Progress report on
Internal Audit Activity
2019-2020

ARA
AuditRiskAssurance

Gloucestershire
COUNTY COUNCIL

(1) Introduction

All local authorities must make proper provision for internal audit in line with the 1972 Local Government Act (S151) and the Accounts and Audit Regulations 2015. The latter states that a relevant authority "must undertake an effective internal audit to evaluate the effectiveness of its risk management, control and governance processes, taking into account public sector internal auditing standards or guidance". The Internal Audit Service is provided by Audit Risk Assurance under a Shared Service agreement between Gloucestershire County Council, Stroud District Council and Gloucester City Council and carries out the work required to satisfy this legislative requirement and reports its findings and conclusions to management and to this Committee.

The guidance accompanying the Regulations recognises the Public Sector Internal Audit Standards 2017 (PSIAS) as representing "proper internal audit practices". The standards define the way in which the Internal Audit Service should be established and undertakes its functions.

(2) Responsibilities

Management are responsible for establishing and maintaining appropriate risk management processes, control systems (financial and non financial) and governance arrangements.

Internal Audit plays a key role in providing independent assurance and advising the organisation that these arrangements are in place and operating effectively.

Internal Audit is not the only source of assurance for the Council. There are a range of external audit and inspection agencies as well as management processes which also provide assurance and these are set out in the Council's Code of Corporate Governance and its Annual Governance Statement.

(3) Purpose of this Report

One of the key requirements of the standards is that the Chief Internal Auditor should provide progress reports on internal audit activity to those charged with governance. This report summarises:

- The progress against the 2019/20 Internal Audit Programme, including the assurance opinions on the effectiveness of risk management and control processes;
- The outcomes of the Internal Audit activity during the period July to September 2019; and
- Special investigations/counter fraud activity.

(4) Progress against the 2019/20 Internal Audit Programme, including the assurance opinions on risk and control

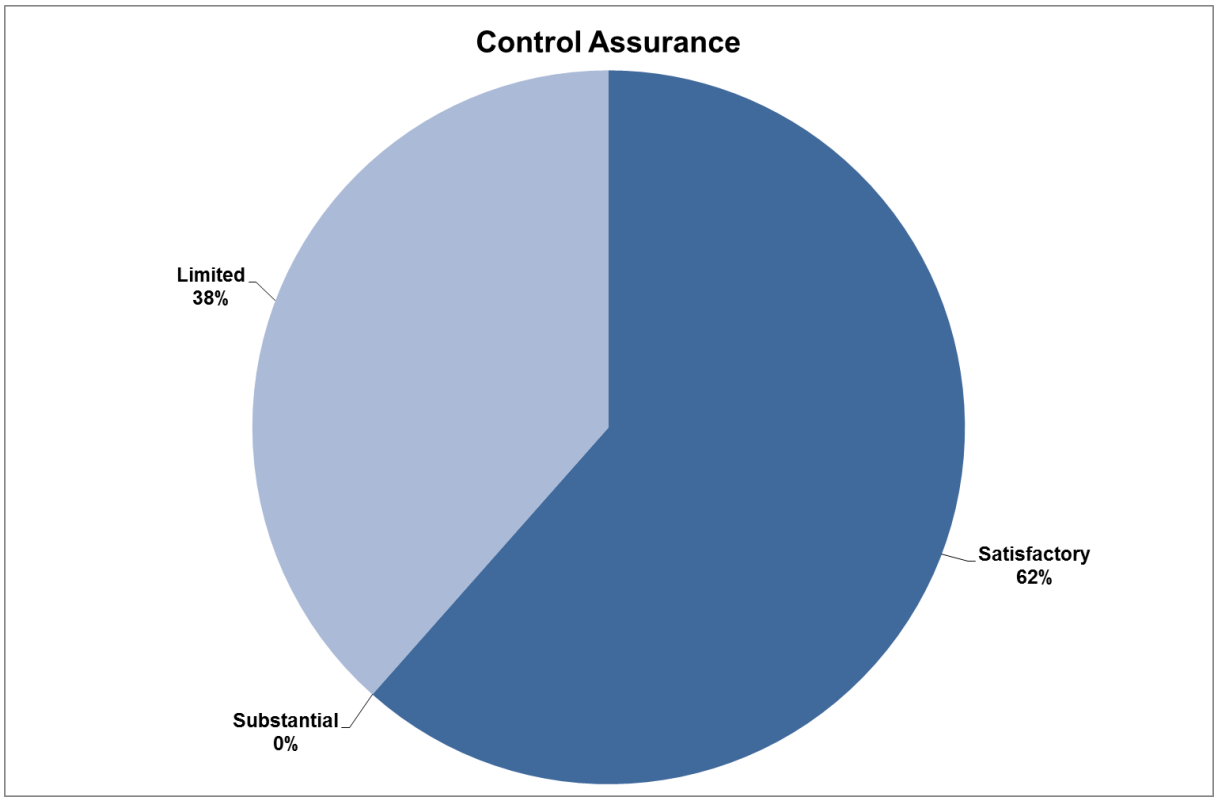
The schedule provided at **Appendix 1** provides the summary of 2019/20 audits which have not previously been reported to the Audit and Governance Committee.

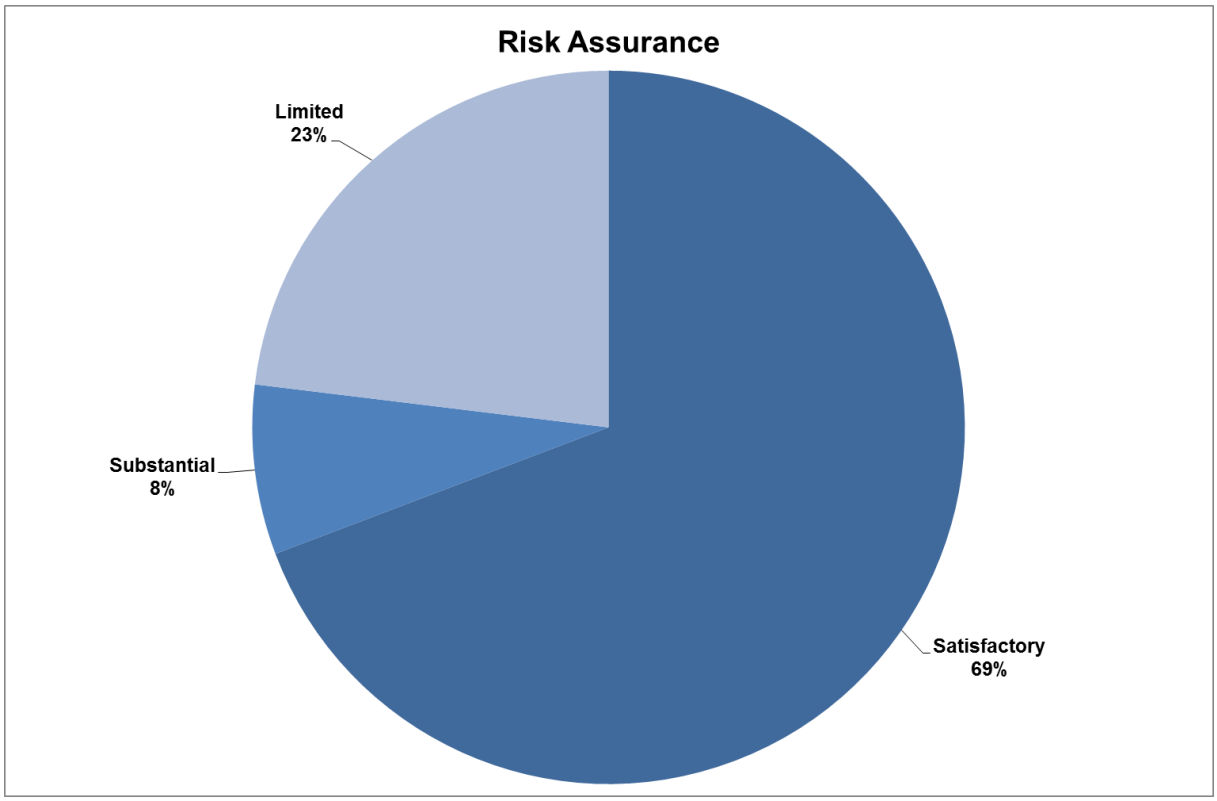
The schedule provided at **Appendix 2** contains a list of all of the audit activity undertaken during 2019/20, which includes, where relevant, the assurance opinions on the effectiveness of risk management arrangements and control processes in place to manage those risks and the dates where a summary of the activities outcomes has been presented to the Audit and Governance Committee. Explanations of the meaning of these opinions are shown below.

Assurance Levels	Risk Identification Maturity	Control Environment
Substantial	**Risk Managed** Service area fully aware of the risks relating to the area under review and the impact that these may have on service delivery, other service areas, finance, reputation, legal, the environment, client/customer/partners, and staff. All key risks are accurately reported and monitored in line with the Corporate Risk Management Strategy.	• System Adequacy – Robust framework of controls ensures that there is a high likelihood of objectives being achieved • Control Application – Controls are applied continuously or with minor lapses
Satisfactory	**Risk Aware** Service area has an awareness of the risks relating to the area under review and the impact that these may have on service delivery, other service areas, finance, reputation, legal, the environment, client/customer/partners, and staff, however some key risks are not being accurately reported and monitored in line with the Corporate Risk Management Strategy.	• System Adequacy – Sufficient framework of key controls for objectives to be achieved but, control framework could be stronger • Control Application – Controls are applied but with some lapses
Limited	**Risk Naïve** **Due to an absence of accurately and regularly reporting and monitoring of the key risks in line with the Corporate Risk Management Strategy, the service area has not demonstrated a satisfactory awareness of the risks relating to the area under review and the impact that these may have on service delivery, other service areas, finance, reputation, legal, the environment, client/customer/partners and staff.**	• **System Adequacy – Risk of objectives not being achieved due to the absence of key internal controls** • **Control Application – Significant breakdown in the application of control**

(4a) Summary of Internal Audit Assurance Opinions on Risk and Control

The pie charts provided below show the summary of the risk and control assurance opinions provided within each category of opinion i.e. substantial, satisfactory and limited in relation to the audit activity undertaken during the period April 2019 to September 2019.





The contributing factor to the high limited assurance percentage in the above charts is due to a number of the GFRS audit reports having a limited assurance opinion on risk and control.

Please be advised that accompanying this progress report, the findings / outcomes in respect of the GFRS activity during this period can be found within the separate GFRS Investigation Action Plan report, which has been presented to the Committee on 11th October 2019.

(4b) Limited Control Assurance Opinions

Where audit activity records that a limited assurance opinion on control has been provided, the Audit and Governance Committee may request Senior Management attendance to the next meeting of the Committee to provide an update as to their actions taken to address the risks and associated recommendations identified by Internal Audit.

(4c) Audit Activity where a Limited Assurance Opinion has been provided on Control

During the period July to September 2019, five limited assurance opinions on control have been provided on completed audits from the 2019/20 Internal Audit Plan. These relate to Approval of Payment to Agency Staff limited assurance follow up; GFRS HR and Payroll – Expenses and service benefits; GFRS Fleet management – use of pool cars, personal and leased cars and fuel schemes; Alternative Provision Schools – Stroud and Cotswold; and GFRS – Syrian Refugee Grant.

It is important to note that whilst limited assurance opinions have been provided, management have responded positively to the recommendations made and actions are being taken to address them.

In addition, where a limited assurance opinion is given, a follow up audit is undertaken to provide assurance that the agreed actions have been implemented by management.

(4d) Satisfactory Control Assurance Opinions

Where audit activity records that a satisfactory assurance opinion on control has been provided, where recommendations have been made to reflect some improvements in control, the Committee can take assurance that improvement actions have been agreed with management to address these.

(4e) Internal Audit Recommendations

During the period July to September 2019 Internal Audit made, in total, **60** recommendations to improve the control environment, **36** of these being high priority recommendations (**100%** of these being accepted by management) and **24** being medium priority recommendations (**100%** accepted by management).

The Committee can take assurance that all high priority recommendations will remain under review by Internal Audit, by obtaining regular management updates, until the required action has been fully completed.

(4f) Risk Assurance Opinions

During the period July to September 2019, three limited assurance opinions on risk have been provided on completed audits from the 2019/20 Internal Audit Plan. These relate to GFRS HR and Payroll – Expenses and service benefits; GFRS Fleet management – use of pool cars, personal and leased cars and fuel schemes; and Alternative Provision Schools – Stroud and Cotswold.

Where a limited assurance opinion is given, the Shared Service Senior Risk Management Advisor will be provided with the Internal Audit report(s) to enable the prioritisation of risk management support.

Completed Internal Audit Activity during the period July to September 2019

Summary of Limited Assurance Opinions on Control

Service Area: **Strategic Finance**

Audit Activity: **Approval of Payments for Agency Staff limited assurance follow-up**

Background

Agency staff are engaged by Gloucestershire County Council (GCC) through an organisation (a neutral vendor – currently GRI) which acts as a broker to liaise with recruitment agencies, rather than GCC dealing directly with the agencies.

The contractor's timesheet and vacancy management system (e-tips) requires GCC managers to approve agency worker's timesheets by a set time each week, however should they fail to do this then the timesheets will be auto-approved by the system, to enable the individual agencies to pay their staff.

During 2017/18 Internal Audit undertook a review of the operating effectiveness of the systems and processes in place for authorising agency staff timesheets and payment of invoices (in particular timesheets which are auto-approved for payment). The review established that at the time of the original audit the level of timesheet auto-approval was significant (the final quarter of 2016/17 showed a 56% auto-approval rate). Management action to address this could not be taken as reports available from the system did not provide sufficient details to highlight individual users. The system was due for an upgrade in 2017/18 and this was due to be addressed as part of the upgrade.

The findings emanating from the 2017/18 review resulted in one high priority recommendation being made and a limited assurance opinion in respect of the control environment.

Scope

The objective of the follow-up audit was to establish whether the agreed management actions from the original audit report have now been fully implemented.

Risk Assurance – Satisfactory

Control Assurance – Limited

Key Findings

- The recommendation made in the 2017/18 review stated that management should review the current level of agency staff timesheets auto-approval and consider whether formal documented process change was required.

- Auto-approval rates have not changed significantly since the original audit of 2017/18. Between January and March 2019 an average of 54% of timesheets were auto-approved each month. The total spend on agency workers through GRI for this period was £3,796,931, of which £2,949,126 was auto-approved (78% of total spend value). A number of timesheets which were auto-approved are for interim staff, with Directors set up as the approver.

- The Council's budget monitoring approach is acknowledged as a mitigating control, however it is a control completed after the event of payment and if not completed appropriately may not pick up inappropriate agency staff expenditure.

- It is understood that senior management, including the members of the Corporate Management Team (CoMT), receive details of the quarterly spend on agency staff and the percentage of timesheet approval per cluster based on number of timesheets. However, this excludes the value of auto-approved timesheets.

- A proposed upgrade to e-tips was due to take place in quarter two 2017/18 but was delayed until 31st January 2018. However, not all the expected system enhancements were included in the upgrade. During the original audit review, Internal Audit was advised that the upgrade to the system would include a notification being sent to a timesheet approver to advise them that there were timesheets awaiting approval and also a mobile app would be included to allow authorisers to access their emails via their mobile phones. This has not occurred at the point of the audit follow-up. In addition, the information from the GRI reports can still not be broken down to highlight the individual timesheet authorisers, which again, had been expected from the upgrade.

Conclusion

The Internal Audit follow-up review has identified that the 2017/18 limited assurance recommendation raised has not been fully actioned and that there has been minimal/no impact on the level of payments for agency auto-approval.

The follow-up audit has recommended that full details in relation to the value of auto-approved timesheets is provided to senior management, to ensure corporate awareness; enable senior management accountability for their service areas' spend on agency staff and the relevant auto-approval position; and to enable a decision on whether the current level of auto-approval is within the Council's risk appetite.

Management Actions

Management has responded positively to the recommendations made.

Due to the limited assurance outcome for control, it is recommended that Audit and Governance Committee requests senior management attendance at the next meeting of the Committee to provide an update on the actions taken in relation to the recommendations made in the Approval of Payments for Agency Staff limited assurance follow-up report.

Service Area: **Education**

Audit Activity: **Alternative Provision School – Stroud and Cotswold**

Background

Alternative Provision Schools (APS) provide education for children who have been permanently excluded from school. They have the same delegated powers and duties as maintained schools. There are three such schools in Gloucestershire, covering the following areas:

- Cheltenham & Tewkesbury (CTAPS);
- Gloucester & Forest (GFAPS); and
- Stroud & Cotswold (SCAPS).

This audit was undertaken at SCAPS.

Each APS has its own arrangements in place to provide support and advice for schools situated in their local area. Schools can contact the APS directly to discuss what may be available to support them with children at risk of exclusion. In addition, an APS can be commissioned by the Local Authority to provide a number of places for pupils who have been excluded from mainstream education and children who do not have a school place.

Scope

The objective of the audit was to review the management and governance processes in place to provide assurance that the funds are being spent appropriately on the pupils and for the purposes intended.

Risk Assurance – Limited

Control Assurance – Limited

Key Findings

The audit reviewed the following areas at the school: Governance and Budgetary Control, Staffing and Payroll, Income, Purchasing, Petty Cash, Debit Card, Vehicles, Pupil Attendance and Bank Account Reconciliation.

Ten recommendations were made, all of which are classed as high priority, in respect of governance and budgetary control, staffing and payroll, income, purchasing and vehicles. The recommendations cover finance information which is provided to Governors, the recording of decisions made by Governors, updating the School's Finance Policy and Declaration of Interest forms. In respect of staffing and payroll, the recommendations relate to checks being undertaken on payroll data as well as checks of staff driving licences and vehicle MOT and insurance. The remaining recommendations relate to compliance with purchasing requirements and ensuring that school vehicles are serviced as required.

Conclusion

The period covered by this audit was 1st April 2018 to 3rd June 2019. Between 1st April 2018 and 31st March 2019 the school was a cheque book school, which meant that all income and expenditure was processed by the school through its own bank account. From 1st April 2019 the school changed to a central school and all expenditure is now processed via the Business Service Centre at Shire Hall.

Until 31st August 2019 there was one overarching Business Manager covering all three APS, with a separate Finance Administrator based in each of the three schools. The Business Manager was responsible for a large part of the financial processes but with effect from 1st September 2019 the structure of the APS changed and a separate Business Manager was appointed for each school. It was recommended that a full handover is undertaken by the previous Business Manager of all financial documents and records relating to SCAPS as well as a thorough outline of processes.

The content of the audit report contained comments on some processes which took place in the previous financial year and may not occur or will change from 1st September 2019. The recommendations provided the school with guidance on how to improve systems and processes going forward.

Management Actions

Management has responded positively to the recommendations made.

The following management assurance framework has been agreed with the Director of Education for 2019/20 onwards.

Schools internal audit outcomes are reported to the Chair of Governors and presented to the Full Governing Body. On an annual basis, the Governing Body submit a return to the Education Service to confirm that all audit recommendations have been implemented.

The Director of Education will attend Audit and Governance Committee on an annual basis to report and provide assurance to Committee that processes are in place to manage the internal audit identified schools risks and confirm update on audit recommendation implementation. Committee attendance is due in July 2020.

Appendix 1

Summary of Satisfactory Assurance Opinions on Control

Service Area: **Adults**

Audit Activity: **Direct Payments – Payment Cards**

Background

GCC (the Council) is committed to promoting individual wellbeing and to supporting independence through preventing, reducing or delaying the need for care and support. Direct Payments are the Government's and the Council's preferred mechanism for personalised care and support as they promote service user independence, choice and control over how their needs are met.

A Direct Payment is a payment of money from the local authority to either the person needing care and support, or to someone else acting on their behalf, to pay for the cost of arranging all or part of their own support.

A Direct Payments team was set up in September 2015 and their role includes a monitoring function to ensure service users in receipt of a Direct Payment use their accounts appropriately.

In October 2017, the Council adopted the use of Payment Card Accounts (card accounts) and it is the expectation that all new and existing service users who are in receipt of a Direct Payment will use this system unless there are exceptional circumstances i.e. elderly service users who find technology difficult. Eligible service users will be provided with a physical card linked to a bank account and it is intended that the card will be used in a similar way to a banking debit card. The Council pay its contribution into the card account to which the service user must add any assessed contribution at no less than four weekly intervals. The account is managed by the service user or their authorised or nominated person.

As at May 2019 there were 584 service users with a Direct Payment, of which 301 had an active card account.

Scope

The objective of this review was to determine whether there is an effective framework in place for the monitoring of Direct Payment card accounts, and that the monitoring arrangements are in line with legislative and internal policy and procedures.

Risk Assurance – Satisfactory

Control Assurance – Satisfactory

Key Findings

- Introduction of card accounts has brought a number of benefits to the Council, such as, enabling better management of the inherent financial risks including fraud or any other irregularity, more effective monitoring arrangements and deployment of staff resource, cost savings and the recovery of excess funds. For example during the period 1st April 2019 to 24th July 2019, the team successfully recovered monies to the sum of £202,129.93.

- The Council has a Direct Payments Policy which reflects the review requirements of the Care Act 2014, the Care and Support (Direct Payments) Regulations 2014 and the Care and Support Statutory Guidance for the Care Act 2014.

- From a review of the Council's Direct Payment Agreement (DPA) it is evident that the DPA states that an initial review will be undertaken within eight to twelve weeks (which is sooner and therefore more challenging than the statutory requirement to review within the first six months, and council policy).

- A Microsoft Excel spreadsheet is used to capture service users who are in receipt of a Direct Payment and this is used to manage and monitor Direct Payments.

- Internal Audit selected a sample of 12 service users who had a card account set up and activated between December 2017 and February 2019 to determine whether the monitoring arrangements were in line with legislative and Council policy/procedure and found that:

    - Reviews were documented using the expected checklist for 11 of the service users, for the outlier, a different checklist had been used, however the Direct Payment Specialist had fully documented the review as expected;

    - All 12 service users had their payments checked by a Direct Payment Specialist, during the initial review period, to ensure they were meeting their documented needs - which confirms that there is a strong initial review process being followed;

    - All 12 service users had an initial review within six months to check that they were managing their payment and card account, evidencing good scheduling of initial reviews;

    - It was evident that employer checks had been performed and documented where appropriate; and

    - For two service users a review within 12 months of the initial review had not taken place as expected.

- Review of an additional sample of 15 service users with a card account recorded on the spreadsheet as not having been reviewed for at least 12 months, found that five of these had in fact been reviewed within the last 12 months. Internal Audit established that the spreadsheet had not been updated to reflect the review as the requirement to complete a Service User Change Request had not been actioned.

- In light of this, going forward management may need to consider undertaking a data cleansing exercise to ensure that the review dates within the spreadsheet are all accurately recorded and that appropriate staff be reminded of the importance of ensuring that the expected procedures are diligently undertaken. The pending introduction of the Liquidlogic Adult Services (LAS) system in July 2020 may provide an option to automate the scheduling of ongoing Direct Payment reviews in the future.

- Internal Audit also reviewed the procedures in place for the management of Direct Payment accounts for deceased service users. Introduction of documented procedures and regular management reporting and reconciliation of records held within the Adult Social Care Case Management System (ERIC) and Prepaid Financial Services Card System (PFS) should further enhance the current control environment and enable oversight of the arrangements for effective and timely management of the closure of the card account.

Conclusion

Internal Audit can confirm that there is an appropriate framework in place for the monitoring of card accounts, this could however be strengthened further by:

- Standardising the expectations for when an initial review will take place within the Council's Direct Payment Policy and Direct Payment Agreement;

- Ensuring the scheduling of ongoing reviews is robust and takes place as expected; and

- Improving how card accounts are managed when a service user dies by documenting the process and reconciling data.

Management Actions

Management have responded positively to the recommendations made in respect of the above.

Service Area:	**Adults**
Audit Activity:	**Winter Planning Discharge Beds**

Background

For most people, hospital treatment is successful, and they are able to return home. However, some need to be transferred to other forms of care for assessment to determine ongoing care needs. Effective discharges in these cases require joined-up working otherwise delays in transfer of care can occur.

The demand management programme has had a significant development lead time and a framework is now in place. There are a number of links in the delivery chain which require close management in order to optimise outcomes. This service is provided under the "One Gloucestershire" Integrated Care System which is intended to join up all parties in the health and adult care systems (NHS, GCC, external providers) in order to provide a cohesive operation to service users.

The audit focusses on the point between (normally) an elderly patient being discharged from one of the acute hospitals in the district and the point at which they are assessed for ongoing care needs / pathways. This process is known as Discharge to Assess (D2A) and is one of several elements in the Older Peoples hub (others being Community and Domiciliary Care).

Each of these services works under a brokerage arrangement to ensure that the patient is transferred as quickly as possible to the right place. The D2A process is time critical for several reasons; it represents the next step in a person's care pathway, delays can cause bed blocking, and payments up to the point of an individual being assessed are fully funded and do not attract a service user contribution.

It is therefore imperative to ensure that when a patient is ready to be discharged into the community, the system whereby a patient is accepted and then assessed and if appropriate moved into permanent care accommodation is efficient and effective.

Scope

The scope of this audit was to establish whether there are effective arrangements in place for winter planning and that these beds are being utilised, as intended, and to their optimum in line with the agreed processes.

Risk Assurance – Satisfactory

Control Assurance – Satisfactory

Key Findings

- The operation works under the umbrella of a national initiative and so the strategic framework is derived from this. Operating procedures reflected that framework.

- The system was seen to be well understood by experienced and dedicated staff that clearly worked under some pressure but retained the best interests of service users as the main priority. The system was seen to operate according to the defined, documented processes.

- There has been recognition within the D2A operation, and its wider brokerage remit under the overarching Integrated Care System, that organisational improvement could be made. It has taken time to reach this point, but progress is now being made in the form of a revised staff structure having been agreed and the introduction of changing shift patterns to speed up the process for placing service users.

- There are a series of key projects in place with project leads appointed to review areas relevant to the D2A process and the wider brokerage function. These include contract management and market shaping. There is also a significant data analysis project ongoing that should better inform demand and capacity requirements.

- In terms of the understanding of demand to manage peaks and troughs within a finite current capacity of 30 beds, local systems are used to deal with this which gives a snapshot of the position at any one time, but which is not sufficient to capture trends, timing peaks and troughs and other such demand and capacity planning information.

- Audit testing (12 cases) did not identify any significant delays in the D2A care journey. Both pre-placement contracts and individual service user contracts identified no areas of concern with the contract documentation and content in relation to placements for subsequent payments. In all but one case tested, there was a signed contract in place with the key details documented.

- Bed availability and capacity management is a critical element and is currently a manually undertaken task. Better use could be made of IT in that there are currently disparate IT facilities in place with limited systems integration taking place and also some utilities not being used – e.g. capacity planner and e-brokerage. Implementation of these applications has slipped from the original date and is behind schedule, this is due to provider delays in developing them.

- Management and local operational information are produced which identify budget spend and also some performance information such as the 28 day referral to assessment timeliness and also the current and historic Detoc (delayed transfer of care) performance criteria. The Detoc indicator has increased in each of the last two available reporting periods.

Conclusion

Based on the audit testing completed, the evaluation of documentation and the review of activity, the system is given a “satisfactory” assurance for both risk maturity and control management. The satisfactory opinion is based on the existing process being robust and consistently followed. However, it should be noted that this system is in a state of flux with a number of key areas being internally reviewed.

Management Actions

Management has responded positively to the one medium priority audit recommendation that was made in relation to relevant IT system integration to help efficiency and effectiveness within brokerage.

Service Area: **Children and Families**

Audit Activity: **Section 20 Limited Assurance Follow-Up**

Background

Local authorities have a duty to identify children in need in their local area, undertake an assessment and then use the findings to determine whether the child should be provided with accommodation under Section 20 of the Children Act 1989.

Section 20 agreements are voluntary arrangements between the local authority and the parents, where the parents cannot provide their children with suitable accommodation or care on a temporary or permanent basis. However, the parental responsibility remains with the parents until permanence arrangements are agreed in court e.g. adoption, Special Guardianship Orders, etc. As at April 2019, GCC had 718 children in care of which 238 (33%) were under a Section 20 voluntary arrangement.

During 2017/18 Internal Audit undertook a review of the operating effectiveness of the systems and processes in place for Section 20 agreements. The audit resulted in Limited assurance opinions being given for both risk management and the control environment.

Scope

The objective of this Limited Assurance Follow-Up audit was to establish whether the agreed management actions to address the six high priority recommendations have been fully implemented.

Risk Assurance – Substantial

Control Assurance – Satisfactory

Key Findings

There is a Children's Social Care procedures manual which includes comprehensive policies and procedures for the management of Looked After Children, including those subject to Section 20 arrangements.

The current Scheme of Officer Authorisations that relate to Children's Services was signed by the Director of Children's Services on 8th January 2019. It specifies the post titles of those officers that have delegated authority to make decisions in relation to the accommodation of children which would include those accommodated under Section 20 arrangements.

An Ofsted Improvement Plan has superseded the Implementation Plan that had been developed to ensure improvements were made to the management of Section 20 arrangements. Regular updates on Entry to Care, which includes Section 20 arrangements, are submitted to the Improvement Board as part of a long-term programme entitled Building the Best.

The above framework was reviewed for compliance by selecting a 25% sample of children taken into care under Section 20 arrangements (nine in total) over the period December 2018 to February 2019. Testing revealed some lapses in terms of compliance with the required procedures for consulting with Legal, appropriate authorisation for entry to care and recording and ongoing monitoring of Section 20 arrangements.

Management oversight, Team Manager audits and dip sampling of case files should continue in order to identify and correct any areas of non-compliance. Understanding the root cause of the issues identified should enable a cycle of continuous improvements to be put in place.

Conclusion

Four of the original six recommendations have been implemented. Two relating to the accurate completion and uploading of Section 20 agreements and subsequent timely Statutory Reviews were still in progress at the date of the follow-up audit and are being subsequently monitored for implementation. A further two recommendations have been made in relation to correcting specific errors identified from the follow up audit sample testing and the need for ongoing management oversight and monitoring which should enhance the existing control environment.

Although good progress has been made against the original recommendations, further improvements in social work practice are still required.

Management Actions

Management has responded positively to the recommendations made in respect of the issues identified.

Service Area:	**Strategy and Challenge - ICT**
Audit Activity:	**Capita 360**

Background

The Capita Pay360 application has been deployed at GCC to securely process customer debit and credit card payments. Pay360 is scheduled to replace the legacy PARIS card payment system. Hosted by Capita, Pay360 is designed to process on-line, face to face and telephone card payments. Pay 360 first went live at GCC in November 2018.

Scope

The scope of the Capita Pay 360 audit included review of the following areas:

- Validity of user access rights and privileges;
- Password security settings;

- Limit on failed login attempts;
- Restriction on access to superuser rights;
- External security testing;
- Payment Card Industry (PCI) Data Security Standards (DSS) accreditation; and
- Business Continuity and Disaster Recovery arrangements.

Risk Assurance – Satisfactory

Control Assurance – Satisfactory

Key Findings

The review identified a number of areas of good practice. Pay360 has been implemented to replace the non PCI DSS compliant PARIS card payment system (system decommissioned within April 2019). ICT technical support has been provided throughout the project to implement Pay360. A contract is in place with the software vendor (Capita) covering key elements including PCI DSS, Disaster Recovery, client confidentiality and data protection.

All users must complete a mandatory training module before being allowed system access. Access rights are restricted to valid and uniquely identifiable users and a comprehensive Pay360 system guide is in place.

Audit testing confirmed that robust password policies are in place to prevent unauthorised system access.

The existing Business Continuity plan is undergoing review and will be updated as part of the ongoing Pay360 implementation project (i.e. it is a documented action). This will consider the processing of customer credit and debit card payments in the event of any significant system downtime.

The findings from this audit have identified the following control areas that require strengthening:

- The absence of two factor authentication on the Pay360 web portal; and
- The need to ensure the Pay360 system is subject to external penetration testing.

Three audit recommendations have been raised as a result of the above findings.

GCC has committed to becoming PCI DSS compliant. The implementation of the new Pay360 application is a key part of that commitment. Alongside this, GCC commissioned a dedicated PCI DSS consultant to work with in-house lead officers within 2018/19 and early 2019/20 to progress specific actions including updating policies and procedures, staff training, user awareness of PCI DSS requirements together with improving governance arrangements.

A PCI DSS internal audit is contained within the 2019/20 GCC Internal Audit Plan, to review the position post PCI DSS accreditation attainment and review/test a sample of GCC sites that take card payments to provide assurance regards compliance with the Council's PCI DSS policy and procedures.

Conclusion

This review of the Pay360 application has resulted in satisfactory assurance for both risk identification maturity and control environment. Implementation of the three audit recommendations will further strengthen controls and the resulting assurance levels.

Management Actions

Management has responded positively to the recommendations made.

Service Area:	**Strategy and Challenge**
Audit Activity:	**General Data Protection Regulation (GDPR) Compliance**

Background

The General Data Protection Regulation (GDPR) (Regulation (EU) 2016/679) is a regulation by which the European Parliament, the Council of the European Union and the European Commission intend to strengthen and unify data protection for all individuals within the European Union (EU). GDPR replaces the Data Protection Directive (officially Directive 95/46/EC)[2] of 1995.

The regulation was adopted on 27 April 2016 and became enforceable from 25 May 2018 after a two-year transition period. Unlike a directive, it does not require national government to pass any enabling legislation and is thus directly binding and applicable.

Scope

The aim of this audit was to review whether the Council has an effective framework in place for ensuring that personal information gathered is only used for the purpose for which it was originally intended.

The review sought to cover key GDPR elements including:

- Data protection policy;
- User awareness;
- Information Asset Register;
- Individual's rights;

- Privacy Impact Assessments/Privacy by Design;
- Subject Access Requests (SARs);
- GDPR Supplier Contract Clauses;
- Protection of children's data;
- Data breaches process; and
- Appointment of a Data Protection Officer (DPO) and local GDPR leads.

Risk Assurance – Satisfactory

Control Assurance – Satisfactory

Key Findings

Discussion with key officers and review of supporting documentation has confirmed compliance with GDPR requirements and the application of good practice in the following areas:

- Key Council GDPR/data protection policies and procedures have been developed/updated to meet GDPR requirements and made available to staff;
- Council staff have been made aware of GDPR requirements via a number of channels, including a series of training exercises, communications and guidance issued via email and Staffnet (the Council intranet), the use of a range of posters and the use of the MetaCompliance system (the Council policy management system) to communicate policy changes to staff;
- The Council has published a detailed high level privacy notice on its website pages and this includes links to approximately 40 departmental/service specific privacy notices;
- The Council was found to have a suitably documented process in place around the use of Data Privacy Impact Assessments (DPIAs) as required by GDPR;
- A defined process was found to be in place for the handling of SARs and this was found to have been updated to meet GDPR requirements;
- A Children's Services privacy notice has been developed and published on the Council website. This covers key requirements around detailing the Council's approach to the processing and storage of children's data;
- A documented process for the reporting of data breaches was found to be in place and regular reporting detailing the number and severity of incidents is produced and distributed to senior management;
- The Council has a designated DPO in place as required by regulations; and

- Advisers from the Information Management Service (IMS) team with GDPR Practitioner training are available to help assist service areas with data protection/GDPR queries and a nominated IMS point of contact has been put in place for each Council cluster.

The following improvement actions have been recommended by Internal Audit in order to support the Council's ongoing efforts to achieve compliance with GDPR requirements:

- Management should ensure that the proposed data protection e-learning is rolled out to all staff, that plans are made to make this training available to any staff without access to a computer, and that reporting is in place to monitor staff completion of this training;

- Management should complete a full update and roll out of the record of the processing activities system. In addition, an annual review process should be developed and implemented to ensure the data in the system remains up to date and complete;

- Management should ensure privacy notices are drafted and published for all Council service areas involved in the processing of personal data;

- A communications exercise around the need for a DPIA should be performed following the completion of the new template. The executive decision form should be updated to require confirmation that a DPIA has been completed where this is necessary; and

- Management should ensure all Council supplier/third party contracts are identified, added to the contracts repository, and reviewed and updated to include mandatory GDPR clauses.

Conclusion

Based on the results of audit enquiries and testing, it is apparent that a significant amount of work has been undertaken to put in place the necessary systems and processes to enable the Council to comply with GDPR requirements.

Management were able to demonstrate a good level of knowledge and awareness of their obligations under GDPR and of the range of controls that have been implemented. Implementation of the five audit recommendations will help to move the Council further towards full compliance with GDPR.

Management Actions

Management has responded positively to the audit recommendations made.

Service Area: **Education**

Audit Activity: **Schools Whistleblowing**

Background

In accordance with Government requirements and the Local Authority's (LA) Scheme for Financing Maintained Schools (the Scheme) every school maintained by the LA should have a whistleblowing policy.

School employees are expected to give the highest possible standard of service to the public and to support Governors and fellow employees with impartiality. Whistleblowing policies protect staff members who report colleagues they believe are doing something wrong or illegal, or who are neglecting their duties.

Governing Bodies of maintained schools are responsible for agreeing and establishing the school's whistleblowing policy and ensuring that staff are made aware of the policy and how to use it should the need arise. The policy should state how, and to whom, whistleblowers are to report any incidences. A model Code of Conduct and confidential reporting policy (whistleblowing) is available on Schoolsnet, GCC schools intranet.

Scope

The purpose of the audit was to review the arrangements in place in GCC's maintained schools to ensure that they have an appropriate whistleblowing policy, which has been approved by Governors and communicated to all school staff.

Risk Assurance – Satisfactory

Control Assurance – Satisfactory

Key Findings

The Scheme states that all schools maintained by the LA should have a whistleblowing policy. The wording in the Scheme does not reflect the full scope that a whistleblowing policy should cover. In addition, not all schools have access to the whistleblowing policy on Schoolsnet, as access is dependent upon the level of traded service procured.

All schools are asked to complete an annual safeguarding audit, as required under Section 175 of the 2002 Education Act. Internal Audit was given permission by the Director of Education to add some questions relating to whistleblowing to the Section 175 audit questionnaire. All but two of the LA's 198 maintained schools completed the whistleblowing questions and the vast majority confirmed compliance with the whistleblowing requirements.

From the responses to the Internal Audit questions, a sample of 33 schools was selected and asked to forward documentation to Internal Audit to evidence their responses. In addition, two schools were visited by Internal Audit to review their evidence.

The total sample of 35 schools included the two schools who did not initially respond to the whistleblowing questions. One was visited by Internal Audit and the Head Teacher of the other school was contacted by phone. Documentary evidence was requested from both schools as with the other sample testing that was undertaken.

Out of the 35 schools selected for testing, only 30 provided copies of their whistleblowing policies, with the following findings:

- 14 had a policy based on the LA policy;
- 7 had a policy based on the LA policy but it was not up-to-date;
- 3 policies only covered safeguarding for children;
- 6 policies did not include appropriate information; and
- 7 policies had not been agreed by the Full Governing Body.

The above findings are contrary to the responses to the Internal Audit questions in the safeguarding audit as only one school answered 'no' to the question "Does your school have a whistleblowing policy that is based on the LA policy".

All of the schools who responded confirmed that their staff were aware of the policy and where it could be accessed.

Conclusion

The sample of schools selected for evidence testing equated to 18% of the total number of maintained schools. Although 70% of schools who submitted evidence had a whistleblowing policy based on the LA's policy, not all of them are regularly reviewing their policies to ensure that they include the most up-to-date information.

Once updates to the wording in the Scheme have been made and access to the whistleblowing policy on Schoolsnet has been made available to all schools, a reminder of the Government/LA requirements regarding whistleblowing should be issued, e.g. via Head's Up/What's Up Gov. This should include the need to have a whistleblowing policy that is not solely in relation to safeguarding issues.

Management Actions

Management has responded positively to the recommendations made in respect of the issues identified.

Service Area:	**Pensions**
Audit Activity:	**General Data Protection Regulation (GDPR)**

Background

The General Data Protection Regulation (GDPR) (Regulation (EU) 2016/679) is a regulation by which the European Parliament, the Council of the European Union and the European Commission intend to strengthen and unify data protection for all individuals within the European Union (EU). GDPR replaces the Data Protection Directive (officially Directive 95/46/EC) [2] of 1995.

The regulation was adopted on 27 April 2016 and became enforceable from 25 May 2018 after a two-year transition period. Unlike a directive, it does not require national government to pass any enabling legislation and is thus directly binding and applicable.

Scope

The aim of this audit was to review whether there is an effective framework in place for ensuring that personal information gathered in relation to Pensions processing activities is only used for the purpose for which it was originally intended.

The review sought to cover key GDPR elements including, but not exclusive to:

- Data protection policy;
- Compliance with Local Government Association (LGA) guidelines on pension scheme adherence to GDPR requirements;
- User awareness;
- Documenting data type, source and with whom it's shared;
- Individual's rights and Subject Access Requests (SARs);
- GDPR Supplier Contract Clauses;
- Protection of children's data;
- Data breaches; and
- Appointment of a Data Protection Officer (DPO) and local GDPR leads.

Information asset register, privacy by design and privacy impact assessments were also included in the original Pensions GDPR internal audit terms of reference. To avoid audit duplication, these areas have been reviewed and reported through the GCC GDPR internal audit report only.

Risk Assurance – Satisfactory

Control Assurance – Satisfactory

Key Findings

Discussion with key officers and review of supporting documentation has confirmed Pensions compliance with GDPR requirements and the application of good practice for the following areas:

- Key Council GDPR/data protection policies and procedures are in place and applicable to the Pensions section. There is no requirement for a separate Pensions policy/procedure document.
- Pensions staff have been made aware of GDPR requirements through a series of training exercises; communications and guidance issued via email, Staffnet (the Council intranet) and posters; and the Council policy management system.
- Awareness of GDPR changes to requirements around the handling and processing of Pensions data has been communicated externally to pension scheme holders via a user awareness campaign that included the use of newsletters.
- Employer bodies have been notified of changes to GDPR requirements via the bi-annual Pension Fund Employers Forum and through Local Government Pensions Committee produced bulletins sent to employers on a monthly basis.
- A Council-wide process was found to be in place for the handling of SARs in line with required timelines and a log of access requests is maintained.
- The contracts in place between the Council and the third party supplier of the pensions administration system (Altair) contain GDPR required mandatory clauses and references.
- The Council has a designated DPO in place, which covers the Pensions section. No official local GDPR leads are in place at the Council, however the Pensions Administration Manager is the nominated Pensions information asset owner and as such deals with any local GDPR related queries/issues.
- A documented breach reporting procedure was found to be in place at the Council. Audit walkthrough of a recent potential breach example reported by the Pensions team was found to have been appropriately processed according to the defined procedure.
- The Council's Local Government Pension Scheme (LGPS) privacy notice was found to meet the GDPR requirements around documenting the nature and purpose of the data processed, how the data is used and the Council's obligations in relation to the processing of the data.

The findings from this audit have identified some improvement actions to support Pensions ongoing compliance with GDPR requirements. The main areas that require attention are:

- The Local Government Association (LGA) recommends that a Memorandum of Understanding is produced, with the aim of setting out GDPR requirements and expectations between the Pension Fund and its constituent employers. A Memorandum of Understanding is not currently in place.

- Members' personal pension data is currently retained indefinitely (as declared within the Pensions privacy notice). Article 5 (e) of the GDPR states personal data "shall be kept for no longer than is necessary for the purposes for which it is being processed". It is recommended that Pensions management perform an exercise to review and/or seek further advice on the approach to the retention of pensions data to ensure that data is held for no longer than necessary.

- Scanned images of membership data and supporting documentation are stored in Altair in a format that means particular data and records cannot easily be separated out, for example in the event deletion of particular records is required.

- There is the opportunity to review paper file storage options, to mitigate residual risks regards Pensions data access outside of office hours.

Conclusion

The Pensions management team were able to demonstrate a good level of knowledge and awareness of their obligations under GDPR.

Four audit findings were identified that may potentially impact the sections ability to comply with GDPR requirements and relevant recommendations have been raised to support control improvement in these areas.

Management Actions

Management has responded positively to these recommendations made.

Service Area:	**Pensions - ICT**
Audit Activity:	**Pensions Information and Cyber Security**

Background

The Pension Fund Risk Register contains the risk 'failure to protect the Pension Fund's key information and data as a result of exploited technological vulnerabilities facilitated through malicious attack, primarily from external sources'. This review aims to provide assurance that relevant mitigating controls are in place and operating effectively.

Scope

The internal audit looked specifically at the ICT systems in use within Pensions (primarily the pensions administration system 'Altair') with a focus on user access control and security, in order to give specific assurance that the overall risk is being managed.

This included, but was not limited to, assessment of the following key areas and controls:

- Validity of user access rights and privileges;
- Password security settings
- Limit on failed login attempts;
- Restriction on access to administrator/superuser rights;
- Application activity logging; and
- Database/server security controls.

Risk Assurance – Satisfactory

Control Assurance – Satisfactory

Key Findings

At the time of the internal audit, the Altair system was in the process of being migrated to an upgraded version and moving from being an in-house managed system to being supported by the supplier "Heywood Limited". Internal audit testing was therefore primarily focussed on the user administration and application security elements that will remain the same both before and after the system migration.

It was noted in discussion with management that the system migration is intended to address and resolve a number of known ongoing issues with the support and performance of the pensions administration system that have arisen due to the age of the system and lack of recent security patching.

Internal audit review identified a number of areas of good practice:

- Appropriate and authorised Altair user access rights and privileges based on an officer's role;
- In year review of application user access rights by the Pensions Administration Manager;
- Password security requirements in place regards password expiry, restrictions on the reuse of old passwords and user accounts automatically lock in the event of five failed login attempts;

- Restriction on Altair administration access to two members of staff (however it is noted that the Pensions Administration Manager only leads on this role);

- Application activity logs and reporting enabling a detailed record of all user activity in the system and the interrogation of these logs by the system administrator as required; and

- Key database and server security controls were confirmed as in place, through the supplier information obtained by the Council as part of the project to migrate the system to the new platform (which required the supplier to provide full detail of how the solution addressed key security concerns and the controls in place to mitigate security risks) and the contract between both parties.

The internal audit has also identified two areas where there is the opportunity to further strengthen internal controls:

- Altair password security complexity – there is no minimum password length currently enforced and password strength is set to "mild", meaning that only four of a possible seven criteria must be met when setting passwords; and

- There are a number of key systems activities that only the Pensions Administration Manager has the expert knowledge to perform. While it is acknowledged that supplier support and system help documents are available which may enable a second system user to complete these activities, it is recommended that a deputy is nominated and trained in these tasks in order to minimise the risk of any disruption to services.

Conclusion

Based on the results of audit enquiries and testing, there are robust application security and user administration controls in place for the Altair system.

The two medium priority audit recommendations raised in the report will help to further enhance the existing control environment.

Due to the current project position regards Altair system data migration, pensions information and cyber security internal audit review of the upgraded Altair system will be proposed for consideration within the GCC Internal Audit Plan 2020/21.

Management Actions

Management has responded positively to the audit recommendations made.

Summary of Consulting Activity, Grant Certification and/or Support Delivered where no Opinions are provided

No audit assurance opinions on risk and control are provided in this section as this section relates to other audit activity such as statutory Chief Internal Auditor grant certification sign off and consultancy work i.e. where internal audit advise management on the risk and control environment in relation to new and emerging risks, projects, systems and processes to help 'design out' risk at the developmental stage.

Service Area:	**Strategic Finance**
Audit Activity:	**National Productivity Investment Fund Grant**

Background

Department of Transport (DfT) in 2017/18 made £2.696 million available to GCC through the National Productivity Investment Fund. This funding is part of the Local Transport Capital Block Funding, and is to be funded across two financial years starting in the first quarter of 2018/19. GCC received an allocation of £1,037,540 in 2018/19 from the National Productivity Investment Fund. Under the grant determination: No 31/3222, the grant:

- May be used only for the purposes that a capital receipt may be used for in accordance with regulations made under section 11 of the Local Government Act 2003; and
- Is required to be used for the purpose of works relating to the A38 Cross Keys roundabout capacity improvement and signalisation.

Scope

The Chief Executive and Chief Internal Auditor are required to return to the Department for Transport a declaration by 30th September 2019 in the following terms:

"To the best of our knowledge and belief, and having carried out appropriate investigations and checks, in our opinion, in all significant respects, the conditions attached to the Local Transport Capital Block Funding (National Productivity Investment Fund) Grant No 31/3222 have been and will be complied with".

The audit scope was to provide assurance that, in all significant respects, the conditions of the relevant Grant Determination have been complied with.

The period under audit review was 2018/19, with consideration of relevant internal audit findings from prior year.

Key Findings

- The Council received funding of £1,037,540 in 2018/19 under the Local Transport Capital Block Funding (National Productivity Investment Fund) grant scheme.
- In 2018/19 a total of £515,325.85 was spent against the Local Transport Capital Block Funding (National Productivity Investment Fund) grant scheme.
- Internal Audit has reviewed a sample of transactions covering 62.4% of the 2018/19 expenditure population and confirmed that the sampled expenditure was in accordance with the relevant DfT grant conditions.
- The remainder of the Local Transport Capital Block Funding (National Productivity Investment Fund) grant, £522,214.15 has been carried forward into 2019/20.

Conclusion

Based on discussions with officers and a review of records maintained by the Council, Internal Audit has gained appropriate assurance that the conditions of the grant determination have been met and as such the 2018/19 declaration can be signed and submitted to the DfT.

The balance of the Local Transport Capital Block Funding (National Productivity Investment Fund) grant, £522,214.15, has been carried forward into 2019/20. The remaining allocation of £1,658,460 is expected to be received by GCC in 2019/20 from the DfT.

This will provide a total of £2,180,674.15 of grant funding for 2019/20.

Management Actions

No management actions are required.

Service Area:	**Strategic Finance**
Audit Activity:	**Community Capacity Grant**

Background

In December 2012 the Department of Health (DoH) advised local authorities of their allocations under the Adults' Personal Social Services grant for 2013/14 and 2014/15. As part of this allocation, the Community Capacity (Capital) Grant provides capital funding to support development in personalisation, reform and efficiency.

GCC received a Community Capacity (Capital) Grant allocation of £1,360,488 in 2013/14 and £1,387,970 in 2014/15. The relevant Grant Determinations confirm the grant 'may be used only for the purposes that a capital receipt may be used for in accordance with regulations made under section 11 of the Local Government Act 2003.'

Scope

The Chief Executive and Chief Internal Auditor are required to return to the DoH a declaration by 30th June 2019 in the following terms:

- 'To the best of our knowledge and belief, and having carried out appropriate investigations and checks, in our opinion, in all significant respects, the conditions attached to the Community Capacity Grant No 31/2219 have been and will be complied with'; and
- 'To the best of our knowledge and belief, and having carried out appropriate investigations and checks, in our opinion, in all significant respects, the conditions attached to the Community Capacity Grant No 31/2393 have been and will be complied with'.

The audit scope was to provide assurance that, in all significant respects the conditions of the Grant Determinations have been complied with.

The period under audit review was 2018/19, with consideration of relevant internal audit findings from prior year.

Key Findings

- The Council received Community Capacity (Capital) Grant funding of £1,360,488 in 2013/14 and £1,387,970 in 2014/15.
- A total of £2,024,990.52 was brought forward into 2018/19.
- In 2018/19 a total of £13,470.33 was spent from the Community Capacity (Capital) scheme, with the remaining balance of £2,011,520.19 being carried forward into 2019/20.

Conclusion

Based on discussions with officers and a review of records maintained by the Council, Internal Audit has gained assurance that the conditions of the Grant Determinations have been fulfilled and as such the declaration can be signed and submitted to the DoH.

The remainder of the Community Capacity (Capital) Grant funding, £2,011,520.19 has been carried forward into 2019/20.

Management Actions

No management actions required.

Service Area: **Adults**

Audit Activity: **Social Care (Capital) Grant**

Background

Department of Health (DoH) in 2015/16 made circa £134 million available across all Local Authorities through the Social Care (Capital) grant. This funding is part of the Better Care Fund (BCF), but is allocated directly to councils by the DoH.

GCC received an allocation of £1,409,000 in 2015/16 from the Social Care (Capital) grant. Under the grant determination 2015/16: No 31/2534, the grant:

- May be used only for the purposes that a capital receipt may be used for in accordance with regulations made under section 11 of the Local Government Act 2003; and
- Is required to be transferred into the local BCF pooled budget, under section 75 of the NHS Act 2006, and spent in accordance with a NHS England approved BCF spending plan jointly agreed between the local authority and the relevant Clinical Commissioning Group(s).

Scope

The Chief Executive and Chief Internal Auditor are required to return to the Department of Health a declaration by 30th June 2019 in the following terms:

"To the best of our knowledge and belief, and having carried out appropriate investigations and checks, in our opinion, in all significant respects, the conditions attached to the Social Care Capital Grant No 31/2534 have been and will be complied with".

The audit scope was to provide assurance that, in all significant respects, the conditions of the relevant Grant Determination have been complied with.

The period under audit review was 2018/19, with consideration of relevant internal audit findings from prior year.

Key Findings

- The Council received funding of £1,409,000 in 2015/16 under the Social Care (Capital) grant scheme.
- A total of £568,102.51 was brought forward into 2018/19.
- In 2018/19 a total of £210,870.77 was spent against the Social Care (Capital) grant scheme in line with the agreement between GCC and the Clinical Commissioning Group and the joint spending plan for 2018/19.

- Internal Audit has reviewed a sample of transactions covering 100% of the 2018/19 expenditure population and confirmed that the sampled expenditure was in accordance with the relevant DoH grant conditions.

- The remainder of the Social Care (Capital) grant, £357,231.74 has been carried forward into 2019/20.

Conclusion

Based on discussions with officers and a review of records maintained by the Council, Internal Audit has gained appropriate assurance that the conditions of the grant determination have been met and as such the 2018/19 declaration can be signed and submitted to the DoH.

The remainder of the Social Care (Capital) grant, £357,231.74, has been carried forward into 2019/20. Capital expenditure in future years is planned to support replacement of IT and systems enhancements and replacements along with the project management and implementation costs.

Management Actions

No management actions are required.

Service Area:	**Children and Families**
Audit Activity:	**Caseload Management (Consultancy)**

Background

Following the OFSTED inspection in 2017, GCC has recruited additional Social Workers in order to reduce the average number of children being managed by Social Workers. The model that is currently in place within GCC is as follows:

- Team Managers – no children to manage other than by exception;

- Advanced Practitioners – a low number of children to manage (average six);

- Full-time equivalent (FTE) Social Workers – no more than 18 children at any one time; and

- Newly Qualified Social Workers (NQSW) under ASYE (Assessed and Supported Year in Employment) - having a gradual increase of children to manage.

As at April 2019, internal performance data showed that 29% of Social Workers were managing more than 18 children. The above caseload management model is going to be subject to review during 2019/20.

It was agreed by senior management that a caseload management survey would be conducted by Internal Audit, as opposed to a systems and control-type audit (as proposed within the original 2019/20 Internal Audit Plan), as this would be the most useful means to inform any changes that are introduced.

Scope

The objective of the survey was to review the Team Managers' case allocation processes to Social Workers and to gain an understanding of any barriers faced by Social Workers that could have an impact on effective and efficient caseload management.

Key Findings

- A Survey Monkey was developed for caseload management that covered all of the appropriate localities/areas and grades of staff;
- Ten survey questions were created that addressed the criteria that are taken into account and applied when allocating children and the barriers that exist for effective caseload management;
- Approximately 300 members of staff (given constant staff turnover) were in scope for completing the survey. A total of 104 responses were received which equates to a response rate of approximately 35%. Responses were received from all five localities/areas and all grades of staff;
- From the first set of questions that were asked, the following were the highest scoring results:

QUESTION	**HIGHEST SCORING RESULT**
For Team Managers only - Which of the following criteria do you apply when allocating cases	Social Worker experience
For Team Managers only - Do you apply any initial oversight following case allocation	Yes
For Team Managers only - How is your case allocation applied	An initial face-to-face conversation
For Advanced Practitioners only - Are your caseloads manageable alongside your other responsibilities for supporting other workers	Rarely
For all staff - What is the fairest criteria to use in case allocation	Complexity
For all staff - Does travelling have an impact on your ability to hold cases	Sometimes
For all staff - Is it easier to manage sibling groups or individuals	There is no difference
For all staff - What other barriers are there to managing caseloads	Complexity

- A number of the above questions also had free text options. The responses were analysed in detail and so as not to lose the value of these comments, they were all provided to senior management under separate cover to the report.

Conclusion

The caseload management survey provided useful and interesting feedback which has been provided to senior management so that it can be used to inform any changes that are being considered for the current caseload management model.

Management Actions

Not applicable

Service Area:	**Strategic Finance**
Audit Activity:	**Growth Hub Funding 2018/19 Grant**

Background

The Department for Business, Energy and Industrial Strategy (BEIS) letter dated 10th May 2018 confirmed 'Growth Hub Funding to Local Enterprise Partnerships in 2018/19'. The grant offer letter offered £205,000 to GCC (the Accountable Body) for the period 1st April 2018 to 31st March 2019. Grant offer acceptance was completed by the Council.

The grant is specifically for the giving of advice to business by GFirst Local Enterprise Partnership (LEP) by supporting the further development of growth hubs, aligned to Government's objective to simplify access to support for businesses (the Project).

Scope

The 10th May 2018 BEIS grant offer letter states that:

'Confirmation is required that in the course of the Project, the Accountable Body has expended the sums in respect of which Grant claims were made in undertaking the Project and that all goods and services were received by the Accountable Body by 31st March 2019 and paid for by 24th May 2019. For this purpose a report from an accountant must follow the final claim for the Grant and be submitted to BEIS by no later than the 24th May 2019. The accountant's report must be submitted in the format specified in Schedule 2 and prepared by a professionally qualified member of the Accountable Body's own audit team'.

The Growth Hub Funding 2018/19 internal audit review was designed to meet the above BEIS requirements.

Key Findings

- The internal audit was delivered and reviewed by ICAEW FCA professionally qualified members of the ARA Shared Service team.

- The review confirmed that the 2018/19 year end return and previously submitted in year claims for payment (totalling £205,000) were in accordance with the BEIS offer letter and annex B criteria. Audit trail review also confirmed that none of the costs were incurred before 1 April 2018.

- It was noted that the evidenced GFirstLEP project expenditure for 2018/19 totalled £205,383.09 (excluding VAT). The expenditure in excess of £205,000 was incurred within the labour spend category and was funded directly by GFirstLEP.

Conclusion

The Growth Hub Funding to LEP in 2018/19 – Accountant's Report was submitted to the BEIS as at 17th May 2019 in line with the grant offer letter requirements. No issues were raised within the Accountant's Report.

Management Actions

Not applicable.

Service Area:	**Community Safety**
Audit Activity:	**Fire and Rescue Authorities Grant**

Background

The Department of Communities and Local Government (DCLG) has historically provided funding to local fire authorities to assist in the acquisition of replacement appliances and other capital related projects. In this respect, the Council has received the following grants:

- Grant Determination: 2011/12 (No. 31/1992) £1,700,000; and

- Grant Determination: 2014/15 (No. 31/2322) £822,361.

Scope

This audit reviewed relevant grant expenditure incurred in 2018/19. The aim was to provide reasonable assurance to the Chief Finance Officer that the conditions attached to the grant determinations have been complied with to enable the 2018/19 annual declaration to be signed and submitted to the DCLG.

Key Findings

- Grant carry forward into 2018/19 was £244,039.10.

- £94,824.64 has been expended against both Grant Determinations for the Fire and Rescue Authorities Grant in 2018/19 for relevant capital expenditure.

- Audit review confirmed that expenditure from these grants during 2018/19 has been monitored by Strategic Finance and appropriate records maintained.
- Audit sample testing reviewed 97.9% (£92,859.82) of grant expenditure from 2018/19. Testing identified a revenue expenditure of £6,128 not in accordance with the grant determinations. The remainder of the sampled expenditure was inline with the grant determination capital expenditure requirements.
- £6,128 of identified revenue expenditure was removed from the capital grant allocation leaving total expenditure of the grants at £88,696.64.
- £155,342.46 has been carried forward in 2019/20.

Conclusion

From sample review of the 2018/19 grant expenditure, Internal Audit was able to gain assurance that the expenditure of £88,696.64 has been appropriately classified as a capital related item. Consequently, Internal Audit is able to conclude that the conditions attached to the respective grant determinations have been complied with within 2018/19.

Management Actions

No management actions are required.

Summary of Special Investigations/Counter Fraud Activities

Special Investigations/Counter Fraud Activities

The Counter Fraud Team within Internal Audit has received 13 new referrals in 2019/20, to date, and also continued to work on 10 cases from previous years. One of the brought forward cases plus seven of the new cases referred in 2019/20 has now been completed. None of these cases have previously been reported to Audit and Governance Committee.

The service areas of the cases referred to Internal Audit within 2019/20 to date are categorised as follows: Adults (6); Children and Families (4); Council Wide (1); and Communities and Infrastructure (2).

Previous years' referrals

The one case closed in the current year, which was brought forward from 2018/19, involved the procurement of broadband and ICT support contracts for a group of schools. There was no evidence of fraud but the broadband provision contract had been signed by a member of staff who had exceeded their delegated powers financial limit and it appeared to be expensive. This contract is being reviewed by Legal Services to investigate whether or not there are grounds to exit the contract without penalties.

Current year (2019/20) referrals

Of the current year's closed cases, two involved the personal use of a Council owned vehicle by a member of staff. In the one case management was aware and had allowed limited personal use of an assigned vehicle before/after work but this is against GCC policy and would lead to Council and personal tax implications if continued. The practice has therefore been stopped. In the other case, which was a one-off use usage, permission had not been sought from management and disciplinary action has been taken against the individual.

In one other case a Headteacher had been paid for additional work undertaken in another school as an expense instead of through payroll which would then have ensured PAYE deductions. This has now been rectified by reversing the expense payment and paying it as an additional payment subject to PAYE, and informing the Headteacher and Chair of Governors that all salary payments must be subjected to PAYE.

The fourth closed case involved home to school transport where a parent was paid an agreed amount to transport their child to school, through a personal travel allowance (PTA). The parent had stated they could not drive and were paid an enhanced rate to enable them to use a taxi. The parent was later seen by staff driving their child to school. The parent denied doing this consistently but the rate has now been dropped to the usual amount paid to parents in receipt of a PTA, which is almost £50 per day less than was being paid.

The fifth closed case involved a National Fraud Initiative (NFI) match which identified a full time GCC member of staff also being paid by another public body. NFI data uploaded had indicated that the individual was contracted to work two days per week for the other public body but, even though they had uploaded this data, they advised that there was no intention that the individual would work a specific number of hours but a monthly fee payment was paid to cover the work undertaken. Permission had not been sought from a Director, by the individual, to work in secondary employment although this has now been rectified retrospectively.

No irregularity was identified with the final two closed cases investigated, which concerned procurement and a blue badge application.

Many of the cases referred to Internal Audit involve intricate detail and Police referral. This invariably results in a delay before the investigation can be classed as closed and reported to the Audit and Governance Committee. Internal Audit has also experienced lack of engagement with some cases referred to Action Fraud.

National Fraud Initiative (NFI)

Internal Audit continues to support the NFI which is a biennial data matching exercise administered by the Cabinet Office. The latest data collections were uploaded to the Cabinet Office throughout October 2018 and data matching reports became available for review from January 2019 onwards. Examples of data sets include insurance, payroll, creditors, pensions, care provision, blue badges and concessionary bus passes. Not all matches are investigated but where possible all recommended matches are reviewed by either Internal Audit or the appropriate service area. Reviews are still in progress.

As reported earlier in the year a number of pension overpayments have been identified through NFI, matching death data and pension payments, although many cases were already known to the Pensions team and the pensions had been suspended. In total 19 unknown cases with a value of approximately £19k were identified through the NFI exercise.

Two payroll to payroll matches with other public bodies were also identified, including the one mentioned above within the closed cases paragraph. The other case identified a member of staff claiming sick pay from the other public body, whilst still working for GCC. This case is still ongoing.