Manchester City Council
Report for Information

Report to: Audit Committee – 18 October 2022

Subject: Outstanding Audit Recommendations

Report of: 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

The Committee is recommended to note the service review update and receive further progress reports.

Wards Affected: ALL

Environmental Impact Assessment - the impact of the issues addressed in this report on achieving the zero-carbon target for the city
None

Equality, Diversity, and Inclusion - the impact of the issues addressed in this report in meeting our Public Sector Equality Duty and broader equality commitments
None

Manchester Strategy outcomes	Summary of how this report aligns to the OMS/Contribution to the Strategy
A thriving and sustainable city: supporting a diverse and distinctive economy that creates jobs and opportunities.	An effective internal audit service is an integral part of the Council's governance arrangements. It helps to maintain and develop good governance and risk management and provides independent assurance over the effectiveness of the Council's systems of control. This contributes to being a well-run Council and indirectly to the achievement of organisational objectives and the Our Manchester Strategy.
A highly skilled city: world class and home-grown talent sustaining the city's economic success.	
A progressive and equitable city: making a positive contribution by unlocking the potential of our communities.	
A liveable and low carbon city: a destination of choice to live, visit, work.	
A connected city: world class infrastructure and connectivity to drive growth.	

Full details are in the body of the report, along with any implications for:

- Equal Opportunities Policy
- Risk Management
- Legal Considerations

Financial Consequences – Revenue = None
Financial Consequences – Capital = None

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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 4 years after the date of the meeting. If you would like a copy, please contact one of the contact officers above.

- Internal Audit reports to Audit Committee
- Outstanding Audit Recommendations Report to Audit Committee – July 2022

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 Background

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 In addition to recommendations agreed as part of our planned assurance reviews, we have now formalised our approach to capturing and tracking recommendations made through audit investigations. From July, as part of our continuous improvement regime, in specific circumstances where we find systemic control weaknesses or gaps, we will produce an action plan for management, identify action owners and agree implementation dates. Critical and significant recommendations will be monitored via the existing processes.

2.4 Where system related issues are found, we may include them in standard recommendation reporting to Committee but that may not be appropriate in all cases, for example, if the recommendation relates to actions needed to be taken to reduce the risks of fraud or theft where publishing to the public at large would present an increased likelihood of crime. For completeness we will continue to report progress on all counter-fraud related audit activity to the Committee through the Counter Fraud Annual report.

2.5 Progress made in the implementation of agreed actions 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.

2.6 In accordance with Audit Committee expectations, the risk relating to recommendations that are not fully implemented will not be written back to Strategic Directors when they are over 18 months past the agreed implementation date. Directors will continue to attend this 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 Update

3.1 The position in terms of high priority internal audit recommendations implemented this quarter are summarised below and in detail at Appendix 1. Overdue recommendations are detailed in Appendices 2,3 and 4.

3.2 Recommendations for improving the control environment within schools are monitored by Internal Audit however these are not included within this report for the following reasons. In July 2022 we provided the Committee with a report detailing audit work within schools and a summary of recommendations made and their status. We have started to revisit schools that have outstanding and partially outstanding recommendations from financial health checks and this work will progress through October to December. We will provide a further progress update at the January 2023 meeting and will report further updates on the implementation of recommendations made in school reports every six months.

3.3 At a previous meeting, Members were provided with an update on recommendations made with regards to Housing Operations - Void and Empty Properties audit. We have scheduled a formal follow up review of this area with the client, to consolidate the position regards the implementation of all agreed recommendations. This will be reported to committee in the January 2023 update.

Outstanding Recommendations – over 12 months

3.4 Two recommendations were reported to Audit Committee in July 2022 as being partially implemented and over 12 months overdue. We have closed one of these in relation to Adults Transitions based on evidence and emails provided and can confirm that performance management in this area is now part of directorate leadership reporting arrangements. Therefore, one recommendation remains in the category outlined below.

Directorate	Audit Title	Due Date	Months	Status
Adults	Mental Health Casework	30/9/19	34	Partially implemented

3.5 Our latest update from management confirmed that there is now a Greater Manchester Mental Health Trust (GMMHT) safeguarding process set up on Liquid Logic and this went live on 5 September 2022. Whilst this represents

further progress it is accepted by management that GMMHT staff do not yet have system access to start operationally using the process.

3.6 A total of 22 GMMHT administrative staff have been identified to access Liquid Logic and require training. Two staff in each team will then be able to provide the minimum coverage to both input the safeguarding outcomes and have another sign it off for quality assurance purposes. These 22 staff have been provided with access to the Council network and Liquid Logic system. Three dates in October have been arranged for these staff to receive Liquid Logic training following which they will be able to access the system and begin to input information around mental health casework activity.

3.7 This is further progress since our last report but until the training is completed and the processes of updating records can be assured Internal Audit will continue to consider this recommendation to be partially implemented.

Significant / Critical Overdue Recommendations – 6 to 12 months

3.8 There are two recommendations that have been overdue for between six and twelve months, both are partially implemented and relate to the same audit review - Placement Finding: Review of Core Processes.

3.9 Through follow up work earlier in 2022 we confirmed a number of improvements were made following our initial audit. This included the introduction of steering group meetings attended by finance and commissioning colleagues to review outstanding payments/placements, weekly catch ups between commissioning and finance managers to identify and resolve data discrepancies within systems and use of a 'conversation tool' within the payments system to allow issues with provider invoices to be resolved more. To facilitate the additional work required, the service also introduced a dedicated post for tracking internal foster carer payments and to provide support to social workers to ensure placements are processed correctly and in a timely manner.

3.10 The service acknowledges that some errors or issues can slip through and whilst management information is currently used to track placement ends for over 18s, checks to ensure payments are not being made to multiple carers for a single child as recommended in the audit have not yet been developed. Further work is needed to determine how the use of system data can be used to identify such cases and Internal Audit recognise that this is complex to achieve. There is an acknowledgement from the service that finance input continues to be required and we support the continuation of this resource to reduce the risk of slippage or loss of momentum in identifying and resolving payment issues.

3.11 An audit of foster care overpayments is currently underway, and we will use the results of the audit testing undertaken to confirm the impact of progress made. This work seeks to quantify the extent of the risks of duplicate payments with a view to identifying the root cause and exploration of any options as appropriate for addressing risks. We will report on the outcome of this work during quarter

three and as a result have not asked the Director and Executive Member to attend Audit Committee at this stage to provide an update on planned actions. If issues of concern remain or recommendations remain classified as outstanding following this audit, then then they will be asked to attend and update the Audit Committee on proposed actions.

Significant / Critical Overdue Recommendations – 1 to 6 months

3.12 There are two recommendations that are classified as overdue, relating to an audit review of the Use of Waivers and Extensions within Council contracts. Both are classified as being partially implemented and require further work to be closed as being fully implemented. We are following up actions in relation to Avro Hollows Tenant Management Organisation, as one recommendation is now overdue, as is a recommendation made in our review of Technology Enabled Care. More detail is given in Appendix 4 below.

Not Yet Due

3.13 A total of 16 recommendations rated significant / critical are not yet overdue, these will be tracked through to implementation. All have been agreed as part of audit work and reports finalised in the period April 2022 to September 2022.

4 Recommendation

4.1 Audit Committee is requested to note the current process, the inclusion of recommendations via investigation work, 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
Highways Compensation Events Review	31 March 2022	The further development of quality assurance processes by the Highways PMO should continue and consider other means of gaining assurance and confidence over the management of CEs to facilitate the removal of the need for contract variation reports and approval of the DCECT. This could include the introduction of regular sample review checking of CEs to provide assurance over the operation of controls, compliance with the NEC contract and Council processes, greater scrutiny where the CE is because of a design flaw on our part. This should also consider the introduction of reporting on CEs. This could provide analysis over CEs to inform future learning. This could include: -number of CEs per project grouped per clause. -rejected CEs and defects. -degree of compliance with key contractual timescales.	Reporting is in place and will be issued to senior officers monthly. There is also a Highways Authorisation Matrix which has been shared with staff which details the CE approval process. All full-time staff have received NEC training with PMs and Commercial staff ECC accredited. The reporting of CEs monthly, in line with the approach agreed with the Commercial Board, will commence alongside further contract report approvals. CEs will continue to be reported through project governance structures and approved at Director level depending on value and impact.	The remaining outstanding element of this recommendation has now been completed. We confirmed work has been undertaken by the service to develop spot checks which are now operational. We were provided with the latest report which detailed the findings of spot checks. We understand this process will be repeated each quarter to provide ongoing assurance in this area.	**No further action required**

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.	Recommendation agreed - key performance Indicators (KPIs) to be introduced.	We have confirmed that the transitions recommendation in relation to performance indicators is implemented. We have seen evidence of a performance indicator on the strategic Adult's Better Lives Better Outcomes report regarding the number of care act assessments overdue in relation specifically to the transitions team, with further performance measures being developed, once the referral portal is finalised, user tested and implemented. Onward performance reporting will also include referral numbers, timeliness of (ages at) referral and timeliness of allocation. This is estimated to be operational end of October/early November with monthly reporting. Despite being classified as implemented, Internal Audit will still request an update on this further reporting suite for assurance purposes in December 2022.	**No further action required**
Adults Management Oversight and Supervisions	30 August 2022	The Principal Social Worker should ensure that the guidance document is renamed as a Supervisions policy.	The guidance document has now been renamed as a Policy.	The document has now been updated from guidance to a supervisions policy therefore the recommendation is implemented.	**No further action required**

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
Adults Management Oversight and Supervisions	30 August 2022	The Principal Social Worker should review the requirements for case discussions recording in supervisions to ensure there is clarity over the recording requirements for both the supervision document and liquid logic. Consideration should be given to including minimum expectations for what should be included in the supervision record in the supervision policy. We recommend that the minimum requirement is a short summary of the discussion for each citizen along with details of any agreed actions and any performance challenge. The document should also show follow up of any key actions agreed at previous supervisions. Key actions relevant to the case but not relating to social worker performance could also be added to Liquidlogic to demonstrate management oversight and involvement in that particular case.	Policy has been updated to read as follows: ● Use the supervision template within this policy to record a summary of your case discussions and actions. ● Ensure where there is case discussion that citizen's liquid logic ID number is record on supervision records. Use your professional judgement in recording any key decisions and actions relating to specific cases in the citizen's case notes	We have confirmed that the policy has been updated in line with the management response to bring greater clarity over documentation requirements for casework discussions, therefore we can conclude that this recommendation has been fully implemented.	**No further action required**
Housing Operations (Northwards) - Governance	31/7/22	The committee should own and maintain a risk register for the housing operations service, scoring risks on a RAG basis, allocating ownership, identifying mitigating actions and demonstrating active management of those actions.	Accepted and in development.	Fully Implemented. We have seen the board documentation which confirms the ownership and maintenance of the service risk register, with the first in depth discussion scheduled for November's Housing Advisory Board. The service's risk register forms part of the Council's overall risk management and corporate governance. Draft risk register	**No further action required**

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
				seen.	
Housing Operations (Northwards) - Governance	31/7/22	The service should ensure that a full and comprehensive approach to performance and data is developed that links to consumer regulations and the white paper. Options could include an action plan with assigned owners and timescales or task and finish groups.	Accepted	Fully implemented. The terms of reference set out the board's clear role in overseeing performance. The board will consider the service's performance as well as the newly published Tenancy Satisfaction Measures (forming part of the consumer regulations)	**No further action required**

Appendix 2 – Recommendations Over 12 Months Overdue

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
Mental Health Casework Compliance	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.	Our latest update from the business confirmed that there is now a GMMHT safeguarding process set up on Liquid Logic and this went live on 5 September although GMMH staff do not yet have system access to start operationally using the process. 22 GMMH staff have been identified to access Liquid Logic training with two members of staff per team. These staff will then be able to provide the minimum coverage across the teams to input the safeguarding outcomes and have another person sign it off for quality assurance purposes. These 22 staff have been given user name and passwords to the Council systems, with 12 having logged onto their partner network account to access the systems. Management are following up with GMMHT to ensure all these staff confirm their system access in readiness for liquid logic training. Management confirmed that three dates in October 2022 have been arranged for GMMHT staff to receive Liquid Logic training following which they will be able to access the system and begin to input information around mental health casework activity. **Internal Audit Opinion:** Partially Implemented	**Director:** Bernadette Enright, Executive Director of Adult Social Services **Executive Member:** Councillor Robinson **Status:** 34 months overdue **Action:** Internal Audit to continue to track progress over the completion of Liquid Logic training and the start of data entry to liquid logic by GMMHT staff with progress to be reported verbally in October and in the next formal update to the January 2023 Audit Committee.

Appendix 3 – Recommendations between 6 and 12 Months Overdue

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
Placement Finding: Review of Core Processes	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; -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).	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. 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.	This recommendation remains outstanding in part. An audit review is currently in progress to provide assurance over arrangements in place to prevent foster care overpayments which will help to inform the status of this recommendation. The approach to this work includes the use of data analysis software to review a data set of foster care payments to identify possible duplicate payments. Higher value duplicates are then being reviewed to establish root cause, identify any systemic weaknesses and potential ways to improve controls to prevent reoccurrence. The results of the audit will be shared in quarter three. **Internal Audit opinion:** Partially implemented.	**Director:** Paul Marshall, Strategic Director of Children's Services **Executive Member:** Councillor Bridges **Status:** 12 months overdue **Action:** The findings from the Foster Care Overpayments audit currently in progress will be used to inform subsequent action. If not addressed, then Director and Executive Member to attend Committee
Placement Finding: Review of Core Processes	30 Nov 2021	The Commissioning Service Manager in conjunction with Social Work Managers should consider current placement closedown processes and how the risk of payments to more than one carer for the same child and period could be identified in	As acknowledged this aspect is wider than CPT, the responsibility for entering the details of placements and closing placements are the tasks for social workers. CPT and CC do not routinely know when SGO's are granted, or	This recommendation remains outstanding in part. An audit review is currently in progress to provide assurance over arrangements in place to prevent foster care overpayments which will	**Director:** Paul Marshall, Strategic Director of Children's Services **Executive Member:** Councillor Bridges **Status:** 10 months overdue

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
		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.	children move internally if this is agreed within the duty service for fostering. Meetings have taken place with HOS, LS, finance, and LL lead regarding 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.	help to inform the status of this recommendation. The approach to this work includes the use of data analysis software to review a data set of foster care payments to identify possible duplicate payments. Higher value duplicates are then being reviewed to establish root cause, identify any systemic weaknesses and potential ways to improve controls to prevent reoccurrence. The results of the audit will be shared in quarter three. **Internal Audit opinion:** Partially implemented	**Action:** The findings from the Foster Care Overpayments audit currently in progress will be used to inform subsequent action. If not addressed, then Director and Executive Member to attend Committee

Appendix 4 – Recommendations between 1 and 6 Months Overdue

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
Use of Waivers and Extensions	31 May 2022	The ICP Team should develop a formal system for the process of submitting and approving waiver and contract requests. This should include a mandatory control for all waivers over £50k to be submitted to the Deputy Chief Executive and City Treasurer by ICP, to provide assurance of their agreement. Consideration should be made to integrating the Teams Approvals function into the system to support more unambiguous authorisations and a self-contained audit trail.	The ICP Team are currently exploring options including Teams functionality to support with this. The team are also looking to procure a new contract management system with functionality that will support management of approvals. In the immediate term, the team has already amended the waiver template form to explicitly confirm that ICP Management have been consulted beforehand. We will confirm with directorates that waivers and extensions, along with contract award reports more generally must go through the ICP Team.	We understand system options in teams and SharePoint were explored and not found to be suitable. As such, functionality to submit waivers was specified within the tender for the new contract management system which is currently being progressed. As such, this recommendation remains outstanding in part. **Internal Audit opinion:** Partially implemented	**Director:** Carol Culley, Deputy Chief Executive and City Treasurer **Executive Member:** Councillor Akbar **Status:** Four months overdue **Action:** To continue to request updates from the service and evaluate progress.
Use of Waivers and Extensions	31 May 2022	The ICP team should work with Legal Services to simplify the Constitutional wording around contract authorisations. Wording around delegated authority should be explicit and unambiguous, with clear definitions of authorised officers. This should be reflected in procurement guidance and disseminated to commissioning and authorising officers. We advise that ICP take their observations regarding waivers/direct award and delegated authorities to the Commercial Board for discussion.	Agree, subject to Constitutional amendments being confirmed. The ICP Team are currently working with Legal Services and directorates to develop proposed revisions for the Constitution	We were informed in a recent update that Officers have drafted new contract rules for the Constitution, including on waivers. Contracts Leads and the Commercial Board were engaged in the drafting. The draft is now with Legal who will present the updated draft to full Council. This recommendation therefore remains partially implemented. **Internal Audit opinion**: Partially implemented	**Director:** Carol Culley, Deputy Chief Executive and City Treasurer **Executive Member:** Councillor Akbar **Status:** Four months overdue **Action:** To continue to request updates from the service and evaluate progress.

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
Housing Operations - Governance	31/7/22	The Director of Housing Operations should ensure that the following are added into the governance documentation: Person Specification, Role profile / tasks, Required / desired skills, Membership renewal strategy, Programme of training, Equality, diversity and inclusion statement / policy, Committee member conflict of interest statements, Clarification of how the committee will appoint a chair in the Executive Member's absence, Clear plan to support continuous improvement of the committee, Outline of decision-making arrangements. We also recommend the following: The proposed two-year maximum term for tenant committee membership is extended. The numbers of tenants and members are equal.	Recommendation is agreed.	Role profile created and terms of reference in place (evidence provided). Membership term of Housing Advisory Board set out in Terms of Reference as a minimum of two years, which was amended following the audit. Learning and Development offer for all members, some of which safeguarding, cyber security are mandatory. More detailed L&D and continuous development under discussion subject to individual needs and areas of interest (e.g. Health and Safety, Finance, Communications) Equality, Diversity and Inclusion responsibilities set out in role profile and terms of reference The numbers of residents on the Housing Advisory Board equal the number of councillors (5) except for the agreed Chair, the Executive Member for housing and Growth. There are also 3 co-opted non-resident members. Most of the required documentation is now in place, we are just awaiting confirmation of the continuous improvement of the committee and the membership renewal strategy. **Internal Audit opinion**: Partially implemented	**Director:** Neil Fairlamb Strategic Director Neighbourhoods **Executive Member:** Councillor White **Status:** Two months overdue **Action:** To continue to request updates from the service and evaluate progress.

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
Housing Operations - Governance	31/7/22	Reporting requirements and routes should be defined in the committee ToR. We would expect this to include annual reporting, monitoring of KPIs, regular reporting against equality, diversity and inclusion priorities and objectives, reporting on the declaration of interests register, tenant's annual scrutiny review of the service.	Recommendation agreed.	The Terms of Reference set out the responsibilities and remit of the Board. A declaration of interests' register is in place and has been signed by all parties. This will be reviewed annually. The role of the board is to scrutinise the service, primarily from residents' perspective, an annual report is being produced for late Autumn 2022 where the HAB will have a vital role in overseeing and shaping the content. **Internal Audit opinion**: Partially implemented	**Director:** Neil Fairlamb Strategic Director Neighbourhoods **Executive Member:** Councillor White **Status:** Two months overdue **Action:** To continue to request updates from the service and evaluate progress.
Technology Enabled Care	30/6/22	Reports should be run periodically to identify which service users have not tested their equipment within the period. Staff should contact them to both test equipment and to remind/advise customers of the monthly test requirement to ensure equipment is functioning correctly	The recommendation is agreed. Work is ongoing with the primary supplier to automate testing where manual testing has not been carried out. Once implemented, the risk will be mitigated.	A process to identify and address where testing has not taken place has been documented and reports have been produced identifying where customer testing has not been initiated. The service is in the process of sourcing a business support officer to undertake the required actions to address. They have been unable to recruit a suitable candidate and are short on resource. When this is rectified, they will be able to complete this action. **Internal Audit opinion**: Partially implemented	**Director:** Bernadette Enright, Executive Director Adult Social Services **Executive Member:** Councillor Robinson **Status:** Three months overdue **Action:** To continue to request updates from the service and evaluate progress.

Audit Title	Due Date	Recommendation	Management Response	Update/Opinion	Ownership and Actions
Avro Hollows Tenants Management Organisation	30 June 2022	We found that the formal recording of repair requests was managed through a spreadsheet. However, requests were only added to the spreadsheet at the point that they were approved for referral to the external repairs' contractor. The AHTMO Manager informed us that there was no structured record of repair requests that were refused, and that minor repairs passed to the handyman were only recorded in carbonated job request books. Jobs referred to Housing Operations (previously Northwards) were also not recorded.	Agreed - The Head of Housing Services should seek assurance from the AHTMO Manager over the recording and management of requests for repair at the point of receipt.	The Head of Audit and Risk Management has written to Strategic Housing and the chair of AHTMO in respect of risks and concerns identified through audit and other work. The follow up of this recommendation is part of that wider letter of concerns. **Internal Audit opinion**: Not implemented	**Director:** Becca Heron, Strategic Director of Development **Lead Officer:** Martin Oldfield, Head of Housing Services **Executive Member:** Councillor White **Status:** Three months overdue **Action:** Awaiting a response from AHTMO Chair and Head of Housing. This is an area of active follow up by the Head of Audit and Risk Management.