the use of the going concern assumption is appropriate in the preparation and presentation of the financial statements; and • The adequacy of related disclosures in the financial statements.	Audit Completion Report
Reporting on the valuation methods applied to the various items in the annual [or consolidated] financial statements including any impact of changes of such methods	Audit Completion Report
Explanation of the scope of consolidation and the exclusion criteria applied by the entity to the non-consolidated entities, if any, and whether those criteria applied are in accordance with the relevant financial reporting framework.	Audit Strategy Memorandum and/or Audit Completion Report as appropriate
Identification of any audit work performed by component auditors in relation to the audit of the consolidated financial statements other than by Mazars' member firms	Audit Strategy Memorandum and/or Audit Completion Report as appropriate
Identification of each key audit partner involved in the audit	Audit Strategy Memorandum

APPENDIX A – KEY COMMUNICATION POINTS

Required communication	Where addressed
Description of nature, frequency and extent of communication with the Audit Committee and other relevant bodies including dates of meetings	Audit Strategy Memorandum
Description of distribution of tasks among the auditors where more than one auditor has been appointed	Audit Strategy Memorandum
Description of methodology used, including which categories of the balance sheet have been directly verified and which categories have been verified based on system and compliance testing, including an explanation of any substantial variations compared to the previous year	Audit Strategy Memorandum and/or Audit Completion Report as appropriate
Disclosure of quantitative level of materiality applied to the audit, any specific materiality levels applied to particular classes of transactions, account balances or disclosures, and qualitative factors considered when setting materiality	Audit Strategy Memorandum and/or Audit Completion Report as appropriate
Explanation of judgements about events or conditions identified during the course of the audit that may cast significant doubt on the entity's ability to continue as a going concern and whether they constitute a material uncertainty, and provide a summary of all guarantees, comfort letters, undertakings of public intervention and other support measures that have been taken into account when making a going concern assessment	Audit Strategy Memorandum and/or Audit Completion Report as appropriate
Reporting on significant deficiencies including whether or not the deficiency in question has been resolved by management	Audit Completion Report

APPENDIX B – FORTHCOMING ACCOUNTING AND OTHER ISSUES

Financial reporting changes relevant to 2019/20

There are no significant changes in the Code of Practice on Local Authority Accounting for the 2019/20 financial year.

Accounting standard	Year of application	Commentary
IFRS 16 – Leases	2020/21	The CIPFA/LASAAC Code Board has determined that the Code of Practice on Local Authority Accounting will adopt the principles of IFRS 16 Leases, for the first time from 2020/21. IFRS 16 will replace the existing leasing standard, IAS 17, and will introduce significant changes to the way bodies account for leases, which will have substantial implications for the majority of public sector bodies. The most significant changes will be in respect of lessee accounting (i.e. where a body leases property or equipment from another entity). The existing distinction between operating and finance leases will be removed and instead, the new standard will require a right of use asset and associated lease liability to be recognised on the lessee's Balance Sheet. In order to meet the requirements of IFRS 16, all local authorities will need to undertake a significant project that is likely to be time-consuming and potentially complex. There will also be consequential impacts upon capital financing arrangements at many authorities which will need to be identified and addressed at an early stage of the project. Although this change is effective from 1 April 2020, it is important to note that the Council must disclose the likely future impact in the 2019/20 accounts.

APPENDIX C – EXTENDED AUDITOR'S REPORT

Basis of requirement for an extended auditor's report

We are required to issue an extended auditor's report on the Council's 2019/20 financial statements under ISA (UK) 700 'Forming an Opinion and Reporting on Financial Statements'. This is required as the Council meets the definition of a Public Interest Entity as a result of it having debt that is listed on an EU regulated market.

Layout of the extended auditor's report

The extended auditor's report for 2019/20 is expected to follow the format and structure outlined below, assuming that no emphasis of matter or qualification is required.

Paragraph heading	Summary of key content
Opinion	What we have audited and our opinion thereon.
Basis for opinion	Confirmation: • that the audit is undertaken under the ISAs (UK) • of our independence including with the FRC's Ethical Standard • regarding sufficiency and appropriateness of audit evidence obtained to provide a basis for our opinion.
Conclusions relating to going concern	Reporting by exception on the Council's: • use of the going concern basis of accounting • disclosure of any material uncertainties
Key audit matters	Definition of key audit matters. Clarification that these matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and that we do not provide a separate opinion on these matters. For each key audit matter identified: • a description of the most significant assessed risk(s) of material misstatement • a summary of our response to those risks • key observations arising with respect to those risks including clear reference to relevant disclosures in the financial statements, where relevant.

APPENDIX C – EXTENDED AUDITOR'S REPORT

Paragraph heading	Summary of key content
Our application of materiality	Explanation of how we applied the concept of materiality in planning and performing the group and parent company audit. The overall materiality threshold for the group and single entity financial statements as a whole.
An overview of the scope of our audit	Overview of the scope of the audit, including an explanation of how the scope addressed each key audit matter and was influenced by our application of materiality.
Other information	Responsibilities of the Deputy Chief Executive and City Treasurer and of the auditor for other information included in the Narrative Report.
Responsibilities of the Deputy Chief Executive and City Treasurer for the financial statements	Cross reference to the Deputy Chief Executive andCity Treasurer's Statement of Responsibilities.
Auditor's responsibilities for the audit of the financial statements	Explanation of the 'reasonable assurance' objective of the audit Cross-reference to our responsibilities for the audit on the FRC's web-site
Matters on which we are required to report by exception	Report in the public interest under section 24 of the Local Audit and Accountability Act 2014. Recommendation under section 24 of the Local Audit and Accountability Act 2014. Exercise of any other special powers of the auditor under the Local Audit and Accountability Act 2014.

APPENDIX C – EXTENDED AUDITOR'S REPORT

Paragraph heading	Summary of key content
Value for Money arrangements conclusion	Our conclusion on the Council's arrangements for securing economy, efficiency and effectiveness in its use of resources.
Basis for conclusion	Overview of the scope of our value for money work.
Responsibilities of the Council for arrangements for securing economy, efficiency and effectiveness in its use of resources	Sets out the Council's responsibilities.
Auditor's responsibilities in relation to review of arrangements for securing economy, efficiency and effectiveness in the use of resources	Sets out the auditor's responsibilities, derived from the Local Audit and Accountability Act 2014.
Other matters which we are required to address	Confirms that we have not carried out any prohibited non-audit services and that we remain independent on the Council and its group. Confirms that our audit opinion is consistent with the Audit Completion Report.
Use of the audit report	Sets out who we are reporting to and what the report may be used for.
Audit certificate	Sets out that we have completed the audit of the Council in accordance with the Local Audit and Accountability Act 2014.

Manchester City Council Audit Committee Work Programme 2019/20 and Recommendations Monitor

Meeting Date 11 February 2020, 10am (Report deadline 31 January)				
Internal Audit Assurance Report	Tom Powell Richard Thomas Kathryn Fyfe	Head of Audit and Risk Deputy Head of Audit and Risk Audit Manager	Summary of internal audit activity and report opinions to the end of quarter three. *To consider and comment*	4.4
Outstanding Audit Recommendations	Tom Powell Richard Thomas Kathryn Fyfe	Head of Audit and Risk Deputy Head of Audit and Risk Audit Manager	Update on the implementation of internal and external audit recommendations for each Directorate to the end of quarter three. *To consider and comment*	4.4
Risk Review Item	Tom Powell	Head of Audit and Risk	Update reports from officers on areas of focus to be agreed by Committee arising from limited/no assurance Internal Audit reports, outstanding audit recommendations or management of risk. *To consider and comment*	4.1
Audit Strategy Memorandum 2019/20	Karen Murray	External Audit (Mazars)	Report from the External Auditor on the External Audit Plan for the audit of the accounts and value for money conclusion for year ending 31 March 2020 *To consider and comment*	2 4.7
Work Programme and Recommendations Monitor	Andrew Woods	Governance Team Leader		

Meeting Date 10 March 2020, 10am (Report deadline 28 February)				
Register of Significant Partnerships	James Binks Vicky Clark	Director of Policy, Performance and Reform Head of Performance, Research & Intelligence	Annual review of the register of significant partnerships. *To consider and comment*	4.10 4.12
Accounting Concepts and Policies, Critical Accounting Judgements and Key Sources of Estimation Uncertainty	Carol Culley Janice Gotts Karen Gilfoy	Deputy Chief Executive and City Treasurer Deputy City Treasurer Chief Accountant	To explain the accounting concepts and policies, critical accounting judgements and key sources of estimation uncertainty that will be used in preparing the accounts. *To consider and comment*	1 4.9
Annual Internal Audit Plan	Tom Powell Richard Thomas Kathryn Fyfe	Head of Audit and Risk Deputy Head of Audit and Risk Audit Manager	To provide the Internal Audit Strategy and annual internal audit work plan for Audit Committee consideration in line with Public Sector Internal Audit Standards. *To review and approve*	4.2 4.3
Risk Management Strategy and Risk Register	Tom Powell Richard Thomas John Gill	Head of Audit and Risk Deputy Head of Audit and Risk Risk and Resilience Manager	Update on the Council's risk management strategy and governance arrangements. To include the corporate risk profile as articulated in the latest refresh of the corporate risk register. *To consider and comment*	4.1
Risk Review Item	Tom Powell	Head of Audit and Risk	Update reports from officers on areas of focus to be agreed by Committee arising from limited/no assurance Internal Audit reports, outstanding audit recommendations or management of risk. *To consider and comment*	4.1
Work Programme and Recommendations Monitor	Andrew Woods	Governance Team Leader		

Meeting Date for April TBC (proposed 7 April 2020), 10am (Report deadline 27 March)				
Draft Annual Governance Statement (AGS)	James Binks Vicky Clark	Performance Manager Head of Performance, Research & Intelligence	To advise the processes followed to produce the AGS and obtain Audit Committee input to the draft statement. *To consider and comment*	1 3 4.10 4.12
Head of Audit and Risk Management Annual Opinion	Tom Powell	Head of Audit and Risk	Head of Internal Audit and Risk Management Annual Opinion on the Council's systems of governance, risk management and internal control as well as a summary of audit work undertaken in the year. *To consider and comment*	4.6
Review of Internal Audit and Quality Assurance Improvement Programme (QAIP)	Carol Culley	Deputy Chief Executive and City Treasurer	To consider organisational arrangements for the delivery of internal audit in line with legislation and Public Sector Internal Audit Standards. To include review of the Internal Audit Charter. *To consider and comment*	3
Annual Review of Audit Committee Terms of Reference	Andrew Woods	Governance Team Leader	To review the Committee terms of reference and operation of the Committee. To propose changes (where required) for consideration at Council. *To consider and comment*	
Risk Review Item	Tom Powell	Head of Audit and Risk	Update reports from officers on areas of focus to be agreed by Committee arising from limited/no assurance Internal Audit reports, outstanding audit recommendations or management of risk. *To consider and comment*	4.1

Work Programme and Recommendations Monitor	Andrew Woods	Governance Team Leader		

Recommendations Monitor

Date	Item	Recommendation	Response	Contact Officer
12 November 2019	**AC/19/52 Outstanding Audit Recommendations**	That a report on the overdue recommendations in relation to Disability Supported Accommodation Services be submitted for consideration at an appropriate time, and all relevant Strategic Leads and Executive Members be in attendance.		Executive Director, Adult Social Services

Audit Committee Terms of Reference: as per Constitution (Agreed by Council on 2 October 2019)

Purpose

1. The main purpose of the Committee is to obtain assurance over the Council's corporate governance and risk management arrangements, the control environment and associated anti-fraud and anti-corruption arrangements.

Governance

2. Review the Council's corporate governance arrangements including consideration of the Code of Corporate Governance.

- Review the Annual Governance Statement prior to approval and consider whether it properly reflects the risk environment and supporting assurances, taking into account internal audit's opinion on the overall adequacy and effectiveness of the Council's framework of governance, risk management and control.

- Review the governance and assurance arrangements for significant partnerships or collaborations, including the Register of Significant Partnerships.

- To consider the effectiveness of the Council's risk management arrangements including reviewing the Risk Management Strategy and Policy; and the Corporate Risk Register.

- Review the assessment of fraud risks and potential harm to the Council from fraud and corruption including oversight of key anti-fraud policies and monitoring of the counter-fraud strategy.

- To make recommendations to the Chief Finance Officer and Monitoring Officer in respect of Part 5 of the Council's Constitution (Financial Regulations).

Financial Reporting

3. Review and approval of the annual Statement of Accounts. Specifically, to consider whether appropriate accounting policies have been followed and whether there are concerns arising from the financial statements or from the audit that need to be brought to the attention of the Council.

- Consider the external auditor's report to those charged with governance on issues arising from the audit of the accounts and monitor the Council's response to individual issues of concern identified.

- Approve the Council's Statement of Accounts and associated governance and accounting policy documents in accordance with the Accounts and Audit Regulations 2015.

External Audit

4. Support the independence of external audit through consideration of the external auditor's annual assessment of its independence and review of any issues raised by Public Sector Audit Appointments (PSAA).

- Consider the external auditor's annual audit plan, annual audit letter, relevant reports and the report to those charged with governance.

- Advise and recommend on the effectiveness of relationships between external and internal audit and other inspection agencies or relevant bodies.

Internal Audit

5. Oversee and provide assurance to the Council on the provision of an effective internal audit service and the main issues arising from Internal Audit work. In particular, undertake the duties of the Board as set out in Public Sector Internal Audit Standards (PSIAS) as follows:

- Approve the Internal Audit Charter

- Review and approve the risk-based internal audit plan, including internal audit's resource requirements, including any significant changes, the approach to using other sources of assurance and any work required to place reliance upon those other sources.

- Receive confirmation from the Head of Audit and Risk Management with regard to the organisational independence of the internal audit activity and make appropriate enquiries of management and the Head of Audit and Risk Management to determine whether there are inappropriate scope or resource limitations.

- Provide free and unfettered access to the Audit Committee Chair for the Head of Audit and Risk Management, including the opportunity for a private meeting with the Committee.

- Consider any impairments to independence or objectivity arising from additional roles or responsibilities outside of internal auditing of the Head of Audit and Risk Management. To approve and periodically review safeguards to limit such impairments.

- Receive the results of the Quality Assurance and Improvement Plan annually and the external quality assessment of internal audit that takes place at least once every five years.

- Receive communications from the Head of Audit and Risk Management on the internal audit activity's purpose, authority, responsibility and performance relative to its plan. To include significant risk exposures and control issues, including fraud risks, governance issues and other matters needed or requested by senior management and the Committee.

- Consider the Head of Audit and Risk Management's annual opinion and report.

- Seek assurance on the adequacy of management response to internal audit advice, findings and recommendations in the form of implementation of agreed action plans.

- To monitor the implementation and outcomes of the Council's internal audit programme and where required, to review summary and individual audit reports with significant implications for financial management and internal control.

Treasury Management

6. To monitor the performance of the Treasury Management function including:

- approval of / amendments to the organisation's adopted clauses, treasury management policy statement and treasury management practices;
- budget consideration and approval;
- approval of the division of responsibilities;
- receiving and reviewing regular monitoring reports and acting on recommendations; and
- approving the selection of external service providers and agreeing terms of appointment.

Additional role of Audit Committee

7. To overview the Council's whistleblowing policy.

Delegation: In exercising the above powers and responsibilities, the Committee shall have delegated power to make decisions and act on behalf of the Council.

Note: The Committee may itself determine not to exercise its delegated powers and instead make recommendations to the Council.