Manchester City Council
Report for Information

Report to: Audit Committee - 19 January 2021

Subject: Outstanding Audit Recommendations

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

---

Summary

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

Recommendations

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

Wards Affected: All

Contact Officers:

Name: Carol Culley
Position: Deputy Chief Executive and City Treasurer
Telephone: 0161 234 3506
E-mail carol.culley@manchester.gov.uk

Name: Tom Powell
Position: Head of Internal Audit and Risk Management
Telephone: 0161 234 5273
E-mail t.powell@manchester.gov.uk

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 15 September 2020.
- Adults Audit and Assurance Report 26 November 2020.

1 Introduction

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

1.2 There have been understandable delays in progressing some of the agreed actions as officers across the Council have been refocused on unplanned essential activities that were and are still required to respond to the pandemic. As a result, Internal Audit have engaged with services to understand the impact on timescales agreed pre Covid19 and what the realistic, achievable revised dates for completion of actions is now likely to be. This work will continue and proposed changes will be shared with Audit Committee.

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

2 Standard Process

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

2.2 Progress made in the implementation of agreed actions from audit reports is reported quarterly to Directorate Leadership Teams (DLTs), 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 DLT reports, Internal Audit reporting and annual governance statement questionnaires, which are completed by all Heads of Service.

3 Current Implementation Position

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

3.2 Since the last formal update in September 2020 Internal Audit has confirmed that services have been able to complete actions to address 20 high priority recommendations in thirteen audits as follows:

- Core: Social Value (1)
- Core: Capital Frameworks – Call off Selection and Award (1)
- Core: Prevention and Detection of Procurement Fraud (2)
- Core: GDPR Post Implementation Review (1)
- Core: GDPR Data Protection Impact Assessments (1)
- Adults: Disability Supported Accommodation Services: Quality Assurance Framework (2)
- GMRAPS (1)
- Neighbourhood Investment Fund (2)
- Children's: Early Help and Troubled Families (2)
- Children's: Penalty Notices for Unauthorised Absences (1)
- Children's: Management Oversight and Supervision (1)
- Children's: Assisted and Support Year in Employment (2)
- ICT Software Licensing (3 referred to business)The total above includes ICT

3.3 Software Licensing where three recommendations were discussed at Audit Committee in September 2020 and have been referred back to the business as partially implemented. The original proposal to procure a bespoke Software Asset Management tool software solution, which was an outstanding action, will not be progressed due to the need to prioritise funding and resources in other higher risk areas. The Director of ICT confirmed that he considers that the risks are within tolerance for the service and Internal Audit is supportive of the actions taken to date and this acceptance of remaining risk. Audit Committee noted this decision in September 2020.

Outstanding Recommendation

3.4 There are currently 25 recommendations, from audit reports that are overdue past the agreed implementation dates. This is a decrease from 40 outstanding recommendations reported to Audit Committee in September 2020.

- 14 over nine months overdue.
- 10 between six to nine months overdue.
- 1 between one and six months overdue.

3.5 The overdue recommendations comprise actions that remain fully outstanding (19) or have been partially implemented (6). Actions have continued to progress in some areas but some have been delayed due to Covid19 response and recovery requirements and the reassessment of priorities and action required to mitigate risks. We are working with management to assess and consider these recommendations and appropriate, deliverable actions.

Overdue More than Nine Months (Appendix 2)

3.6 There are 14 recommendations which have been outstanding over nine months, of which 11 are deemed as partially implemented based on actions taken to date. Internal Audit will continue to monitor progress and discuss with Directors the likely timescales for implementation given delays due to Covid19. The current outstanding recommendations are:

- Adults: Transitions (3 of which 2 are partially implemented).
- Core: Purchase Cards (1 partially implemented)
- Adults: Management Oversight and Supervision (2 partially implemented)
- Adults: Mental Health Casework Compliance (6 of which 4 partially implemented)
- Core: Contract Spend Review (1 partially implemented)
- Adults: Floating Support (1 partially implemented)
- Children's: Procurement in Schools (1)

3.7 The Executive Director for Adult Services attended Audit Committee 26 November 2020 to report on the current position in the Service as there were a number of overdue recommendations. She reported on progress and the impact of the Council's Covid19 response activities and current priorities in relation to outstanding recommendations. Confirmation was reached that further work will see implementation of some of the recommendations by March 2021 and some others may be superceded by a refreshed improvement programme. We have met with colleagues involved in the new programme ("Better Outcomes Better Lives") and will work with Adults DLT to ensure that assurances from this and from the six workstreams established to drive improvement are linked into audit work and assurance reporting where appropriate.

3.8 We will follow up specifically on mental health casework and floating support by the end of February 2021 to independently confirm whether actions reported to Committee in November have addressed risks to an acceptable level.

3.9 In the Core an outstanding recommendation from the purchase card audit for the provision of guidance on hospitality has been delayed from its revised of November 2020. A policy is scheduled now to be confirmed at Personnel Committee in January 2021 which will allow implementation shortly after.

Overdue for 6 – 9 months (Appendix 3)

3.10 Ten recommendations have been overdue for between six and nine months, in four audit reports. Internal Audit is monitoring progress on these and reviewing the potential of other mitigation actions. If these recommendations are not implemented or superceded with relevant alternative actions an update will be provided to Audit Committee by the relevant Strategic Director and Executive Member.

- Core: GDPR – Data Protection Impact Assessments (2, partially implemented)
- Adults: Service Improvement Plan Governance (3)
- Children's: Planning for Permanence (3)
- Section 106 (2)

A follow up audit is planned as agreed to assess progress on Planning for Permanence as part of the 2020/21 audit programme in quarter four.

Overdue less than 6 months (Appendix 4)

3.11 There is one recommendation which has been overdue for between one and six months as reported in appendix four and relates to the audit of Decommissioning Contracts: Leaving Care Service (1 recommendation which is 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 which remain outstanding past their due dates.

Appendix 1 – Implemented Recommendations

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 the Integrated Commissioning and Procurement Team have contacted contract leads about further benchmarking opportunities. There was a recognition that there are some challenge associated with benchmarking but systems like the Social Value Portal already used by Highways and with the NWCH currently setting expected social value requirements based on project value and use of TOMs will provide opportunities for benchmarking. Work is progressing with ICT to finalise a specification for a contract management system that will include fields for social value commitments and should make future benchmarking more feasible. **Internal Audit Opinion**: Implemented	**No further action required**
Capital Frameworks – Call off Selection and Award 19 February 2020	30 June 2020	The fee process should be reviewed, where possible the ability to recharge the management fee should be brought forward to ensure it happens as close to the tender activity as possible, or the potential for staging the management fee so that a proportion is paid on the completion of the tender activity should be considered. The team may also	There is currently a process in place for collecting abortive fees from main contractors should projects not go ahead. This is currently being reviewed together with a proposal to charge 'upfront fees' from contractors early in the second stage of the tender process. This will be discussed at board level and with the Managing	The NWCH Board agreed a recommendation in October 2020 to implement a 15% upfront fee (non-refundable) payable within the second stage process when the contractor has received payment from the client. It was agreed that this would be taken forward for discussion with clients and a timeline for implementation agreed. **Internal Audit Opinion:** Implemented	**No further action required**

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		wish to consider reviewing the fee charges to include a small 'aborted tenders' allowance so that the costs of such incidents are covered where no recharge is to be made directly to the client or contractor. Consideration of whether a "cancellation fee" should be charged to the client where a full tender activity has been undertaken but the project is cancelled prior to any work taking place should be given as part of the review of the fee process. Thought should also be given as to how information on the current contractual status of the call offs can be collected promptly and efficiently to ensure that fees are not missed due to the team not being informed that the contract has been signed.	Directors of our Contractor Partners.		
Prevention and Detection of Procurement Fraud 6 June 2019	31 December 2019	The Director of Capital Programmes with the Frameworks Lead (NWCH) should develop a method for monitoring bid patterns across this and other frameworks to ensure transparency and inform any actions required to stimulate greater competition. Consideration could be given to the development of a periodic report outlining engagement with the	The list of commissions is reviewed each quarter with a finance review undertaken to track fees and Social Value outcomes collected. A Capital Programmes (CAPPS) framework has predominantly been used for Council commissions and as such over the 4 years since launch the reliance on the Council to use the framework has diminished as recruitment has taken place. The NWCH team will	Internal Audit confirmed that the outstanding element of this recommendation was being addressed through the commission of a piece of work regarding the setting up of reports on Welcome Home which was underway. **Internal Audit Opinion:** Implemented	**No further action required**

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		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.	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.		
Prevention and Detection of Procurement Fraud 6 June 2019	30 June 2020	The Head of Integrated Commissioning and Procurement should produce / commission an annual review of bid information held in the Chest. This should be done to allow for further investigation of bid patterns if issues are identified. This analysis should include: - Supplier Success Rates. - Single Bidder Activities. - Projects with multiple ITT stages. - Reasons for opt outs. In order to aid in the running of the above the ways of working with the system should be reviewed with the system supplier (as part of the development discussions recommended at 2 above) to ensure that: - the use of multiple ITT stages is	An annual report will be produced to consider the procurement activity over the previous financial year.	Work has been undertaken by the Integrated Commissioning and Procurement team to explore options for addressing this risk. Whilst the Chest functionality enables the processing of tenders and retention of records, the reporting facility within the Chest is limited and does not function sufficiently to produce accurate reporting information that is reliable. Work has therefore been undertaken to identify and assess alternative means of assurance and the strengthening of those where possible. An example being the introduction of a requirement for staff to record in the private notes section in the workflow why a stage has been added if the circumstances are unusual. This will help to create an audit trail. Another control to note is that where the procurement team are the verifiers, they will alert stakeholders to	**No further action required**

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		avoided unless necessary and that the way the system records these is fully understood. - discontinued activities are marked as such in a way which can be identified within both detailed and summary reports.		any free text responses that may require further attention. The strategic group that oversees the Chest is currently preparing to re-tender and the specification will be reviewed to strengthen the reporting element to facilitate improved use of system data moving forward. **Internal Audit Opinion: Implemented**	
GDPR Post Implementation Review 20 June 2019	30 April 2020	The Council's Corporate Records Manager working with its Data Protection Officer (DPO) and the Information Steering Group (reporting to CIARG) should develop a corporate action plan to prioritise and agree actions to improve data retention and disposal arrangements. We are aware that the DPO intends to undertake a risk assessment of all service areas which will be presented to CIARG, this will highlight areas of priority to be included in the plan.	It is accepted that a corporate action plan should be developed to improve data retention and disposal arrangements and build this into the Information Governance Risk Register. The Corporate Records Manager will work with the Deputy Senior Information Risk Officers to assess records management maturity in their areas and develop standardised locally owned action plans for development of records management best practice.	An action plan has been drafted and presented to CIARG for review and comment. Internal Audit considers that the action plan is proportionate and focused on the areas for improvement that the audit identified. **Internal Audit Opinion:** Implemented	**No further action required**
Neighbourhood Investment Fund 2 September 2019	6 September 2019	NIF funding should only be spent where there has been an application from a community group. Team leaders should not approve payment at the request of Members where there is no community group application in support of the payment.	No NIF grant to proceed without written record of decision (email or signature to confirm verbal discussion). The NIF expenditure in Chinatown addressed urgent issues raised by the Accountability Board (drug dealing and rat infestation) however there were no Community Groups available so the cost of this work should have fallen elsewhere.	Members have been reminded in writing of the requirement for application approval to be made either via email or wet signature and that NIF funding should only be allocated and spent where there has been an application from a community group. **Internal Audit Opinion:** Implemented	**No further action required**

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
			This will need reinforcing with local Members.		
Neighbourhood Investment Fund 2 September 2019	31 December 2019	Guidance should be updated to include agreed timescales for monitoring NIF grants and details of checks to be undertaken; management should ensure this is completed.	A task group led by Richard Dudley (Neighbourhood Team Leader) with NIF leads from Central, North and South teams to review content and issue procedural guide to be followed by all three teams. This will ensure consistency across neighbourhoods. Agree programme for each Neighbourhood Officer to deal with outstanding monitoring.	Procedural guidance has been reviewed and updated to enable consistency. **Internal Audit Opinion:** Implemented	**No further action required**
GMRAPS 15 October 2019	31 January 2020.	Ensure permits are in place and updated timely for all in house works.	Accepted.	The requirements for permitting is documented within procedural guidance. Management have met with Manchester Contracts to demonstrate how to input and update a permit and the information required and have issued them with a permit tracker for monitoring permits. **Internal Audit Opinion:** Implemented	**No further action required**
GDPR DPIA 1 November 2019	30 April 2020	The Data Protection Officer should contact the managers identified in our sample, to confirm the completion of a DPIA for each project.	Accepted.	The Data Protection Officer has contacted managers with respect to each project in our sample. He has confirmed the position regarding relevant data protection requirements and considerations, and where appropriate has supported managers with the completion of DPIAs. This support remains ongoing. **Internal Audit Opinion:** Implemented	**No further action required**

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
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 coordinators to implement any actions that are identified. Results can then be assessed and addressed at a strategic level if further support or resources are needed. Clarity as to how registered managers assure themselves that quality control checks are built into day to day service provision. This should help inform the Quality Assurance (QA) Framework, allowing auditors to provide an opinion on these arrangements	I agree with the activity identified within recommendation 1. Register of all details including residents; staff and properties to be sent to Performance, Research and Intelligence team.	The Executive Director for Adults reported to Audit Committee that action to start the DSAS audit programme had started but was then curtailed due to the response requirements to the Covid19 pandemic and the audit programme will be restarted as soon as practicable**.** **Internal Audit Opinion:** Implemented.	**No further action required**

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		rather than lower level, task specific compliance.			
Disability Supported Accommodation Services: Quality Assurance Framework 14 February 2018	31 August 2018	Management should consider integrating oversight of the Supported Living QA process into the role of Adults QA team and revise the content of the Framework. This could include: • A workshop including key partners, support coordinators and registered managers used to inform a revised framework. • Supporting an effective QA audit process and clarifying whether inquiry or inspection of evidence is required for each question/section and QA auditors 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.	With regard to recommendation 2 whilst I have welcomed the support and expertise the Adults QA Team have provided to date and would want this to continue going forward I do not think it is appropriate to integrate oversight into the role of the Adults QA Team. The service is a commissioned In House Provider and is regulated and inspected by CQC and is also 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.	A quality assurance process was developed including a workshop to support it. It includes guidance for service audits to be carried out and a moderation process along with a new schedule of activity. This approach was approved by management and therefore the recommendation was implemented. There have been delays in the launch of the audit programme based on the current priorities in the service which will limit its effectiveness at this time. **Internal Audit Opinion**: Implemented	**No further action required**
Children Services: Management Oversight and Supervision	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 action was taken to address the recommendation and subsequently broader development has been undertaken in relation to quality assurance requirements. Policy	**No further action required**

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
9 May 2019				was updated to include auditing of supervision files principally to look at the quality of direct work as part of the QA Framework. It is reported that adherence to this policy was strong initially however it has been inconsistent over the last 18 months. A new approach to quality assurance was developed with increased levels of audits reportedly 126% more than the year the internal audit was completed. Management have confirmed that the Service is now developing a quality assurance virtual team through the "Close the Loop" activity. **Internal audit opinion:** Implemented	
Assessed and Supported Year in Employment 21 May 2019	30 June 2019	The Workforce Learning and Development Manager should ensure that Social Work (SW) Managers are reminded of their role in supporting delivery of the ASYE programme. In particular, SW Managers should be required to provide confirmation to the Social Work Consultants on the completion of key milestones, including at a minimum the learning agreement, direct observations, and the six- and twelve-month reviews.	A google sheet has been circulated by the Workforce Learning and Development Manager to the North, South and Central Service Leads. Managers with responsibilities for Newly Qualified SWs can update their records each month over the 12 month programme and progress will be RAG rated. This will allow the SW Consultant to provide additional support to those NQSWs that fall into an amber or red position. The Google sheet will be used to capture all the key milestones of the ASYE programme up to completion by the service.	Management confirmed that monitoring is carried out on progress for all NQSW on the AYSE programme. There is regular review and an annual report is produced as part of the assurance process. **Internal Audit Opinion:** Implemented	**No further action required.**
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	Workforce Learning and Development Manager to have greater oversight into the reconciliations and payments from	Management have confirmed that the costs are now tracked and monitored and reported to management. Internal Audit has now seen the annual report	**No further action required**

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		(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.	Skills for Care. Monthly review of spreadsheet and viewing payment when available from Skills for Care. *Please note* Skills for Care close for 5 months for online payment so systems will be in place to monitor this and claim when online system is closed from April 2019 – September 2019. Support from finance has been sought who now are in communication with Skills for Care to ensure we are clear on claims received.	used to provide update and assurance as part of the process. **Internal Audit Opinion**: Implemented	
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.	The Director of ICT attended Committee in September 2020 to present a paper on the Council's current position and management of software licensing. As a result it was agreed to refer the risks associated with this recommendation back to the business to manage. **Internal Audit Opinion**: Risk referred	**No further action required**
ICT Software Licensing 24 July 2018	30 April 2019	Software licensing management roles, responsibilities and capability gaps need to be defined, implemented and communicated to ICT and the Directorates. Additionally, both the end users of licenced applications and IT staff who install and maintain the applications should have a clear understanding of the appropriate	Following the work done in Recommendation 1, ICT will be in a position to define roles and responsibilities for software asset management (SAM). Beyond this, ICT will devise (as part of another recommendation arising from this audit) policies and procedures to support Council-wide compliance to a consistent approach to SAM,	The Director of ICT attended Committee in September 2020 to present a paper on the Council's current position and management of software licensing. As a result it was agreed to refer the risks associated with this recommendation back to the business to manage. **Internal Audit Opinion**: Risk referred	**No further action required**

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		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.	clearly differentiating between centrally managed licensing and those managed locally within business units.		
ICT Software Licensing 24 July 2018	30 April 2019	The current systems used by ICT to support software asset management (SAM) should be reassessed to ensure that they are fit for purpose and possess the capability to process, create and maintain all stores and records for software and related assets. Furthermore, the Council should look to move away from the manually intensive process currently in operation and explore the automation of tasks required to maintain compliance with software licenses and control software spending. The tools available to the Council should provide the functionality to detect and manage all exceptions to SAM policies, processes, and procedures; including license use rights and necessary infrastructure and processes for the effective management, control and protection of the software assets, at	ICT will investigate the work other Council colleagues may be undertaking in relation to the acquisition of tools to manage SAM. ICT will seek to collaborate with such colleagues to ensure best ICT practice implemented and ICT requirements are included in any specifications. If no collaboration opportunities exist, ICT will explore other market solutions and present options to DLT to approve a way forward as part of the business case planned in response to another recommendation arising from this audit.	The Director of ICT attended Committee in September 2020 to present a paper on the Council's current position and management of software licensing. As a result it was agreed to refer the risks associated with this recommendation back to the business to manage. **Internal Audit Opinion**: Risk referred	**No further action required**

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		all stages of the Software license lifecycle. Once reporting is established then regular validation audits should be completed by the SAM team to ensure that the reported position is accurate.			
Early Help and Troubled Families	30 July 2020	The Strategic Head of Early Help should reinforce with all Early Help staff the importance of confirming that the family have consented to the referral before any action is taken, and that, once a referral has been accepted, a written record of this consent is obtained from all relevant family members and uploaded before information is shared with partner agencies.	Agreed, ensuring families read, or are made aware of, the Early Help Privacy Notice continues to be an important part of the offer of early help from referral through to intervention. We accept the findings and will monitor and challenge non-compliance by: • updating the Early Help Process and Practise Standards to provide clearer guidance for practitioners. New GDPR legislation has changed the language on 'consent' which should now be considered within the remit of the Early Help Privacy Notice. • monitoring and challenging compliance through our existing audit cycle and ensuring regular reporting back to senior management.	Internal Audit has confirmed that Early Help Procedures have been updated to include clarity on consent. The procedures have been rolled out to all teams. QAF audit tool was amended to include clearer recording of Early Help consent. Every practitioner team is required to undertake one audit each month. The Head of Service analyses all audits and completes a Head of Service report which monitors compliance around consent. These reports are then discussed in monthly Closing the Loop meetings with Locality Managers. Internal Audit has reviewed examples of these reviews and reports and considers these address the issues raised and seek to improve quality and compliance. In addition, the service is currently completing a Data Protection Impact Assessment (DPIA) to ensure all data 'risks' are identified and mitigated. This will be completed by end of February 2021.	**No further action required**

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
				Internal Audit opinion: Implemented	
Early Help and Troubled Families	30 July 2020	The Strategic Head of Early Help should develop a means of improving compliance with the requirement to create or update a child impact chronology at the start of the Early Help offer. Compliance should be monitored, either on a whole population or sample basis, and the results should be reported to senior management and fed back to individual team leaders.	We accept the findings in relation to chronologies. The importance of chronologies and requirements for completing them will be included in the new process and practice guidance.	Internal Audit has confirmed that The Early Help Procedures have been amended and include guidance on chronologies. Chronologies are now included in the monthly QAF audit cycle and reported on in the Head of Service Monthly reports which are then discussed in monthly Closing the Loop meetings with Locality Managers and shared across teams. **Internal Audit opinion:** Implemented	**No further action required**
Children's Services: Penalty Notices for Unauthorised Absences 1 February 2019	31 Dec 2019	The Strategic Lead for School Attendance & Education Other Than at School should 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.	Regular termly meetings will be held with finance to 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.	Management have confirmed that there is regular review of expenditure on and collection of penalty charges to ensure transparency that the process remains cost neutral. The financial impact of having had no penalty charges issued since April 2020 has been widely reported. **Internal Audit Opinion:** Implemented	**No further action required.**

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

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
Transition to Adult Services 15 Feb 2018	31 October 2018	The Deputy Director of Adults Social Services should ensure that within six months an operational plan is in place for delivering the revised transitions offer in line with the agreed strategy and vision. This plan should include the formalisation of policy and procedure, roles and responsibilities and the use of transition specific documentation referred to in National Institute for Clinical Excellence (NICE) guidance.	Operational Plan in place for delivering the revised transitions offer in line with the agreed strategy and vision	The Executive Director of Adult Social Services confirmed progress to Audit Committee in November 2020. A new operational plan reflecting the vision and strategy will be put in place as part of the action to embed the new strategy. **Internal Audit Opinion:** Partially implemented	**Director:** Bernadette Enright, Executive Director of Adult Social Services **Executive Member:** Councillor Craig **Status:** 26 months overdue **Action:** Revised implementation date - due 31 March 2021
Transition to Adult Services 15 Feb 2018	30 April 2018	The Deputy Director of Adults Social Services should develop a clear transitions strategy and vision in conjunction with Children's Services and other key partners, in line with Care Act requirements. Once developed the strategy and vision should be used to inform the development of a clear service offer for transitions. This offer should be clearly communicated to confirmed key stakeholders including service users. Advice could be sought from other Local Authorities including the Council's Adults Services improvement partner, and differing approaches considered.	Transitions Strategy and Vision to be developed	The Executive Director of Adult Social Services confirmed progress to Audit Committee in November 2020. A new service manager will take this forward developing a strategy reflecting the new vision for Transitions. **Internal Audit Opinion**: Partially Implemented	**Director:** Bernadette Enright, Executive Director of Adult Social Services **Executive Member:** Councillor Craig **Status:** 32 months overdue **Action:** Revised implementation - due by 31 March 2021

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
Transitions to Adult Services 15 Feb 2018	30 June 2018	To support day to day performance management the Interim Deputy Director of Adults Social Services should introduce a suite of Key Performance Indicators. This should be defined once the strategy and vision in place. A long term solution should be considered and built into Liquid Logic to help identify performance trends and provide assurance to senior management.	Key performance Indicators (KPIs) introduced.	The Executive Director of Adult Social Services confirmed progress to Audit Committee in November 2020. A new service manager appointed December 2020 will take forward this recommended action and embed key performance measures into the process as part of the launch of the strategy and action plan. **Internal Audit Opinion**: Partial Implemented	**Director:** Bernadette Enright, Executive Director of Adult Social Services **Executive Member:** Councillor Craig **Status:** 30 months overdue **Action**: Revised implementation - due 31 March 2021
Purchase Cards 19 September 2018	31 Dec 2018	The Deputy Chief Executive and City Treasurer should develop guidelines setting out the general principles for providing hospitality to others, including where a Council officer or member also benefits from the expenditure. This should be supported by examples as appropriate. Internal Audit will support implementation of this recommendation by providing an outline of potential areas for inclusion, and will provide further details of test findings on request.	The City Solicitor, supported by the DCE and City Treasurer, will develop guidance on the provision of hospitality. They will also identify a suitable place within the existing guidance framework for this to be published.	The Code of Conduct was due to be presented to Personnel Committee in November 2020 but this did not take place due to other pressing business in relation to the VS/VER scheme. Once the revised Code of Conduct has been agreed (scheduled 20 January 2021) the policy will be made available to all Officers and Members via the Intranet. The revised Code specifically addresses the provision of Gifts and Hospitality by Council officers. **Internal Audit Opinion**: Partially implemented	**Director:** Fiona Ledden, City Solicitor and Carol Culley, Deputy Chief Executive & City Treasurer **Executive Member:** Councillor Leese **Status:** 24 months overdue **Action:** Personnel Committee 20 January 2021
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).	Audit process to be agreed within the Supervision Task & Finish Group. Process will be embedded into the final Supervision Policy.	The Executive Director reported to Audit Committee in November 2020 that there was a mechanism to collate supervision information to assure senior managers that supervisions are taking place in line with professional practice. It is	**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
		The results in terms of frequency and quality should be audited, analysed, and reported annually.	Additional Resources Required for implementation: Yes – Support from the Reform and Innovation Team secured.	reported at supervising manager meetings whether these are taking place as intended and where compliance looks low this is interrogated further. It was confirmed that it is planned to reconvene a group to review the means to provide for effective audit of the quality of supervisions and the impact of the interim Quality Assurance process. **Internal Audit Opinion**: Partially Implemented	**Status:** 19 months overdue **Action:** Internal audit to review progress as agreed by end of February 2021.
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.	The Executive Director reported to Audit Committee that there is now a programme of supervision training and that this was delivered. There is work under way to pick up any officers who are new starters or did not receive the training. It is proposed that a report will be provided to Performance Board at the end of February 2021 demonstrating progress made on supervision training and delivery and subject to this providing assurance to management over completion this recommendation will be confirmed as completed. **Internal Audit Opinion:** Partially Implemented	**Direct Director:** Bernadette Enright, Executive Director of Adult Social Services **Executive Member:** Councillor Craig **Status:** 13 months overdue **Action** Internal Audit to review the report to Performance Board which is proposed for end of February 2021

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.	Greater Manchester Mental Health Trust and Council to jointly establish a 'Task & Finish' group to investigate, work to resolve, and report progress back to the Director of Adult Services.	As reported to Audit Committee in November 2020 a range of training has been rolled out across the Trust and associated safeguarding plans within divisions. This positive progress as reported to Committee will be tested as part of a follow up in 2021 to ensure that this is operating as expected and if so then this recommendation will be confirmed as complete. **Internal Audit opinion**: Partially implemented.	**Director:** Bernadette Enright, Executive Director of Adult Social Services **Executive Member:** Councillor Craig **Status:** 18 months overdue **Action:** Full follow up audit included on 2020/21 audit plan to be completed early in 2021.
Mental Health Casework Compliance 5 April 2019	30 June 2019	The Director of Adult Services should seek assurance from the Trust in regard to whether Paris, the new case management system, offers improved controls over the initial response to safeguarding concerns, such as requiring management sign-off within 24 hours of receipt of the referral.	Greater Manchester Mental Health Trust and Council to jointly establish a 'Task & Finish' group to investigate, work to resolve, and report progress back to the Director of Adult Services.	As above **Internal Audit opinion**: Partially implemented.	**Director:** Bernadette Enright, Executive Director of Adult Social Services **Executive Member:** Councillor Craig **Status:** 18 months overdue **Action:** Full audit included on 2020/21 audit plan to be completed early in 2021.
Mental Health Casework Compliance 5 April 2019	30 June 2019	The Director of Adult Services should seek assurance from the Trust that manager approval is actively monitored to ensure compliance with quality and time standards.	Greater Manchester Mental Health Trust and Council to jointly establish a 'Task & Finish' group to investigate, work to resolve, and report progress back to the Director of Adult Services.	As above Internal Audit opinion: Partially implemented.	**Director:** Bernadette Enright, Executive Director of Adult Social Services **Executive Member:** Councillor Craig **Status:** 18 months overdue **Action:** Full audit included on 2020/21 audit plan to be completed early in 2021.

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
Mental Health Casework Compliance 5 April 2019	30 June 2019	The Director of Adult Services should seek assurance from the Trust over how the timely and appropriate conclusion of investigations can be better managed and monitored – for example, system workflows to ensure adherence to procedure, and system generated reports of open investigations for which no recent activity has been logged.	Greater Manchester Mental Health Trust (GMMHT) and Council to jointly establish a 'Task & Finish' group to investigate, work to resolve, and report progress back to the Director of Adult Services.	Management reported that performance management during implementation of the improvement agenda would include performance metrics being agreed with Greater Manchester Mental Health Trust management. In November 2020 the Director confirmed a range of arrangements via Divisions that have been established to oversee quality and compliance and arrangements for the reporting and monitoring of performance have been established. These will be assessed by Internal Audit as part of a follow up audit to independently assure whether these arrangements are now addressing the risks noted in the original audit report. **Internal Audit Opinion:** Not Implemented	**Director:** Bernadette Enright, Executive Director of Adult Social Services **Executive Member:** Councillor Craig **Status:** 18 months overdue **Action:** Follow Up audit included on 2020/21 audit plan to be completed early in 2021.
Mental Health Casework Compliance 5 April 2019	30 Sept 2019	The Director of Adult Services should ensure that a formal process is agreed and established with the Trust for a monthly reconciliation between safeguarding referrals sent and received. Trust and Council staff should work together to ensure that the new case management systems in each organisation – Paris and Liquid Logic, respectively – consistently record outcomes of safeguarding referrals, so that these can more easily be transferred across systems to ensure completeness of Council	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.	As above **Internal Audit Opinion:** Not Implemented	**Director:** Bernadette Enright, Executive Director of Adult Social Services **Executive Member:** Councillor Craig **Status:** 15 months overdue **Action:** Full audit included in 2020/21 audit plan, to be completed early in 2021.

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		records and ability to monitor outcomes.			
Mental Health Casework Compliance 5 April 2019	30 June 2019	The Mental Health Commissioning Manager should undertake a review of performance reporting against the agreed KPIs to ensure that performance is being reported accurately and consistently in line with the Section 75 agreement.	The Quality & Performance group is working on improvements to the current performance reporting arrangements; changes are planned for the new financial year (from April 2019 onwards), including addition of commentary.	In a report to Audit Committee in November 2020 the Director confirmed that whilst performance and quality arrangements have been established these are not yet defined in a series of KPIs linked to the S75 Agreement, as the Agreement itself is subject to review which remains outstanding. In audit's opinion the performance monitoring arrangements as described in the November 2020 report should provide a positive level of confidence that risks to service quality and performance are being addressed so this will independently assessed as part of a follow up audit in 2021 and at that stage we will assess whether this recommendation has been largely addressed. **Internal Audit Opinion**: Partially implemented	**Direct Director:** Bernadette Enright, Executive Director of Adult Social Services **Executive Member:** Councillor Craig **Status:** 18 months overdue **Action:** Follow Up audit included in 2020/21 audit plan, to be completed early in 2021.
Contract Spend Review 10 December 2019	31 March 2020	Work should be undertaken to identify the Council's main strategic suppliers. The information contained within contract registers could facilitate this and help to identify those suppliers whether this be by number or value of contracts, or service dependency. A plan for how these contracts should be monitored along with any central oversight to be put in place should then be developed to ensure that the Council	Agree with some comments. Directorates do have some arrangements in place for strategic suppliers. A one size fits all approach is unlikely to work but the Team can develop guidelines and key principles. The management of strategic suppliers will also require	We have confirmed that the Integrated Commissioning and Procurement Team have been working with directorates to: - further refine forward plans. There was a meeting in November 2020 with leads across directorates around identifying opportunities for joined up commissioning. - develop protocols for how to manage contractors with multiple 'customers' across directorates	**Director:** Carol Culley Deputy Chief Executive and City Treasurer **Executive Member:** Sir Richard Leese **Status**: Nine months overdue **Action:** Monitor

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		can take suitable action if becoming aware of any warnings indicating supplier failure.	work between DMTs and key partners, particularly in health.	against a single contract (i.e. multiple users of the same contract, like SAP). - look at how to manage key suppliers in health and social care which is one of the main areas for key suppliers (this will be taken forward with adults and public health commissioners). We have agreed with managers that once the protocols and work to manage key suppliers develops further we will be able to change the status of this to implemented. **Internal Audit Opinion:** Partially Implemented	
Floating Support - Support to Homeless Citizens in Temporary (Dispersed) Accommodation 29 May 2019	30 October 2019	The Strategic Lead - Homelessness and Migration should ensure that documentation requirements for case activity are confirmed for all key tasks. Representatives from the business should then be identified to engage with Liquid Logic to establish what has been designed and whether it meets the needs of the Service. Ideally this would develop formal workflows that will ensure: • All key records to be retained in a consistent format that also enables management sign off (if required), case prioritisation and review as well as alerts where key actions have not been completed.	Meetings with Liquid Logic have already taken place since the initial findings of the audit report to make the new system fit for purpose for the homeless service. Initial discussions show this will not be possible until phase 2 of the roll out. In the meantime, officers will meet with the Liquid Logic team, to see what can be best utilised from the system as it stands to better support the floating support case management and supervision.	Delays in implementation are based on the need to develop documentation requirements within Liquid Logic phase two. A new date for this has now been set for mid 2021. We continue to note that Liquid Logic is being used as far as possible in its current form to support operational activities. **Internal Audit Opinion:** Partially implemented	**Director:** Mike Wright, Director of Homelessness **Executive Member:** Councillor Craig **Status:** 14 months overdue **Action**: Given the timescales required for changes to Liquid Logic phase 2, **a**udit and service management to agree whether the current system is sufficient to address key risks and propose to the Director whether this recommendation should remain open or whether the

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		• 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.			risk is sufficiently addressed to propose that this action be closed as partially addressed. The outcome of this will be shared with Audit Committee for comment. For completion by end February 2021
Procurement in Schools 12 July 2019	30 Nov 2019	Director of Education to consider arranging procurement workshops for Governors, Head Teachers and Business support staff. These sessions should be used to highlight the risks and issues as identified during this audit along with guidance, support and templates where necessary to address these issues and risks. These forums can also be used to re-promote the DfE schools buying hub. We are happy to support this work however consideration should be given to involving Head Teachers and Business Managers from schools where procurement practices are strong in sharing their knowledge and expertise with their peers. Internal Audit propose issuing a circular to all schools following this work around areas where improvements are required. This circular will include a tool for schools to self-assess their own procurement practice ahead of the proposed workshops.	Joint workshops for stakeholders to be facilitated by representatives from Procurement, Schools Finance and Audit. The focus will be on an overview of procurement risk and processes, access to and understanding of national and Council guidance, relevant procurement and finance regulations and reasons why they must be followed.	There has been limited progress on this proposal which has now been further delayed by Covid19. Based on a recent update Internal Audit has agreed to review options with Procurement and Education Finance for addressing procurement governance, risk and awareness and the means to ensure that all school have sufficient access to appropriate guidance and support. **Internal Audit Opinion:** Not implemented	**Director:** Paul Marshall, Strategic Director of Children's Services **Executive Member:** Councillor Bridges **Status:** Twelve months overdue **Action:** Internal Audit and service management in finance and procurement to re-assess options to support and strengthen procurement governance.

Appendix 3 – Recommendations 6-9 Months Overdue

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
GDPR Data Privacy Impact Assessments (DPIA) 1 November 2019	30 April 2020	The Data Protection Officer, with support from Corporate Communications, should ensure that the data protection communications plan includes messages to address the awareness gaps identified in our audit. The messages should be presented to CIARG for review and approval.	Accepted	Following the COVID-19 lockdown the priority for data protection communications was security of working from home and using new ICT tools. This meant that no DPIA-specific communications had been scheduled. The move to Microsoft 365 was then prioritised. However a new mandatory information governance e-learning course has now been rolled out, including messages on DPIAs, and further communications will be linked to a new DPIA format aimed to launch in early 2021. **Internal Audit Opinion:** Partially implemented	**Director:** Fiona Ledden City Solicitor **Executive Member:** Councillor Sir Richard Leese **Status:** Eight months overdue **Action:** Continue to monitor
GDPR DPIA 1 November 2019	30 April 2020	The Data Protection Officer, with support from the Directorate Senior Information Risk Owners, should establish arrangements for the periodic monitoring of compliance with DPIA requirements.	Accepted	Progress on this has been impacted by a focus on other corporate priorities arising, notably, from the COVID situation and the Microsoft 365 change programme. The new and centrally captured DPIA format and links to project and finance management frameworks will proactively support monitoring. **Internal Audit Opinion:** Partially Implemented	**Director:** Fiona Ledden City Solicitor **Executive Member:** Councillor Sir Richard Leese **Status:** Eight months overdue **Action:** Continue to monitor
Adults Improvement	31 March 2020	The Strategic Lead Business Change should re-evaluate the	As part of a 12 month stock-take of the Improvement Programme	The recommendations fell due for implementation during the COVID19	**Direct Director:** Bernadette Enright,

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

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
9 January 2020		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.	workstream. The TEC workstream is being considered as part of the wider MLCO portfolio with a clear action plan to be finalised by April 2020.	seek an update as the Plan is stepped back up and reassessed. **Internal Audit opinion:** Not implemented	**Executive Member:** Councillor Craig **Status:** Eight months overdue **Action:** Follow Up Audit to be completed later in the 2020/21 audit year.
Children's: Planning for Permanence	1 April 2020	Locality Managers should confirm which staff in their locality have not received any training or briefings on the policy and consideration should be given to running some additional events for those who have not yet been trained.	This will be addressed by continuing to run additional training events to ensure all staff have receive required training and by refresh of the induction process to include reference to awareness of the revised policy.	The recommendations fell due for implementation during the COVID19 lockdown. We have not received confirmation of implementation from management at this stage and will seek an update. **Internal Audit opinion:** Not implemented	**Director:** Paul Marshall, Strategic Director of Children's Services **Executive Member:** Councillor Bridges **Status:** Nine months overdue **Action:** Internal Audit to re-engage with management to review and assess next steps
Children's: Planning for Permanence	1 April 2020	The Permanence Improvement Board should review the impact of the initial roll out of the policy and to address any key issues, such as those identified in our review. In particular focus should be given to Permanence Planning Meetings (PPM) and how arrangements can be revised to make them more achievable. Requirements of PPM should be included, where applicable, in the Children's QA	Senior Management will continue to raise awareness of the importance of the PPM process and engagement of social workers in this process.	The recommendations fell due for implementation during the COVID19 lockdown. We have not received confirmation of implementation from management at this stage and will seek an update. **Internal Audit opinion:** Not implemented	**Director:** Paul Marshall, Strategic Director of Children's Services **Executive Member:** Councillor Bridges **Status:** Nine months overdue **Action:** Internal Audit to re-engage with

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		framework to ensure a level of consistency across each locality.			management to review and assess next steps
Children's: Planning for Permanence	1 April 2020	Further performance measures should be developed to assess the effectiveness of permanence planning and then incorporate these in the Permanence score card.	Performance Improvement Board will continue to review performance monitoring to ensure continuous improvement and in considering the effectiveness of the permanence scorecard.	The recommendations fell due for implementation during the COVID19 lockdown. We have not received confirmation of implementation from management at this stage and will seek an update. **Internal Audit opinion:** Not implemented	**Director:** Paul Marshall, Strategic Director of Children's Services **Executive Member:** Councillor Bridges **Status:** Nine months overdue **Action:** Internal Audit to re-engage with management to review and assess next steps
Section 106	31 May 2020	Formalise and update the resources and team structure, finalise policies and procedures and formalise governance proposals.	Accepted as recommended	A dedicated officer is now in place with regards to section 106. Governance arrangements have been put in place in the form of a advisory Board and a working Group. A terms of reference was provided for the newly formed advisory group. At the time of follow up we have not yet obtained a copy of the term of reference for the working group or the updated policies and procedures to review. **Internal Audit opinion:** Partially implemented	**Director:** Eddie Smith **Executive Member:** Councillor Stogia **Status:** Seven months overdue **Action:** Internal Audit to request further information to assess progress

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
Section 106	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.	Accepted as recommended	The new database is being reconciled however progress on this has been slowed by the priority response to the COVID19 pandemic**.** **Internal Audit opinion:** Partially implemented	**Director:** Eddie Smith **Executive Member:** Councillor Stogia **Status:** Seven months overdue **Action:** Review proposals for complete of the reconciliation and agree a new implementation date**.**

Appendix 4 – Recommendations 1-6 Months Overdue

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
Decommissioning Contracts: Leaving Care 23 March 20	30 Sept 20	A guidance framework to assist future decommissioning activity should be created which should include information on the following areas: - Decision options - Who to include in the project - Key project Staff (e.g. permanent v consultant, Interim v permanent) - Timelines that need to be considered (e.g. TUPE consultation, pension set up) - How to document the process - Approval process - The importance of impartial review and challenge - Lessons learnt review - Achievement of aims review A guidance framework should be created which should include information on the following areas:	As recommendation.	An update provided by management confirmed a draft guidance framework has been developed which once finalised will be displayed on the intranet. **Internal Audit Opinion:** Partially Implemented	**Director: Carol Culley** Deputy Chief Executive and City Treasurer **Executive Member:** Sir Richard Leese **Status: Three** months overdue **Action:** Monitor and confirm timeline.