PROGRESS REPORT ON INTERNAL AUDIT ACTIVITY

July 2024

1. Introduction

1.1 The Council's Internal Audit service is provided by Audit Risk Assurance (ARA) under a Shared Service agreement between Gloucestershire County Council (GCC), Stroud District Council and Gloucester City Council.

1.2 ARA provide these services in accordance with the Public Sector Internal Audit Standards 2017 (PSIAS) which represent the "proper Internal Audit practices". The standards define the way in which the Internal Audit service should be established and undertake its operations.

1.3 In accordance with the PSIAS, the Head of ARA is required to regularly provide progress reports on Internal Audit activity to management and the Audit and Governance Committee. This report summarises:

i. The progress against the Internal Audit Plan 2024-25 (Appendix B);

ii. The outcomes of the 2024-25 Internal Audit activity delivered up to 28th June 2024 following the last audit Committee meeting in April 2024; and

iii. Special investigations and counter fraud activity.

1.4 Internal Audit plays a key role in providing independent assurance and advice to the Council that these arrangements are in place and operating effectively. However, it should be emphasised that management are responsible for establishing and maintaining appropriate risk management processes, control systems (financial and non-financial) and governance arrangements.

1.5 The following Assurance criteria are applied to Internal Audit reports:

Substantial	Acceptable	Limited	No
• All key controls are in place and working effectively with no exceptions or reservations. The Council has low exposure to business risk.	• All key controls are in place and working but there are some reservations in connection with the operational effectiveness of some key controls. The Council has low exposure to business risk.	• Not all key controls are in place or are working effectively. The Council has a medium to high exposure to business risk.	• No key controls are in place, or no key controls are working effectively. The Council has high exposure to business risk.

2. Summary of 2024-25 Internal Audit work delivered up to 28th June 2024

2.1 Table 1 below summarises the audits delivered up to 28th June 2024, since the previous Committee in April 2024.

Audit	Assurance Level	No. of Recommendations				Supporting Paragraph
		High	Medium	Low	Rejected	
Asset Valuation	Substantial	0	0	0	0	2.2
Voids within OSJ Homes	Acceptable	2	4	0	0	2.3
Financial Approval Process for Placing Children in Care	Acceptable	1	3	1	0	2.4
Event Alerting	Acceptable	0	3	0	0	Exempt (Annex 1)
Local Authority Maintained Schools	Substantial – 1 Acceptable – 3 Limited - 6	52	37	0	2	2.5
Health & Safety Risk Assessment for Agile Workers	Limited	4	0	0	0	2.6
Grant Certification (Service Areas: EEI and Adult Services)	Grants Certified	0	0	0	0	2.7
Direct Payments (Children's) 2nd Follow Up	N/A	N/A				2.8

Table 1 – Summary of audits delivered to date

Summary of Assurance Opinions

2.2 Audit Activity: Asset Valuation (Service Area: Corporate Resources)

2.2.1 **Scope** – The audit reviewed the procedures and controls in place in regard to the Asset Valuations of property assets within the fixed asset register.

2.2.2 **Key Findings**

i. The Council's Annual Accounts have the prescribed detail notes on non-current (fixed) assets. For the 2022-23 Accounts, infrastructure assets were listed separately as required by the update to the Code on Infrastructure Assets. Notes to the accounts detail the accounting policies and treatment of property assets, including their valuation and depreciation arrangements.

ii. The Council revalue all property assets on a two year rolling programme, with all assets being reviewed annually for any impairment. In 2022-23 there was a full revaluation for all non-school assets and in 2023/24 there is a full revaluation of all school assets.

iii. It was verified that there was a signed *Instructions to the Valuer Conditions of Engagement* letter for 2022-23, and:

- The 2023/24 Conditions of Engagement had been updated with regards to the requirements of Financial Reporting Exposure Draft 82 relating to changes in leases which may potentially impact on valuations; and

- The engagement letter clearly defines the requirements and information to be included in the valuation report. The 2023-24 valuation report has not yet been drafted, as this cannot be completed until all the individual valuation reports have been completed. It was verified that individual valuation reports are produced using a standard template that includes site photos, details on the valuation including the apportionment between land and buildings. When completed valuations are signed by the independent valuer who includes their RICS membership number.

iv. It was confirmed for ten valuations that each showed the calculations of the valuation, including the apportionment of the value between the building and land elements. It was verified that site and building plans were held on the ten valuations reviewed and the valuation reports state the date of the site visit and contain photographic evidence of the site and buildings.

v. The three points raised by External Audit in their 2022-23 management letter related to fixed assets have been addressed. These were specific issues relating to three individual sites and not seen as systemic or wider control matters.

2.3 **Audit Activity: Voids within OSJ Homes (Service Area: Adult Services)**

2.3.1 **Scope** - This audit review was to provide independent appraisal of the Council's arrangements with regards to void beds within Order of St Johns (OSJ) run care homes. GCC have a 35-year contract with OSJ to provide care within Council owned care homes. GCC purchase 60% of the beds within nine of these care homes for service users. However, if there are beds which are unoccupied or GCC uses over 70% of the beds across districts, charges are incurred by the Council.

2.3.2 **Key Findings**

i. From discussions with the Brokerage Team, Internal Audit were made aware that the reconciliation process was under review. Brokerage were attempting as of March 2024 to complete a full reconciliation of a void invoice from OSJ to be able to confirm the accuracy of the charges incurred.

Risk: Overpayments of voids charges, potential financial lose to GCC.

Recommendation: The reconciliation process should be completed. Once completed, the previous 18 months of invoices should also be reviewed in line with the agreement currently in place for invoice queries held between GCC and OSJ.

ii. Since 2022 there had been a number of care home closures, in addition to capacity changes. This has led to changes in the number of beds that GCC would guarantee as well as the number of beds above which GCC would pay a premium. These were recorded in Schedule 4 and 5 documents as part of the contract. The schedules had not been reviewed or amended subsequent to the most recent care home closures in November 2022.

Risk: Overpayments of voids charges, potential financial lose to GCC.

Recommendation: A yearly review should be undertaken by Brokerage alongside OSJ to determine the number of beds available, with this captured within the Schedule 4 document. This should be recorded and agreed by both parties for the year ahead. Should there be a significant change in any of the care homes in year, the Schedule 4 should be reviewed and amended at the earliest possible time to ensure the document is kept up to date. At the same time the Schedule 5 document should be reviewed and agreed between GCC and OSJ.

iii. Review of the most recent Schedule 4 document identified that the Forest of Dean care home had a committed bed figure that included a fractional amount of 46.8 beds.

Risk: Added complexity to the process of reconciliation of invoices received when having to deal with figures related to fractional bed numbers.

Recommendation: Fractional numbers for committed beds should be avoided and rounded either up or down through agreement between OSJ and GCC.

iv. OSJ inform GCC of the number of free beds (that would incur voids charges). Staff within Brokerage were aware that these were not broken down in such a way to be able to identify the type of bed. This meant that brokerage may spend time identifying an individual for a bed when in fact it was not an appropriate bed for the service user.

Risk: Ineffective use of Brokerage time when identifying potential places for service users that could turn out to be unsuitable.

Recommendation: GCC and OSJ should discuss and agree on the best way for providing the data to Brokerage on bed capacity. This should include a breakdown of the types of beds to better assist Brokerage in then being able to effectively fill the empty beds.

v. Data provided by OSJ show the committed bed figures by district. This method could complicate how empty beds within care homes can appear. This was due to the over 70% capacity (premium charges) rule being worked out across the district and not the care home in isolation. Therefore, it is not always easy for brokers to establish if a potential vacancy within certain care homes could trigger additional charges to GCC via premium rates.

Risk: Financial loss due to premium charges being incurred through the way districts calculate committed beds.

Recommendation: If a similar situation was to arise in the future, GCC should consider how the bed allocation is calculated.

vi. It was identified that although voids and premium charges as well as capacities were being recorded and monitored, this was not being reported to management for scrutiny.

Risk: Potential lack of scrutiny and challenge by management could lead to being unable to take action to try to avoid potential overspend.

Recommendation: Brokerage should ensure that a report (monthly or quarterly) is provided to senior management for the ability to review and scrutinise the performance against the GCP Contract. Brokerage management should review whether some specific KPI's could be introduced for the purpose of monitoring performance against the GCP Contract.

2.4 Audit Activity: Financial Approval Process for Placing Children in Care (Service Area: Children's Services)

2.4.1 **Scope** - This audit reviewed the procedures and controls in place regarding financial approval processes for placing children in care. The audit covered both in-house and external placements with a greater focus on the latter.

2.4.2 **Key Findings**

i. Roles and responsibilities in the placement pathway have been clearly defined and identified within 'A Gloucestershire Right Placement First Time Guide' (the Guide). This was evidenced through sample testing of 54 placements (27 in-house and 27 commissioned). Segregation of roles was confirmed in the various stages of the placement pathways in relation to completion of documentation, review, and the approval process.

ii. The current processes adopted for financial approval of placements are neither in line with those stipulated in the Guide nor formally captured in a procedure document elsewhere. For example, the Guide provides that further authorisation is required from the Assistant Director for Integrated Children and Families Commissioning where placements exceed £4,500 per week. This is now being undertaken by the Sign Off Panel.

Risk: Inconsistency in practices could occur.

Recommendation: The current process adopted for the financial approval of placing children in care should be appropriately documented to provide staff with the requisite instructions. This should also detail the financial approval process within the existing procedures showing clearly mapped out roles and responsibilities.

Reference to the requirement for the Assistant Director for Integrated Children and Families Commissioning to sign off high-cost placements should be removed.

iii. Currently, there is a lack of clarity within the Guide in respect of the financial approval process and the involvement of Budget Holders in determining the availability and management of funds.

Risk: The financial approval process and responsibilities of Budget Holders are not well defined.

Recommendation: The roles and responsibilities of the Sign Off Panel, including those of Budget Holders, should be appropriately defined within the Guide.

iv. A sample of ten Sign Off Panel minutes was reviewed in relation to the approval of the cost of placements. The minutes of the Panel do not record who attended the meeting. This is especially significant to confirm Budget Holder attendance and that a quorum for the meeting was met. Furthermore, in two out of ten (20%) sets of minutes examined, the costs agreed for the placements were not recorded or evidenced in any other way.

Risk: Inadequate evidencing of the responsibility for the financial decisions made.

Recommendation: The Sign Off Panel minutes should include information on the members who were present at every meeting. All decisions made should be recorded, including any Budget Holders who made them. The Sign Off Panel minutes should, at all times, include information on any costs agreed for the child placements.

v. In 25 out of the 54 cases examined (46%), involving in-house, external, new, and moving child placements, the costs involved had not been recorded in LiquidLogic. Financial information in respect of child placements was not accessible to all users.

Risk: Incomplete records could result in a lack of management information for reporting purposes.

Recommendation: Records in LiquidLogic should at all times show the agreed cost of placements to provide the requisite information to all users.

vi. Although the service area is aware of the financial risks associated with placing children into care, there are no formal operational risk registers for the management of such risks.

Risk: Risks may be overlooked or not adequately managed.

Recommendation: Management should undertake a formal exercise to identify risks associated with the financial costs of placing children in care and record them in an operational or Directorate risk register. The risks and the effectiveness of the controls for managing them should be regularly reviewed.

2.5 Audit Activity: Local Authority Maintained Schools (LAMS) (Service Area: Children's Services)

2.5.1 **Scope** - The Council's Chief Financial Officer (S151) is required to submit an annual return to the Department for Education confirming that there is a system of audit in place for schools. The return confirms whether there is adequate assurance over the schools' standards of financial management and the regularity and propriety of their spending. Internal Audit provides independent assurance as to the effectiveness of these financial management arrangements within the schools audited.

2.5.2 ARA has consistently allocated 7% of the productive plan days to LAMS audits. Due to Covid, schools' audits were delayed and subsequently delivered on an academic year

basis. However, during 2023-24, schools' audits reverted to being delivered on a financial year basis. As such, this reporting period covers audits that were delivered during the 2022-23 academic year and the 2023-24 financial year.

2.5.3 Internal Audit's activity within schools is prioritised by risk. Due to the financial risk of the academisation of schools, the then Director of Children's Services requested that all schools with an actual deficit at the start of 2022-23 should be audited. As such, 14 primary schools and one special school were selected for audit. By July 2023, six audits were finalised, and the outcomes reported to the Audit and Governance Committee. The remaining nine 2022-23 audits, plus a further two audits, were delivered during the 2023-24 financial year. Of the 11 audits, one remains in draft form, so this report includes the outcomes for the ten audits that were finalised.

2.5.4 The themes selected to support the financial risk of academisation were:

i. Governance and Budgetary Control;
ii. Purchasing;
iii. Income (including breakfast and after-school clubs); and
iv. Staffing and Payroll.

2.5.5 **Key Findings**

Below is a summary of the key themes from the schools that were audited:

i. Governance and Budgetary Control:

- Register of Interest forms are not completed by all the Governors and the Headteacher and the register is not published on the school's website;
- The Full Governing Body (FGB) agenda did not include, as a standing item, the requirement to declare any interests;
- Governors were provided with a Chart of Accounts report but it did not include any supporting narrative;
- No evidence from the minutes confirming that the FGB had reviewed and approved the Schools Financial Value Standard (SFVS) and Governors' Budget Plan (GBP). These documents were not always submitted to Gloucestershire County Council (GCC) by the deadline date;
- School policies are not being reviewed on a regular basis;
- The FGB and Committee minutes are not signed as correct at the subsequent meeting and retained;
- The Finance Committee Terms of Reference (TOR) does not clarify the Committee's responsibilities and is not approved by the FGB; and
- Reports from the Finance Committee are not being presented to the FGB.

ii. Purchasing:

- Orders are not always raised on the accounting system and therefore commitments are not shown.
- The Finance Policy is not consistently followed for obtaining approval for orders, involving Governors where required and ensuring all decisions are recorded in the Governor minutes.

- The required His Majesty's Revenue and Customs (HMRC) employment status checks are not completed prior to an individual's engagement to undertake work at the school.
- Information provided by GCC is not being consistently used to support reconciliations to local reports. Where these reconciliations are undertaken, there is a lack of evidence of the checks being performed.
- No Contract Register with sufficient details to support robust contract management.

iii. Income:

- The Finance Policy does not include guidance on the procedures to follow when managing income. This resulted in debtor invoices not being raised, debts not being monitored and managed, income not being correctly banked, income received not reconciled to financial reports from GCC, and payment terms not added to invoices.
- No Lettings Policy in place which could lead to maladministration, incorrect decisions and actions being taken.
- Cash kept on site often exceeds insurance limits.
- Wrap-around care payments deposited into the school fund account are not regularly transferred to the school's GCC bank account. There was also no reconciliation of payments received for wraparound care to attendance records.

iv. Staffing and Payroll:

- The process for submitting and approving claims is not robust, for example claim forms had been completed in advance of the activity and were not dated. Headteachers had authorised their own claims or failed to obtain Chair of Governor's approval.
- There is a lack of oversight by Headteachers of the payroll changes or claims process. This included there being no evidence of authorisation or reconciliation of the payroll reports by the Headteacher.

2.5.6 **Management Actions**

2.5.7 Individual reports were issued to each school audited for which management responses were obtained and agreed.

2.5.8 Two medium risk recommendations were rejected as detailed in Table 1 previously.

i. The first recommendation related to the removal of the school Business Manager as a cheque signatory on the school fund account to maintain appropriate segregation of duties. This was rejected due to compensating controls being in place whereby the Headteacher, Chair of Governors or Deputy Headteacher initially signing the cheque.

ii. The second recommendation related to the school raising purchase orders on the finance system. This was not accepted due to the school Business Manager capacity and quick turnaround between orders, delivery and processing of invoices.

2.5.9 On an annual basis, the Governing Bodies whose schools were audited are required to provide a progress update on the implementation of the agreed recommendations. A summary report of the outcomes is presented to the Audit and Governance Committee by an Education officer, providing assurance that processes are in place to manage Internal Audit identified risks. The annual assurance report for the 2022-23 and 2023-24 audit recommendations will be presented to the July 2024 Audit and Governance Committee.

2.5.10 **Publication of audit findings**

2.5.11 The common themes from the 2022-23 and 2023-24 school audits will be published on Schoolsnet (the Council's schools intranet) and in the 'Heads Up' and 'What's Up Gov' newsletters. This will enable the schools to undertake a self-assessment against the findings identified and implement improvement actions to address the risks, should they apply.

2.5.12 **Collaborative working**

2.5.13 Within 2023-24, ARA continued to work with the following service areas in the Council to ensure a joined-up approach when delivering Internal Audit services to schools:

i. Children's Services Senior Leadership Team, including the Director of Education – to provide periodic progress updates on the completion of the Children's Services Internal Audit Plan and to agree the annual risk-based focus for schools audits.

ii. Director of Partnerships and Strategy – to provide regular progress updates in relation to the Children's Services Internal Audit plan including schools audits.

iii. Governor Services – to collaborate on matters arising when planning or reporting on schools audits.

iv. Area Finance Officers – for information exchange on individual school audits and to provide internal control advice.

v. Education Data Hub – to maintain and build on the annual schools' risk assessment process.

vi. School Improvement – for information exchange and to obtain support and advice for schools causing concern; to collaborate on the schools' annual assurance statements for the implementation of recommendations made.

vii. Counter Fraud – for information exchange and to make referrals for suspected fraud and irregularity.

viii. GCCPlus Traded Services – to further develop an Internal Audit traded service for Academies and LAMS. During 2023-/24, 11 Internal Audits were completed at Academies and LAMS on a traded basis.

2.6 Audit Activity: Health and Safety Risk Assessment Process for Agile Workers (Service Area: Corporate Resources)

2.2.2 **Scope** - The audit reviewed the procedures and controls in place in regards to Health and Safety Risk Assessments of Agile Workers.

2.2.3 Health and Safety 1974 legislation applies to agile workers and is one of a duty of care by the employer. Health and safety responsibilities will apply equally to home workers as to other office-based workers. Risk Assessments are therefore a requirement for home workers' workstations. The Health and Safety Act 1974 requires every employer to have a written policy with respect to the health and safety at work for their employees. The employer is to bring the policy and any revisions to the notice of their employees.

2.2.4 **Key Findings**

i. The Safety, Health and Environment (SHE) Team have produced a Corporate Policy titled "Health and Safety Policy Document". This policy includes the arrangements for Agile Workers and Risk Assessments. The Council is therefore compliant with health and safety legislation because it has a Health and Safety Policy Document available. The SHE Team bring health and safety matters to the attention of staff and assist them with their risk assessments and outcomes arising. GCC Staffnet provides guidance for Display Screen Equipment (DSE) and home working and internal newsletters have been issued for Celebrating Agile Working and Health and Safety when Working Remotely.

ii. The Council's Health and Safety Policy Document requires the risks to home workers to be assessed. In addition, there is information and advice available to managers and their staff who may work from home. Managers are required to have regular contact with home workers to prevent them becoming isolated and to check on their wellbeing. This will include confirming they have a safe place to work and have the equipment required to work. The underlying process which informs safety management is risk assessment. Risk assessment is a line management responsibility. The SHE team monitors all assessments that are completed to identify any that do require follow up.

iii. The SHE team has procured an online off-the-shelf solution called Evotix Assure, a safety management system which the Council uses for accident reporting and procedural audits. The audit module allows SHE to develop questionnaires and checklists. Display Screen Equipment (DSE) risk assessment checklists have been developed for two distinct kinds of worker. Staff only need to complete the type that reflects their working pattern. Audit testing shows that collectively over 60% of employees have not completed a workstation assessment during 2023 (either for agile working or an office workstation).

Risk: Without proper risk assessments, the likelihood of accidents and incidents by agile workers increases. This not only affects the well-being of employees but may also lead to employees needing time off work, compensation costs and a loss of productivity.

Recommendation: A check and confirmation process by line managers to verify that all their staff have undertaken risk assessments as required by the Health and Safety Policy Document should be introduced

iv. Staff can (and should) access and complete the self-assessment checklist of their working set-up via a portal. As per the policy, it is line managers' responsibility to ensure that staff complete the checklists. The SHE team does not monitor whether individuals have completed their DSE checklist assessment annually, nor whether line managers have checked and verified that they have been completed.

Risk: Not complying with (or enforcing compliance to) the Council's Health and Safety Policy Document could be seen as a breach of employment conditions. Therefore the Council is more vulnerable to enforcement action.

Recommendation: A procedure or process should be introduced to verify that managers and staff have complied with the Health and Safety Policy Document regarding annual risk assessments for display screen equipment.

v. There is no central log of agile workers to enable the monitoring of the completion of Health and Safety Risk Assessments. The Council does not have detail of who has not completed a risk assessment. Nor does it have a register of all staff on the Evotix Assure system. Consequently, there is no comprehensive record of staff completing health and safety risk assessments as required by the Health and Safety Policy Document.

Risk: Not recording risk assessments may lead to failure to identify hazards, to assess the risks that are associated with those hazards, and to provide solutions that agile workers can take.

Recommendation: A comprehensive record should be established for all staff which identifies that a risk assessment has been completed and actioned.

vi. The Council does not have a robust system in place to ensure and confirm that all members of staff have undertaken a risk assessment and adequately managed the risk. Compliance levels are currently not adequate , despite SHE reporting regularly on this.

Risk: Without adequate monitoring, oversight and review of Health and Safety matters it is not possible to see whether the measures implemented have reduced risks effectively.

Recommendation: The SHE team should take a more proactive role and closely oversee the process. This would help managers improve compliance with the Risk Assessment requirement of the Health and Safety Policy Document.

Summary of Grant Certification and Follow Ups where Assurance Opinions are not provided

2.7 Audit Activity: Grant Certification (Service Areas: EEI, Adults)

2.7.1 **Scope** – The audit reviewed whether the conditions of the relevant grant determinations had been complied with during 2023-24. The following individual grant certifications have been completed:

i. Growth Hub;
ii. Community Capacity Grant; and
iii. Contain Outbreak Management Fund (COMF).

2.7.2 **Key Findings**

i. Internal Audit review confirmed that expenditure during 2023-24 had been monitored by Strategic Finance and appropriate records maintained;

ii. Where appropriate, Internal Audit tested a sample of expenditure from the grants. Expenditure was in accordance with the grant conditions; and

iii. Internal Audit gained appropriate assurance that the conditions of the grant determinations had been met. Therefore, declarations were signed and submitted to the relevant Departments.

2.8 **Audit Activity: Direct Payments (Children's) 2nd Follow Up (Service Areas: Children's Services)**

2.8.1 The audit followed up the implementation of five recommendations made from the first follow-up audit that was finalised in 2022-23. Three recommendations were high priority and two were medium priority. The final report for the second follow-up audit was issued in July 2024 where it was confirmed that the five recommendations had been implemented.

2.8.2 Recommendation one (high priority) related to the direct payments (DP) process documents and flowchart requiring update to reflect the management of both one-off and ongoing payments. From reviewing the Children's Social Care Direct Payments Policy and Process document, it was confirmed that the agreed actions had been implemented.

2.8.3 Recommendation two (medium priority) related to the Service Level Agreement and DP flowchart requiring update to reflect the process for ending DPs and closing the Payment Card Accounts. Management confirmed the closing of Payment Cards is an action following the review of DP accounts and involves an email to the Finance Officer to close. This, together with the documentation reviewed for recommendation one, confirmed the action had been implemented.

2.8.4 Recommendation three (high priority) related to the recording, monitoring and reporting of DP Service Users' 12-month reviews. A checklist was also recommended to be implemented to ensure that all reviews are standardised. A process has been developed for the monitoring of DPs that was approved by the Head of Service and Service Manager. This includes identifying when the 3- and 12-month reviews are due and have been completed. The outcomes from the tracking and monitoring spreadsheet will be reported to the Head of Service and Service Manager for review and action on a regular basis. Evidence was seen of Performance Surgeries taking

place monthly where senior managers are present to review reports. A review checklist is also in place.

2.8.5 Recommendation four (high priority) related to the closing of four payment cards that had been identified as part of testing in the previous audit. The Task Lead – Finance confirmed that the four card holders' accounts had been closed and the balances reclaimed. The spreadsheet evidence showed that the four card holders no longer appeared on the quarterly financial report used for monitoring DP excesses being held in the accounts.

2.8.6 Finally, recommendation five (medium priority) related to the requirement for oversight of DPs by management through a quarterly reporting procedure. Management provided evidence that quarterly meetings, with a revised format, are now in place for financial oversight of DPs. This was also confirmed through a review of evidence provided for recommendation three.

3. Counter Fraud Update – Summary of Counter Fraud Activities

Current Year Referrals

3.1 Table 4 below summaries the 2024-25 referrals and subsequent action taken by the ARA Counter Fraud Team (CFT) following review.

Referrals Received in 2024-25	Closed Referrals	Closed Referrals Previously Reported	On-going Referrals	Referrals converted to cases
13	4	0	9	0

Table 4 – Summary of CFT Referrals

3.2 All referrals are reviewed. Following initial triage by the CFT some may only require light touch such as advice or guidance. Where more in-depth investigation is required, the referrals are converted to cases.

3.3 Please note that, on occasion, information is such that a case is started from the onset and the referral stage is bypassed. This could result in a difference between the 'number of referrals converted to cases' and the 'number of cases worked on'. In addition, there may be some cases that were started in prior years but continue to be worked on in subsequent years.

3.4 Closed referrals not been previously reported to the Audit and Governance Committee:

i. The CFT and Debt Recovery Team have been working together to recover outstanding debts to the Council and reduce the number of debts having to be written off. The referral was a request to identify an alternative address for the debtor. No alternative address could be found on this occasion, although a potential email address was identified and provided to the team.

ii. In the second referral the CFT were asked by the Childrens and Families Team to review a concern that a mother who had presented to Children' Services as

homeless and destitute when there was evidence to suggest that she had over £5,000 in the bank. The CFT identified several mitigating circumstances and as a result no further involvement was required. The CFT signposted the mother to the correct services and updated the teams involved; and

iii. Following initial triage by the CFT two further referrals were considered to be outside of the CFT's remit. In agreement with the Monitoring Officer these were signposted to more appropriate teams for action.

Current Year Cases

3.5 Table 5 below summarises the cases progressed during 2024-25 and the current status.

Cases Progressed in 2024-25	Closed Cases	Closed Cases Previously Reported	Ongoing Cases
9	0	0	9

Table 5 – Position of on-going cases

3.6 The outcomes of the remaining open referrals and cases will be reported to Committee on their completion.

3.7 A previously reported Direct Payment misuse closed case from 2023-24 has resulted in the repayment, in full of £20,000 in 2024-25.

3.8 Not all investigations (for example conduct, non-compliance and ethics issues) can have an assessed value attached to them or result in the recovery of monies. CFT investigations, analytics and consultative work may add value in other ways such as providing assurance to members and residents, reducing Council vulnerabilities and mitigating risk.

3.9 It should be noted that many of the cases referred to the CFT involve intricate detail and, sometimes, police referral. This invariably results in a delay before the investigation can be classed as closed and the summary outcome reported to Committee.

3.10 The CFT continues to provide wider counter fraud support and guidance to Council staff where required. This often includes providing advice on how to strengthen internal controls to prevent fraud occurring.

3.11 Counter fraud intelligence and alerts from reputable sources are routinely provided outside of the creation of referrals and cases.

National Fraud Initiative (NFI)

3.12 The CFT continues to support the NFI which is a biennial data matching exercise administered by the Cabinet Office. The data for the 2022-23 exercise has been uploaded and the data matching reports released for review. The relevant teams within the Council have been notified and progress to review the matches is ongoing.

3.13 The full NFI timetable can be found using the link available on GOV.UK – https://www.gov.uk/government/publications/national-fraud-initiative-timetables.

3.14 Examples of data sets include insurance, payroll, creditors, and pensions.

3.15 To date, a review of the pension related matches by the Pensions Team have identified a number of irregularities and are recovering circa £63,709. The irregularities are usually where the Council has not been identified of a death and have therefore continued to make pension payments. Had the irregularities not been identified and payments had continued, the value would have continued to rise and could have eventually been as high as circa £500,000.

3.16 Not all matches are always investigated but where possible all recommended matches are reviewed by either Internal Audit or the appropriate service area within the Council. The CFT will progress, often in conjunction with the relevant team, any matches where fraud or irregularity is identified.

National Anti-Fraud Network (NAFN)

3.17 NAFN is a public sector organisation which exists to support its members in protecting the public interest. It is one of the largest shared services in the country managed by, and for the benefit of its members. NAFN is currently hosted by Tameside Metropolitan Borough Council.

3.18 Membership is open to any organisation that has responsibility for managing public funds or assets. Use of NAFN services is voluntary, which ensures delivery of value for money. Currently, almost 90% of councils are members and there are a rapidly growing number of affiliated wider public sector bodies including social housing providers.

3.19 Many potential attempted frauds are intercepted. This is due to a combination of local knowledge together with credible national communications, including those from the NAFN. Fraud risk areas are swiftly cascaded to teams by the CFT for the purpose of prevention, for example national targeted frauds.