Manchester City Council
Report for Information

Report to: Audit Committee - 27 July 2021

Subject: Outstanding Audit Recommendations

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

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Summary

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

Recommendations

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

Wards Affected: All

Contact Officers:

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

Tom Powell - Head of Internal Audit and Risk Management
Tel 0161 234 5273
E-mail tom.powell@manchester.gov.uk

Richard Thomas - Deputy Head of Internal Audit and Risk Management
Tel: 0161 455 1019
E-mail richard.thomas@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 - January 2021
- Head of Audit and Risk Management Annual Opinion – June 2021

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 have now re-established contact with senior managers and this report outlines the current status on overdue recommendations.

1.2 There had 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 and what the realistic, achievable revised dates for completion of actions is likely to be.

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 show that agreed actions have been implemented. 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 Where a limited or no assurance opinion is issued, a full follow up audit is undertaken after 6-12 months to test whether agreed areas for improvement have been addressed.

2.3 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.

2.4 In accordance with Audit Committee expectations, the risk relating to recommendations will not be written back to Strategic Directors when agreed actions are over 12 months past the agreed implementation date. This period has been extended to 18 months and Directors will continue to attend Committee to outline the reasons for delay and mitigating actions that they consider have reduced risk exposure to a tolerable level.

3 Current Implementation Position

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

3.2 Of 26 outstanding recommendations reported to Audit Committee in the last full, formal update in January 2021 the current position is:

- Implemented: 17
- Superseded: 3
- Outstanding: 6

3.3 Internal Audit has confirmed significant progress in that services have been able to complete actions to address 17 high priority recommendations in 10 audits, as follows:

- Adults: Mental Health Casework Compliance (5)
- Adults: Transitions (2)
- Adults: Management Oversight and Supervision (2)
- Growth and Development: Section 106 Agreements (1)
- Homelessness: Floating Support to dispersed homeless citizens (1)
- Core: Decommissioning Contracts: Leaving Care (1)
- Core / Children's: Procurement in Schools (1)
- Core: Contract Spend Review (1)
- Core: General Data Protection Regulation: Data Protection Impact Assessments (2)
- Core: Purchase Cards (1)

3.4 In addition to the above, three recommendations from an audit of the Adults Improvement Plan have been superseded. These recommendations related to the governance management and monitoring of improvement activities across the Directorate. During 2020/21 the Adults Improvement Plan has been superseded by the workstream on Health and Care Integration and development of the Manchester Local Care Organisation (established as part of the Council-wide Future Shape Programme) and the Better Outcomes Better Lives Programme (BOBL) which is designed to further develop the strengths based approach to service improvement, quality and engagement across adult social care. Internal Audit have been engaged in the development of governance for Future Shape and BOBL and whilst the original audit recommendations are no longer applicable, we consider that relevant learning and improvement points from the audit have been applied in these successor programmes and the exposure to risk has been addressed.

3.5 Positive progress has been made by the Directorate of Adults in three audits where recommendations have been outstanding or partially implemented for over 18 months.

3.6 The **Transitions** audit report from 2017 included three principal recommendations to develop a transitions vision and strategy; operational plan; and associated key performance indicators. These were due for implementation

by October 2018 with actions agreed by senior officers who have all since left the Council. The current Strategic Director and Assistant Director (Complex Needs) have led on a series of improvement actions having established a new Transitions Board in 2019; produced a transitions strategy and delivery plan; and appointed a Service Lead who started in December 2020.

3.7 The risks identified in the original audit were centred around the need to develop a clear approach to transitions and to ensure that this approach and associated plans for delivery were in place. The actual activity undertaken by management has gone beyond these recommendations with comprehensive, system wide engagement both with Childrens' Services but wider partnerships and stakeholders across the City.

3.8 Key priorities were established and agreed across children and education services and adult social care in February 2021 focused on (i) protocols and processes, (ii) integrated commissioning; and (iii) mapping of future demand. The Service Lead has also taken forward practice-based development to reflect key risk areas (Mental Capacity Act, Liberty Protection Safeguards, Transitional Safeguarding) as well as having developed information, advice and guidance and a transitions team development plan.

3.9 These actions largely address the risks on which the original audit recommendations were based, but the service is also incorporating transitions in the BOBL programme and a key outcome of this planned work is to focus on key success criteria, rather than the original proposal from Internal Audit which was to develop key performance indicators. We support this approach and as a result Internal Audit consider that the recommendations in respect of strategy and operational plan are now implemented but will follow up on the outcome of the BOBL work on success criteria before confirming that aspect of the original agreed actions as being complete.

3.10 A follow up audit of **Mental Health Casework Compliance** has been completed and report drafted. This audit focused on all the recommendations from the original report and from these we confirmed that agreed actions to improve the transparency of the system audit trail, assurance over recording in Paris (the Mental Health Trust system), the timeliness of annual reviews of care packages, controls over protection plan review dates and the reporting of Section 75 KPI's had been fully implemented.

3.11 Controls over data quality have been implemented to enable reporting against expected standards including the requirements for management approvals; sign-off of safeguarding referrals; and completion of investigations. A daily data quality report has now been introduced alongside training and the establishment of new roles to oversee and drive improvements in standards and levels of compliance. The audit confirmed that the agreed recommendations to improve oversight and reporting had been addressed but noted that further work is still needed, utilising this management information, to further develop the behaviours and practice necessary to ensure consistent levels of compliance with agreed standards. Until this is achieved there remains a level of risk. As a consequence, actions to continue improving levels of compliance must remain an area of focus for senior management within the Council and the Trust but from an Internal Audit perspective the agreed actions have been taken and the recommendations have been classified as implemented.

3.12 One recommendation remains outstanding. A proposed process for reconciling safeguarding referrals and the outcomes of these between the Council and the Trust was not in place. Issues arising from the Council's move to Liquid Logic and the Trust's move to Paris, along with a change in priorities and working arrangements because of Covid19 have impacted on both organisations' abilities to prioritise this work. We were told work was being planned to develop the required reconciliation processes between Liquid Logic and Paris. The timing for this is to be confirmed but we understand this is unlikely to be in place until late 2021.

3.13 Whilst undertaking this follow up audit we were also made aware that the Trust had worked with the Council to undertake further work to improve safeguarding practice. Whilst not contributing directly to the management of risks identified during the original audit this activity provides confidence that the Trust is committed to taking the necessary steps to improve performance. Specifically the Trust had undertaken an internal qualitative audit of safeguarding practice which identified areas of good practice as well as areas in need of improvement, the outcome of which (as shared with the Council) was an action plan to address generic issues with individual practice issues addressed on a case by case basis. A second qualitative audit is planned for completion by the end of 2021. Internal Audit fully support this approach of ongoing periodic review. The Trust has also introduced new roles (Professional Lead for Social Care and Divisional Lead for Social Care) to develop all aspects of social care. This includes specific responsibilities to support and improve safeguarding practice.

3.14 Follow up on the audit of **management oversight and supervision** confirmed that the two recommendations previously reported as partially implemented had been addressed. A comprehensive policy and approach for supervisions had been established and this provided detailed guidance and templates for use. Training for staff had been rolled out pre-Covid19 and we were provided with evidence that this had been supplemented by further on-line and face to face training in 2021. Systems were also in place using the new tools in Microsoft 365 to track and report the completion of supervisions in line with the agreed supervisions policy. Whilst this process did identify some areas where the timeliness of supervisions needed further focus and attention, it did address the original recommendation which was to have a system of management and oversight in place and as a result these recommendations are now classified as implemented.

Outstanding Recommendations

3.15 There are six recommendations from audit reports that are overdue past the agreed implementation dates. All of these are now overdue by more than 9 months and are shown in Appendix 2.

- Adults: Mental Health Casework Compliance (1)
- Adults: Transitions (1)
- Growth and Development: Section 106 Agreements (1)
- Children's: Planning for Permanence (3)

3.16 Management have confirmed that actions in response to the Planning for Permanence recommendations have been completed and have provided a description of progress made. Work is being scoped for a follow up audit to be completed by the end of August 2021 and the outcome of this will be reported to Audit Committee in the next assurance update.

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
Mental Health Casework Compliance 5 April 2019	30 June 2019	The Director of Adult Services should seek assurance from the Trust over consistency in recording safeguarding investigation activities, including whether the new case management system, Paris, can enforce correct procedures via system workflows. This may involve strengthening timely management oversight on case work and enhanced training for all case workers to ensure that procedures are understood.	Greater Manchester Mental Health Trust and Council to jointly establish a 'Task & Finish' group to investigate, work to resolve, and report progress back to the Director of Adult Services.	Management have undertaken qualitative assurance work over safeguarding practice in January 2021 and they have informed us of their intent to do so again before the end of the year. Our view is that this work is sufficiently beneficial to suggest that these reviews should be done periodically on an ongoing basis. Whilst there were still some performance issues, the Trust has undertaken every reasonable effort to address the systemic issues previously identified. **Internal Audit opinion**: Implemented	**No further action required**
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.	The current Section 75 agreement with the Trust is to be replaced as these contractual arrangements will end on 31 March 2022. Although not all of the KPI's are currently being reported by the trust because of system limitations, the majority are. Given the future changes to the contract and the Section 75 agreement it was considered that further work at this time to address the shortfall would not be beneficial and instead a review of the KPIs was taking place to ensure that the new S75 will agreement would contain reportable KPIs. Given that the existing Section 75 agreement is due to be superseded, and	**No further action required**

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
				that most of the agreed performance indicators are being reported we have considered this recommendation as Implemented. **Internal Audit Opinion:** Implemented	
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.	The Trust have developed a new training plan, the electronic elements of which have been undertaken and have issued guidance to staff regards their responsibilities. This has also been supported by the introduction of Professional Leads for Social Care to provide advice and support including for safeguarding. A daily data quality (DQ) report has been introduced which highlights where decisions have not been recorded, referral forms are not yet authorised, and provides dates where they have. Based on the DQ reports provided it is clear there have been improvements in the design of controls for recording and reporting of management approvals, sign off and investigations as recommended in the audit report. However, performance was still inconsistent and there were still performance issues with evidence of decisions not recorded, referrals not approved, and referrals not approved in a timely manner. This remains a risk for management to focus on but the system	**No further action required**

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
				controls now in place provide a basis for management and improvement of performance which was the focus of original audit recommendation. Therefore whilst management in the Trust and Council must continue to use these reports to monitor and manager performance and drive actions for improvement, the original recommendation has been addressed. These points are emphasised in a formal Internal Audit follow up report to be issued to senior management in July 2021. **Internal Audit opinion:** Implemented	
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:** 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 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.	As above. **Internal Audit opinion:** Implemented	**No further action required**

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
Transition to Adult Services 15 Feb 2018	30 April 2018	The Deputy Director of Adults Social Services should develop a clear transitions strategy and vision in conjunction with Children's Services and other key partners, in line with Care Act requirements. Once developed the strategy and vision should be used to inform the development of a clear service offer for transitions. This offer should be clearly communicated to confirmed key stakeholders including service users. Advice could be sought from other Local Authorities including the Council's Adults Services improvement partner, and differing approaches considered.	Transitions Strategy and Vision to be developed	Vision and strategy was developed as part of refreshed governance and a new Transitions Board from 2019. This has been the baseline for ongoing development of the transitions offer and whilst senior management want to further develop this and further embed engagement across all stakeholders. Strategic Plan signed off by Board in March 2020 and the new service manager appointed from December 2020 to drive this forward. The Service Manager is revising the approach and this includes ongoing engagement throughout 2021. The service offer has been developed and shared via consultation and stakeholder engagement - whilst this is ongoing work there is a strategy and vision and plans in place for the delivery of transitions activity and in the assessment of Internal Audit the key recommendations from the original report have been addressed. **Internal Audit Opinion**: Implemented	**No further action required**
Transition to Adult Services 15 Feb 2018	31 Oct 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	Operational Plan in place for delivering the revised transitions offer in line with the agreed strategy and vision	As above a plan is in place for delivery and the further development of transitions activity. This is based on system wider engagement and underpinned by three key priorities and workplan within these around: • Protocols and processes • Integrated commissioning	**No further action required**

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		responsibilities and the use of transition specific documentation referred to in National Institute for Clinical Excellence (NICE) guidance.		• Mapping of future demand Whilst plans will continue to adapt based on the ongoing development of the approach to transitions and engagement of partners and stakeholders it is the assessment of Internal Audit that the key recommendations from the original report have been addressed. **Internal Audit Opinion:** Implemented	
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.	Comprehensive supervision policy in place to sustain quality standards supported by training programme for team and service managers during 2020 and 2021. System in Microsoft 365 (using forms and excel) developed for tracking of supervision completeness with reporting to Adults DLT via the Principal Social Worker (Adults). This is used to track completeness against targets for all service areas. **Internal Audit Opinion**: Implemented	**No further action required**
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.	Training for team and service managers based on revised policy which includes standard forms and guidance. Training included face to face (pre covid) and then a mix of virtual and face to face refresher training during late 2020 and 2021.	**No further action required**

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
				Updates and refresher plans overseen by Adults DLT via the Principal Social Worker (Adults).	
Section 106	31 May 2020	Formalise and update the resources and team structure, finalise policies and procedures and formalise governance proposals.	Accepted	Governance processes have been improved with the establishment of the S106 Operational Group. The terms of reference for this group detail its role and the officers from across various Council services that make up the group. Revised procedures have been developed and are recorded on a central database. The structure review is approaching completion which involves a major revision to the team, and it is expected to commence the recruitment process for a dedicated S106 officer. Until then the current officer will continue to take the lead on S106 activities. **Internal Audit opinion:** Implemented	**No further action required**
Floating Support - Support to Homeless Citizens in Temporary (Dispersed) Accommodation 29 May 2019	30 Oct 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	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 utilized from the system as it stands to better support the floating support case management and supervision.	Delays in implementation were based on the need to develop and implement core documentation requirements within Liquid Logic (LL) phase two. Work is estimated to take 12-18 months with delays exacerbated by Covid 19. Internal Audit have seen compensating controls in operation through the use of spreadsheets and Microsoft Teams that are being used to effectively monitor service performance and quality. These are used in six weekly supervisor meetings with teams to analyse reports, caseloads and cross reference with	**No further action required**

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		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.		records in LL. The assessment of management and of Internal Audit is that these additional compensating controls provide effective assurance over floating support case management. **Internal Audit Opinion:** Implemented	
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.	A guidance framework in respect of decommissioning has been added to the How to Buy Something section of the intranet. This includes: • what you need to know/do • who to notify • options if goods/service are still needed • new provision and what to consider • procurement requirements • estimated timescales • who you may need to involve. **Internal Audit Opinion:** Implemented	**No further action required**
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	Joint workshops for stakeholders to be facilitated by representatives from Procurement, Schools Finance and Audit. The focus will	Discussions have taken place between finance, procurement and internal audit. It was agreed that the principal approach to procurement advice would	**No further action required**

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		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.	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.	be signposting in the DFE Procurement Hub which offers guidance, tools and support to schools. Internal Audit have observed this approach being applied as part of the process of school meals contracts support in 2021. Procurement, audit and schools finance will continue to offer ad hoc advice to schools where possible. The wider offer to schools may be reconsidered as part of assessing the role of the Core in the Future Shape work but at this stage no commitment to further support can be made. **Internal Audit Opinion:** Implemented	
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	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 work between DMTs and key partners, particularly in health.	As part of our recent supplier due diligence audit we concluded that work has been undertaken to identify the Council's strategic suppliers. This was through discussions with commissioning leads and Project Management Office staff and through use of the criticality tool and the resultant rating then added to the relevant contract registers that are in place across Directorates and	**No further action required**

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		oversight to be put in place should then be developed to ensure that the Council can take suitable action if becoming aware of any warnings indicating supplier failure.		overseen by the Procurement and Integrated Commissioning Service. A plan for how they should be monitored has been developed in the 'Guide for extent and frequency of contract management activities'. Subsequent dissemination and oversight of this is covered in the recommendations made in the Supplier Due Diligence audit. **Internal Audit Opinion:** Implemented	
GDPR Data Protection Impact Assessments (DPIA) 1 November 2019	30 April 2020	The Data Protection Officer (DPO), 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	Communication regarding the requirements for DPIAs has been addressed in two ways: 1. A general GDPR awareness message was included in The Forum on 25 May, the third anniversary of GDPR. This was followed up by inclusion of the DPO in Staff Spotlight on 4 June. The DPO's story included a substantial section covering DPIA. 2. On 23 March, SMT considered the six-monthly joint report of the City Solicitor (as Senior Information Risk Officer) and DPO. The report addressed DPIA requirements and made a specific recommendation that Strategic Directors cascade the message through their management teams. The recommendation was accepted. Whilst the above actions address the specific audit recommendation, future communications about information	**No further action required**

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				governance will reiterate DPIA awareness where appropriate. **Internal Audit Opinion:** Implemented	
GDPR DPIA 1 November 2019	30 April 2020	The Data Protection Officer (DPO), with support from the Directorate Senior Information Risk Owners (DSIROs), should establish arrangements for the periodic monitoring of compliance with DPIA requirements.	Accepted	The DPO is monitoring compliance through two key routes: 1. Reviewing the Register of Key Decisions each time it is published and following up with DSIROs and lead officers where a DPIA is likely to be required. This measure has been in place since January 2020 and has identified cases of both compliance and non-compliance. Where non-compliance has been identified DPIAs have been progressed. 2. The DPO is now a member of the ICT Change Board and reviews all proposed changes and follows up where the change request indicates the need for a DPIA. This measure has only been in place since mid-May 2021 but has already identified one change project where a DPIA had been completed and two others where a DPIA might have been required but turned out not to be on further examination. **Internal Audit Opinion:** Implemented	**No further action required**
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	The City Solicitor, supported by the DCE and City Treasurer, will develop guidance on the provision of hospitality. They will also identify	The Code of Conduct was agreed by Personnel Committee in January 2021 and has been made available to all Officers and Members via the Intranet.	**No further action required**

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		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.	a suitable place within the existing guidance framework for this to be published.	The revised Code specifically addresses the provision of Gifts and Hospitality by Council officers. **Internal Audit Opinion**: Implemented	
Adults Improvement Plan Governance 9 January 2020	31 March 2020	The Strategic Lead Business Change should re-evaluate the 'action type' categories and how these can be clarified and simplified. For example, each action could be assigned a priority level (1/2/3) to indicate whether it is currently an area of active focus. We recommend that the workstream leads include an update on each action of the highest priority level in the highlight reports	As part of a 12 month stock-take of the Improvement Programme the action plans are being refreshed, which will include clearer indication of priority level and milestones/sequencing which will flow through into highlight reporting.	Adults Improvement Plan has been replaced by Future Shape (Health and Social Care Integration) and Better Outcomes Better Lives Programme. Internal Audit assured that lessons learned from the Improvement Plan audit have been reflected in governance, project management and reporting arrangements in these successor programmes. **Internal Audit opinion:** Superseded	**No further action required**
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	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).	As above **Internal Audit opinion:** Superseded	**No further action required**

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		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.			
Adults Improvement Plan Governance 9 January 2020	30 April 2020	The Technology Enabled Care (TEC) and Workforce workstream plans should be refreshed using the standard template, which allows for increased clarity over action owners, target timescales, and updates on current status. The workstream leads should ensure these are regularly reviewed and kept up to date and use these to inform the highlight reports.	As part of a 12 month stock-take of the Improvement Programme the action plans are being refreshed. This has already taken place for the Workforce workstream. The TEC workstream is being considered as part of the wider MLCO portfolio with a clear action plan to be finalised by April 2020.	As above **Internal Audit opinion:** Superseded	**No further action required**

Appendix 2 – Recommendations Over 9 Months Overdue

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
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.	A system for reconciling safeguarding referrals and outcomes between the Council and the Trust is the final recommendation from this report to be addressed. Whilst overall the risks in this area have reduced as a result of the evident improvement in governance and controls in all other areas from the audit, this one recommendation remains outstanding. This specific recommendation has been impacted by the Council's move to Liquid Logic and the Trust's move to Paris, along with a change in priorities and working arrangements because of Covid. This has impacted on both organisations' abilities to prioritise this work. Internal Audit advised that work being planned to develop processes between Liquid Logic and Paris, however this is still likely to take time. **Internal Audit Opinion:** Not Implemented	**Director:** Bernadette Enright, Executive Director of Adult Social Services **Executive Member:** Councillor Midgley **Status:** 22 months overdue **Action:** To follow up by December 2021
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	Key performance Indicators (KPIs) to be introduced.	Qualitative measures of success have been developed based on the transitions strategy and cross system engagement and as a result the risks in this area have	**Director:** Bernadette Enright, Executive Director of Adult Social Services **Executive Member:** Councillor Midgley

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		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.		been reduced but not yet addressed in full. These are to be assessed as part of a three month review within the BOBL programme following which measures of success rather than specific KPIs will be determined and agreed. **Internal Audit Opinion**: Partial Implemented	**Status:** 36 months overdue **Action**: To review and confirm measures following completion of BOBL work by end November 2021
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	This activity has started by was impacted by Covid19 lockdown given both the need to work from home and on the allocation of resources to urgent areas of focus. Completion is partially dependent upon the appointment of a dedicated officer in the new structure and the planned return to the office from July 2021. The timescale for completion is to acknowledge the current lack of certainty over the volume of work required to ensure all S106 agreements across the Council are recorded in one place to fully address the recommendation. This will not be known with certainty until the reconciliation has commenced (from end of July 2021). **Internal Audit opinion:** Partially implemented	**Director:** Julie Roscoe until Becca Heron starts as new Strategic Director in October 2021. **Executive Member:** Councillor Rawlins **Status:** 14 months overdue **Action:** Remains partially implemented – to check progress again in October 2021 and liaise with newly appointed Director, with view to new Section 106 post being fully operational by March 2022.

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
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 recommendation fell due for implementation during the COVID19 lockdown. Management have confirmed that actions are now complete. We will be undertaking a follow up audit for completion by the end of August 2021 which will include confirming the evidence to show the progress against this recommendation. **Internal Audit opinion:** Not implemented – management state this is complete but to be tested and confirmed by end August 2021	**Director:** Paul Marshall, Strategic Director of Children's Services **Executive Member:** Councillor Bridges **Status:** 16 months overdue **Action:** Follow Up audit planned for completion by end August 2021
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 framework to ensure a level of consistency across each locality.	Senior Management will continue to raise awareness of the importance of the PPM process and engagement of social workers in this process.	The recommendation fell due for implementation during the COVID19 lockdown. Management have confirmed that actions are now complete. We will be undertaking a follow up audit for completion by the end of August 2021 which will include confirming the evidence to show the progress against this recommendation. **Internal Audit opinion:** Not implemented – management state this is complete but to be tested and confirmed by end August 2021	**Director:** Paul Marshall, Strategic Director of Children's Services **Executive Member:** Councillor Bridges **Status:** 16 months overdue **Action:** Follow Up audit planned for completion by end August 2021
Children's: Planning for Permanence	1 April 2020	Further performance measures should be developed to assess the effectiveness of permanence	Performance Improvement Board will continue to review performance monitoring to ensure continuous	The recommendation fell due for implementation during the COVID19 lockdown. Management have confirmed that actions are now complete. We will be	**Director:** Paul Marshall, Strategic Director of Children's Services **Executive Member:** Councillor Bridges

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		planning and then incorporate these in the Permanence score card.	improvement and in considering the effectiveness of the permanence scorecard.	undertaking a follow up audit for completion by the end of August 2021 which will include confirming the evidence to show the progress against this recommendation. **Internal Audit opinion:** Not implemented – management state this is complete but to be tested and confirmed by end August 2021	**Status:** 16 months overdue **Action:** Follow Up audit planned for completion by end August 2021