Manchester City Council
Report for Information

Report to: Audit Committee - 15 February 2022

Subject: Outstanding Audit Recommendations

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

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Summary

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

Recommendations

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

Wards Affected: All

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Background documents (available for public inspection):

The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of the background documents

are available up to four years after the date of the meeting. If you would like a copy, please contact one of the contact officers above

- Outstanding Audit Recommendations Report to Audit Committee – November 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.

1.2 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 is 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 that are not fully implemented will <u>not</u> be written back to Strategic Directors when they 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. Overdue recommendations are detailed in Appendices 2 and 3.

3.2 We also attach Appendix 4 which details the Planning for Permanence recommendations previously reported as implemented to Committee in November 2021. The Committee questioned the rationale for closing elements of these recommendations and the decision to remove formal prescribed targets for the frequency of planning for permanence meetings. At the request of Committee the Deputy Director of Children's Services will attend the meeting to provide further information on the approach being taken.

Outstanding Recommendations – over 12 months

3.3 The three outstanding recommendations reported to Audit Committee in Nov 2021 remain partially implemented, as summarised in the table below:

Directorate	Audit Title	Due Date	Months	Status
Adults	Mental Health Casework	30/9/19	29	Not implemented
Adults	Transitions	30/6/18	44	Partially implemented
Growth and Development	Section 106 Agreements	31/5/20	21	Partially implemented

3.4 Mental Health Casework – seven recommendations have been completed but one remains outstanding. This relates to the development of processes for reconciling safeguarding referrals and the outcomes of these between the Council and the Trust. This is currently a manual process that involves re-keying of information between systems and as such is time intensive and presents risk of error. 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. Work has progressed in addressing these issues and Trust staff now have access to Council systems to enable reconciliations to be assured and Liquid Logic training is in the process of being arranged for them. Once training is completed Trust staff will be able to update Liquid Logic with real time updates on progress with safeguarding referrals and this should address the original risk of systems holding unreconciled data. We will update the position as part of the annual audit opinion and report progress to Audit Committee.

3.5 Transitions – As previously reported to Audit Committee this audit resulted in three recommendations of which two have been completed. The final one to be implemented relates to the agreement of Success Criteria for transitions from Children's to Adults social care. These are being developed as part of the Better Outcomes Better Lives Programme, including a review of these criteria.

3.6 We planned to review these arrangements in our audit of the BOBL programme in December 2021. However, our most recent update from the business has confirmed that there have been delays in bringing transitions into the BOBL programme due to COVID. Work will start to bring it into the programme this month (January 2022). The Assistant Director Adults Social confirmed that the main performance measure is completing the first assessment in the transitions process in a timely fashion and passing over cases at the right time which they are now able to report on, however this has yet to be completed in practice. Management have agreed to start reporting on these key performance measures from March 2022. Once completed and reviewed by Internal Audit as operating in practice we can agree the implementation of this recommendation.

3.7 Section 106 Agreements - Significant work has been completed to create a new database; providing clear and comprehensive information required to monitor and report the status of S106 across the Council. The database continues to be updated, refined and improved, on an incremental basis. To assure that this positive progress continues and that changes are sustained, we classed the recommendation as being 'partially implemented'. Changes in operational governance and a revision of the staffing structure are planned to facilitate and enable this. Recruitment is expected by the end of February 2022 and we will close the recommendation as complete once this final element of the process is complete.

Significant / Critical Overdue Recommendations – less than 6 months

3.8 There are five recommendations that have been overdue for between one and six months. Five are partially implemented and one is outstanding. These relate to three audits - Our Town Hall (Management of Work Packages), Children's Services Placement Finding, and Supplier Due Diligence. More detail is given in Appendix 3 below.

Not Yet Due

3.9 A total of 9 recommendations are not yet overdue (2 critical / 7 significant) that will be tracked through to implementation. These have been agreed as part of audit work and reports finalised in the period October 2021 to February 2022.

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
Placement Finding - Review of Core Processes	24 May 2021	The Service Lead should work with the various Team Managers on how the current development work being undertaken can seek to include and address the compliance issues identified in audit testing. The C&C Service Plan could be used to identify actions and track progress. Additional actions could include: • A review of templates to remove any fields which are not required and provide prompts of instances when certain sections (e.g. approvals) are required. • Improvements around the evidence trail of approvals particularly in relation to high cost placements and uplifts which take the cost per week over original approval requirements. • The inclusion and communication of any expectations over timescales for the completion of certain tasks for instance the updating of Liquid Logic and setting up of CLA payments. • Revisions to the set-up of the CPT Tracker to make use of auto populated fields to minimise the manual input required from officers. • Consideration to the introduction of a matching form for external placements. • Systems for identifying and chasing IPAs which have yet to be returned by the provider.	Draft paperwork/process 31 May 2021 Service wide implementation 31 August 2021 Embedded across service and practice 30 November 2021 Agree that the tracker requires a review and agree that process for IPA's require a tighter grip to ensure timely completion and agreements. The forms will be reviewed as part of the service plan and the priorities across CSC in relation to small change requests for LL.	Audit confirmed this action has been completed through its follow up review currently being finalised, awaiting publication. Other recommendations regarding this follow up remain partially implemented.	**No further action required**

Technology Enabled Care	1 April 2022	The Service should confirm with City Solicitors if signed contracts are required and if retrospective action is necessary to agree them for services supplied during the Covid pandemic.	The action is accepted. Legal advice has been sought from the City Solicitor, received, and retained which confirms that a signed contract is not required. The service will continue to monitor its options in this regard while considering ongoing COVID regulations.	Action completed – legal advice received.	**No further action required**
Client Financial Services - Appointeeships	1 Jan 2022	The Business Support Locality Manager should reiterate to the ASOs the importance of altering their routes for cash withdrawals.	The ASOs tend to use the ATM machines where they feel safer, i.e. within a bank or shop. Bad weather and/or machines not always working sometimes determine which ATM machines are used. Manager has reiterated the need for the ASOs to vary their route for their own safety.	Action completed - confirmed that ASO officers have been instructed to vary their routes when withdrawing money from ATM's.	**No further action required**
Client Financial Services (Appointeeships)	31 Jan 2022	The Business Support Locality Manager should ensure that for cash payments made to clients via the ASO officers the pre COVID receipting arrangements are reinstated. Periodic checks of records held at local offices should be completed to ensure that appropriate receipts are being retained and signed as evidence of receipt.	Prior to covid, the ASOs would get receipts from the ATM machines when they withdrew cash and they would also ask the citizens to sign a receipt when they gave them their cash. These receipts would be scanned and uploaded into the citizen's record on Liquid Logic. Post Covid, in an attempt to reduce the handling of paper and, because the ASOs were not going into citizens' houses, the ASOs stopped getting receipts from ATMs and	The Business Support Locality Manager confirmed that the arrangements have reverted to pre COVID arrangements with receipts being uploaded. Spot checks have already been undertaken and the Business Support Locality Manager is in the process of gathering the evidence of these spot checks across the three localities to show us to enable this recommendation to be signed off as implemented. Evidence to validate this has been received.	**No further action required**

			stopped asking citizens to sign for the payments; instead, they would take a photograph when they handed over the cash. This method of handing over the cash had been approved by Internal Audit at the time. The ASOs have now been told they can now go into citizens houses and have been instructed that they must resume getting receipts from ATMs and from citizens Business Support staff in the locality offices will scan and upload these receipts into the relevant citizen's account. Linda will carry out random checks each week to check that these receipts have been uploaded.		

Appendix 2 – Recommendations Over 12 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. Our latest update on progress confirmed that the trust sends data every month to the council and this includes data on all safeguarding activity, so this includes safeguarding generated externally and thereby logged on Liquid Logic, and safeguarding alerts generated within the trust which does not get logged on Liquid Logic. The Governance and Performance Manager (Mental Health) however confirmed that GMMH admin staff are	**Director:** Bernadette Enright, Executive Director of Adult Social Services **Executive Member:** Councillor Midgley **Status:** 25 months overdue **Action:** To follow up progress by next Audit Committee and ensure Liquid logic training has been provided and activity being routinely updated.

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
				still yet to have access to liquid logic to allow safeguarding outcomes to be concluded on Liquid logic and closed. He stated he has received confirmation that 6 GMMH admin staff are now able to log on to the council's network and is now in the process of arranging for them to have Liquid Logic training. Once this is completed Trust staff will be able to directly input updates to Liquid logic. **Internal Audit Opinion:** Partially Implemented	
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) 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 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. Our most recent update from the Business has confirmed that there have been delays in bringing transitions into the BOBL programme due to COVID, however work will start to bring it into the programme this month (January 2022). The Assistant Director Adults Social confirmed that the main performance measure is completing the first assessment in the transitions process in a timely fashion	**Director:** Bernadette Enright, Executive Director of Adult Social Services **Executive Member:** Councillor Midgley **Status:** 40 months overdue **Action:** To confirm with management by the end of February 2022 that reporting on the two key performance measures identified has commenced.

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
				and passing over cases at the right time which they are now able to report on, however this has yet to be completed in practice. **Internal Audit Opinion**: Partially Implemented	
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	The creation of the new database to bring together various records held across the Council has been completed. All the records have now been merged and the new database continues to be updated and improved on an ongoing basis. Older agreements requiring reference back to paper files for reconciliation is ongoing and is expected to be completed by the end of the financial year - 2021/2022. The appointment of a dedicated officer in the new structure will not be completed until the review of the structure has been implemented, at which point recruitment will be started and is expected to be in post by the end of the financial year - 2021/2022. **Internal Audit opinion:** Partially implemented	**Director:** Becca Heron, Strategic Director Growth and Development **Executive Member:** Councillor Rawlins **Status:** 17 months overdue **Action:** Remains partially implemented – to check progress again and liaise with newly appointed Director, with view to new Section 106 post being fully operational by March 2022.

Appendix 3 – Recommendations between 1 and 6 Months Overdue

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
Our Town Hall: Management of Work Package Delivery and Payments 21 July 2021	31 Aug 2021	Follow up action is undertaken by the Project Team to confirm the Construction Cost Report maintained by F&G is updated to reflect the discrepancies identified as part of the audit and ensure the figures reported is in alignment with those maintained by the management contractor. Further work may be needed to undertake similar reconciliations for the other work packages to ensure the issues identified here are not widespread amongst other work packages.	1. Conduct thorough review of each Works Package to ensure accurate allocation of budget transfers against all Instructions. 2. Transition the project from the current system of separate Lendlease and F&G cost reporting into a single project cost report based on the Kahua system. 3. Merge the two separate MEP packages contracted to NG Bailey into a single package to tidy up divergences.	A recent update from the OTH Finance Lead confirmed action to address the recommendation is taking longer than originally expected but more focus is now being undertaken on aligning all the budgets. Regular meetings are taking place to update on progress which are being managed by the project managers for the project. It is currently anticipated that it should all be aligned by the end of January/early February. We have requested a further update and the provision of evidence early February to confirm the action taken. **Internal Audit opinion:** Partially implemented	**Director:** Carol Culley, Deputy Chief Executive and City Treasurer **Executive Member:** Councillor Craig **Status:** Five months overdue **Action:** To review progress again in February and undertake a review of evidence where appropriate.
Placement Finding: Review of Core Processes 24 May 2021	30 Sept 2021	The Commissioning Service Manager with the support of officers from finance should determine how management information and reports can be used to more promptly to identify and act on: -outstanding unpaid invoices which require resolving; -unbilled care received;	This is a complex area and one that also requires the input from finance officers and practitioners linked to the practice of placing children with care givers. CPT and CC do not always know when such issues arise particularly if they are internal foster carers.	Established business as usual processes now include weekly touch points between Team Manager Commissioning and Team Manager Children's Finance. This identifies any duplicate Care Package Line Items (CPLIs), open CPLIs with no invoices and placement	**Director:** Paul Marshall, Strategic Director of Children's Services **Executive Member:** Councillor Bridges **Status:** Four months overdue

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		-instances where payments are being made to multiple carers for a single child. -Other overpayments to carers/providers. This should then be produced regularly and shared with relevant officers to allow for these cases to be addressed. Work should also be undertaken with providers to ensure they are billing correctly to facilitate payment i.e., one invoice per child and this should include all costs related to the placement (accommodation plus any support costs).	The Controcc system requires a high level of expertise which we do not have in the service, particularly to run reports which are accurate. This aspect is also a resource and capacity issue and discussions are on-going with senior leaders regarding this aspect.	endings. This information is reported on a weekly basis to the strategic lead of children's finance and into the Children's services budget report. To facilitate the additional work required, the service also introduced a dedicated post for tracking internal foster carer payments which continues to have a positive impact; there is now extra capacity to investigate payment anomalies and work with social workers to provide support to ensure placements are processed correctly and in a timely manner The service acknowledged that some incidents can slip through and currently, whilst management information is used to track placement ends for over 18s, checks to ensure payments are not being made to multiple carers for a single child have not yet been developed. Further work is therefore needed to determine how the use of system data can be used to identify such cases. We plan to use the findings of our upcoming audit of Foster Care Payments to provide additional assurance using data analytic techniques, to	**Action:** To reconsider the status of the recommendation following the results of the Internal Audit data analytics review.

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
				identify any cases where we suspect duplication may have occurred. **Internal Audit opinion:** Partially implemented	
Placement Finding: Review of Core Processes 24 May 2021	30 Nov 2021	The Commissioning Service Manager should enhance the current controls in place to make the process around IPAs more efficient. This should consider: • Expectations around issuing IPAs following a placement and ways of ensuring these timescales are met. • How is can be easily determined when an IPA has not been returned by the provider. • Expected timescales over chasing non returned IPAs along with any forms of escalation to be applied. • Varying signatory requirements on the IPAs in accordance with the cost of the placement.	We accept the findings and will review the agreements in the IPA.	We were satisfied that IPAs are now on Liquid Logic which has improved the overall controls and visibility of the IPA position. A new procedure manual for the completion of IPAs has also been produced. There however remain some issues in relation to the timeliness and return of IPAs. To help address this the service is looking to put a freeze on provider payments where a signed IPA has not been returned. There are also plans to trial the use of the provider portal function within ContOCC with a view to wider roll out if successful. As such we consider this recommendation to be partially implemented at this time. **Internal Audit opinion**: Partially implemented	**Director:** Paul Marshall, Strategic Director of Children's Services **Executive Member:** Councillor Bridges **Status:** Two months overdue **Action:** To continue to monitor progress.
Placement Finding: Review of Core Processes	30 Nov 2021	The Commissioning Service Manager in conjunction with Social Work Managers should consider current placement	As acknowledged this aspect is wider than CPT, the responsibility for entering the details of	Steps have been taken to improve the overall closedown processes. This has included sessions with	**Director:** Paul Marshall, Strategic Director of Children's Services

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
24 May 2021		closedown processes and how the risk of payments to more than one carer for the same child and period could be identified in advance to prevent significant repeated overpayments. This should include ceased arrangements and transfers in internal foster carers; Special Guardianship Orders, extra allowances, and other costs. Once the correct process is determined this should be reflected in the Fostering, Post 16 and Residential workflow diagrams which have been produced recently.	placements and closing placements are the tasks for social workers. CPT and CC do not routinely know when SGO's are granted or children move internally if this is agreed within the duty service for fostering. Meetings have taken place with HOS, LS, finance, and LL lead with regard to this matter and there is not a resolution in the system which would allow more control in the fostering service. The practice continues and the issues become compounded if children are in multiple short-term placements. We are implementing weekly check ins for all children moving in and out of the service to try to get ahead of the payment issues. However, further work is needed from across CSC localities to support this aspect.	key officers to reinforce the required process to reduce the risk of placements continuing to be paid following a placement end and the sharing of updated procedure notes. In addition, an approach to the dip sampling of cases has recently been agreed to provide ongoing assurance. We plan to use the findings of our upcoming audit of Foster Care Payments to provide additional assurance using data analytic techniques, to confirm whether issues remain regarding the closure of placements. **Internal Audit opinion**: Partially implemented	**Executive Member:** Councillor Bridges **Status:** Two months overdue **Action:** To reconsider the status of the recommendation following the results of the Internal Audit data analytics review.
Supplier Due Diligence 12 August 2021	30 November 2021	The ICP team should work with the Due Diligence Working Group, Internal Communications and directorate leads to develop the current contract management guides to include sections on ongoing financial due diligence and disseminate guidance to all relevant	We have a workshop with Commissioning and Contracting Leads, and Finance, on 12 August to help develop a more consistent approach to identifying, monitoring, and responding to risks. We will	We have requested an update from the service and are awaiting their response. **Internal Audit opinion**: Not implemented	**Director:** Carol Culley, Deputy Chief Executive and City Treasurer **Executive Member:** Councillor Craig **Status:** Two months overdue

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		contract management and commissioning staff. Guidance should include the following: • Consideration and reflection of relative risks in their contracts based on criticality, materiality, nature of market etc, • Clarification of roles and responsibilities, • Market Intelligence: (Given the diversity of Council contracts and commissions this will need to be flexible to reflect sectoral intelligence but could include for example GM or Core Cities Networks / Professional Networks (ADASS etc.) / Central Government Bulletins / Trade and Financial Press), sign ups to strategic supplier updates, • Local Intelligence: Guidance to emphasise the need for regular, ongoing contract management to consider potential red flags or lead indicators that could suggest potential financial failure or non-delivery of contracts. Indicators could include Non / reduced attendance on site or within services, Slowing of work or unexplained delays in deliverables, Sub-contractor complaints over timeliness of payments,	update guidance on the intranet accordingly and circulate to staff.		**Action:** Await response from service and then make an assessment regarding progress made.

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		• Use and frequency of Company Watch reports and alerts, with a simple guide for staff on its use and interpretation. • Formal escalation process, including referral to finance where concerns are flagged, • The potential use of management information to facilitate oversight of contracts including those suppliers considered to be strategic suppliers to facilitate prompt action if becoming aware of any warnings indicating supplier failure.			

Appendix 4 – Planning for Permanence Recommendations (to be discussed)

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
Planning for Permanence	20 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.	We can confirm that training is included in the staff induction and in the ASYE (newly qualified social worker) training plan. We have also seen evidence of more catch-up training courses being arranged for any social workers who have not completed the necessary training including one to be run in November. We are therefore now more assured that there are sufficient arrangements in place to ensure all staff are appropriately trained. We therefore consider this recommendation to be fully implemented.	**No further action required**
Planning for Permanence	20 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.	We can see a number of performance measures have been introduced and are reported on a monthly basis, the benchmarks used are part of the strategic PMF (Performance Management Framework) with targets including Placement Stability, long term stability and Permanence Plan at 2nd LAC review. All of these have clear targets to aim for. We therefore consider this recommendation to be fully implemented.	**No further action required**

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
Planning for Permanence	20 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. 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.	Management confirmed they have reviewed and revised the permanence strategy to be clear that 'permanence' is everything done to secure loving homes for children at the earliest opportunity. They confirmed that the QA framework scrutinises every aspect of the child's journey whilst working with social work is firmly captured in the QA framework. Management confirmed that the requirements around permanence planning meetings have changed. Rather than there being set timescales for these meetings, as was the case at the time of our audit, they should happen as and when required; to secure a loving home for children within a *'team around the child*' framework. There are therefore no targets for completing planning for permanence meetings within specific timescales and so they are now more achievable as a result. We therefore consider this recommendation to be fully implemented.	**No further action required**
Placement Finding: Review of Core Processes 24 May 2021	30 November 2021	The Service Lead should work with the various Team Managers on how the current development work being undertaken can seek to include and address the compliance issues identified in audit testing. The C&C Service Plan could be used to identify actions and track progress.	Agree that the tracker requires a review and agree that process for IPA's require a tighter grip to ensure timely completion and agreements. The forms will be reviewed as part of the service plan and the	Discussions with key officers and a review of documents confirmed that improvements have been made to manage the previous risks identified. These include: -the update of policies and pathways. -amendments to the duty officer system which has increased capacity	**No further action required**

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		Additional actions could include: • A review of templates to remove any fields which are not required and provide prompts of instances when certain sections (e.g. approvals) are required. • Improvements around the evidence trail of approvals particularly in relation to high cost placements and uplifts which take the cost per week over original approval requirements. • The inclusion and communication of any expectations over timescales for the completion of certain tasks for instance the updating of Liquid Logic and setting up of CLA payments. • Revisions to the setup of the CPT Tracker to make use of auto populated fields to minimise the manual input required from officers. • Consideration to the introduction of a matching form for external placements. • Systems for identifying and chasing IPAs which have yet to be returned by the provider.	priorities across CSC in relation to small change requests for LL.	within the team to focus on important tasks. - streamlining the CPT tracker to improve the functionality of this tool. -Delegated approval given to service leads and Heads of Service up to a specific value. -A more consistent approach to quality assurance and improved communication between the multiple teams involved. We therefore consider this recommendation to be fully implemented.	