Progress report on Internal Audit Activity

2020-2021

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 (ARA) 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 undertake its functions. The Shared Service Internal Audit function is conducted in conformance with the International Standards for the Professional Practice of Internal Auditing.

There is a requirement under the PSIAS i.e. Standard Ref '1312 External Assessments' for internal audit to have an external quality assessment (EQA) which must be conducted at least once every five years by a qualified, independent assessor or assessment team from outside the organisation. The latest review was undertaken during May 2020 by the Chartered Institute of Internal Auditors (CIIA).

The EQA assessment concluded that:

"We are pleased to report that the ARA team meet each of the 64 Standards, as well as the Definition, Core Principles and the Code of Ethics, which form the mandatory elements of the Public Sector Internal Audit Standards (PSIAS) and the Institute of Internal Auditors' International Professional Practices Framework (IPPF), the globally recognised standard for quality in Internal Auditing. There are no formal recommendations made for improvement."

"In conclusion, this is an excellent result and the Chief Internal Auditor and the ARA team as a whole should be justifiably proud of their service, its approach, working practices and how key stakeholders' value it.

It is therefore appropriate for the function to say in reports and other literature 'Conducted in Conformance with the International Standards for the Professional Practice of Internal Auditing'."

The full EQA report was provided to Audit and Governance Committee virtually in July 2020 and can be accessed here.

(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 2020/21 Revised Internal Audit Plan, including the assurance opinions on the effectiveness of risk management and control processes;
- The outcomes of the 2020/21 Internal Audit activity concluded between October 2020 and December 2020; and
- Special investigations/counter fraud activity.

Gloucestershire Fire and Rescue Services (GFRS) Action Plan Follow Up Internal Audit activity is separately reported to Audit and Governance Committee, with the second progress report being presented to the Audit and Governance Committee on 22nd January 2021.

(4) Progress against the 2020/21 Revised Internal Audit Plan, including the assurance opinions on risk and control

The schedule provided at **Appendix 1** provides the summary of 2020/21 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 the financial year to date, 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.

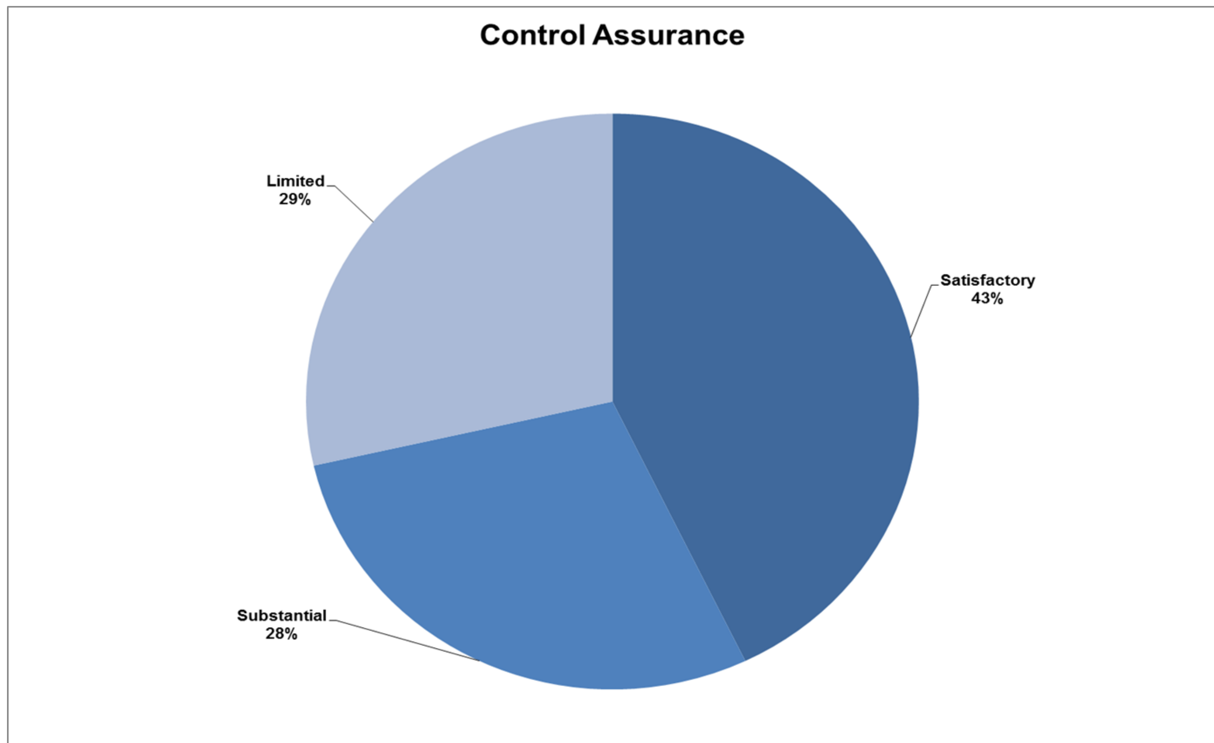
Explanations of the meaning of these opinions are shown below.

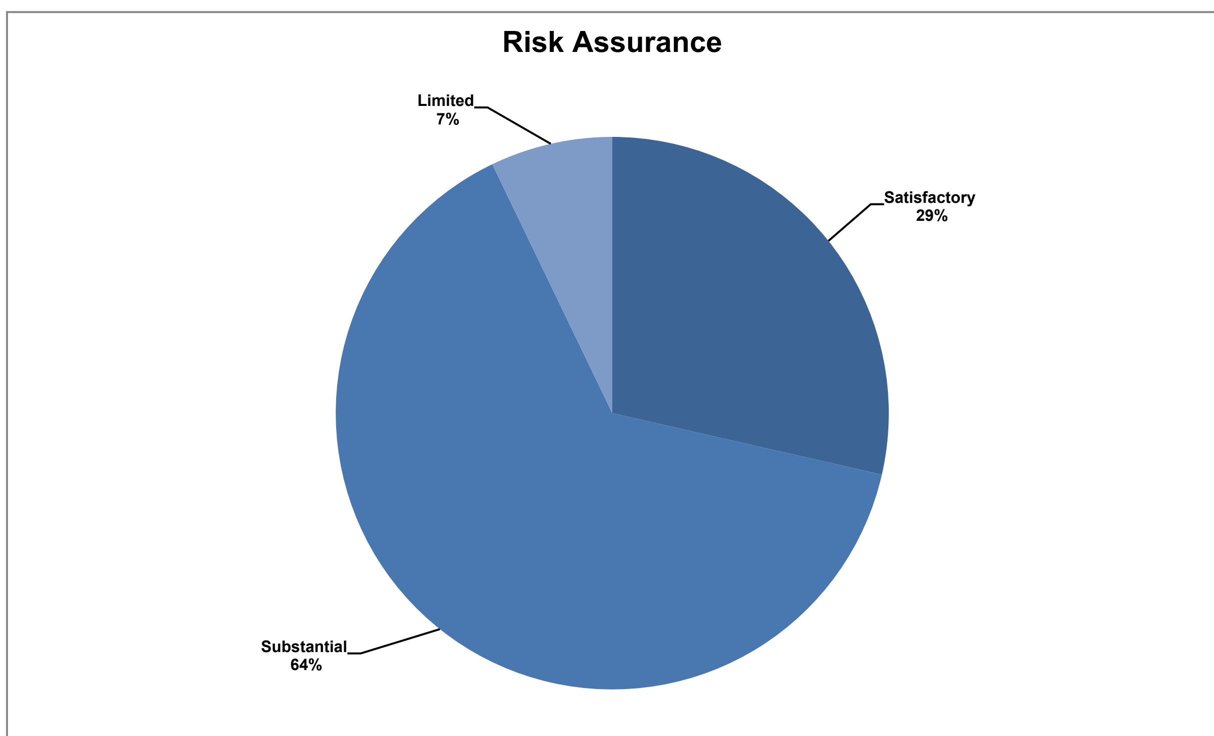
Assurance Levels	Risk Identification Maturity	Control Environment
Substantial	**Risk Managed** Service area fully aware of the risks relating to the area under review and the impact that these may have on service delivery, other service areas, finance, reputation, legal, the environment, client/customer/partners, 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 accurate and regular 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 2020/21 audit activity undertaken up to December 2020.

It is noted that the split assurance control opinion (Limited/Satisfactory) on Client Affairs reported to Committee in January 2021 has been reflected in the satisfactory segment only of the control assurance pie chart.





The pie chart outcomes for 2020/21 audit activity undertaken to December 2020 compare to last year's performance (as reported in the Internal Audit Annual Report 2019/20) as follows:

- 2019/20 control assurance opinion outcomes: substantial 2%; satisfactory 70%; and limited 28%; and

- 2019/20 risk assurance opinion outcomes: substantial 20%; satisfactory 70%; and limited 10%.

(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 October 2020 to December 2020, one limited assurance opinion on control has been provided on completed audits from the Revised Internal Audit Plan 2020/21. This relates to Direct Payments (Children's).

In addition, one partial limited assurance opinion was provided on some areas of risk within the Client Affairs internal audit.

It is important to note that whilst a limited assurance opinion has been provided on the above areas, 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 October 2020 to December 2020 Internal Audit made, in total, **30** recommendations to improve the control environment, **11** of these being high priority recommendations (**100%** of these being accepted by management) and **19** 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 October 2020 to December 2020, one limited assurance opinion on risk has been provided on completed audits from the Internal Audit Plan. This relates to Direct Payments (Children's).

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

(4g) Internal Audit Plan 2020/21 Refresh (Covid 19)

Covid 19 has placed significant pressures on Council services and has impacted (and continues to impact) the Council's priorities, objectives and risk environment.

Due to this changing position and to ensure that the Risk Based Internal Audit Plan meets the assurance needs of the Council, the Internal Audit Plan 2020/21 was reviewed and refreshed in consultation with Executive Directors / Directors (with input from Heads of Service and Service Managers). This included consideration of newly identified activities, current activities that should be prioritised within 2020/21 and activity deferrals/cancellations (due to risk).

The revised Internal Audit Plan 2020/21 was presented to Audit and Governance Committee on 30th October 2020 and approved.

The revised document included the new activities completed by ARA since the outcome of the pandemic. For example and as reflected within the Internal Audit Progress Report, within 2020/21 ARA:

- Is providing consultancy support (from both our internal audit and counter fraud teams) regards Supplier Relief and Integrated Transport Unit (ITU) Supplier Payments;
- Supports the Council's Covid 19 volunteering effort (e.g. food packages for shielding individuals within the County and the County Covid 19 mass testing pilot) with input from a number of ARA team members;
- Continues to work with Strategic Finance to review/provide assurance regards Premiums for Care Providers;
- Is providing counter fraud team support and action in regard to Covid 19 relevant irregularities (see report section below 'Summary of Special Investigations/Counter Fraud Activities'); and
- Has completed Internal Audit review of the Lost Sales, Fees and Charges Grant (Covid 19) claim 1 and is progressing review of the second grant return.

Completed 2020/21 Internal Audit Activity for the period October 2020 to December 2020

Summary of Limited Assurance Opinions on Control

Service Area: Children's Services

Audit Activity: Direct Payments

Background

Gloucestershire County Council (GCC) 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 GCC'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 parents/carers of young people needing care and support so that services and/or equipment can be purchased to meet assessed needs. This allows parents/carers and young people greater choice and flexibility in obtaining individual services that will meet their needs. The 2020/21 budget for Direct Support Payments which is held by Disabled Children and Young People is £724,000.

Children's Services within GCC has adopted the use of Payment Card Accounts provided by Prepaid Financial Services Limited (PFS) and started issuing the cards in September 2018. Eligible Service Users will be set up with a Payment Card Account and provided with a card that will be used in a similar way to a banking debit card. The Payment Card Account is managed by the parents/carers with oversight by Children and Young People's (CYP) Business Support and Care Services Finance (CSF).

Scope

The objectives of the audit were to determine whether there were effective arrangements in place for the:

- Monitoring of Direct Payments currently being made to parents/carers to ensure they are being effectively used to provide the agreed support to meet the assessed needs; and
- Administration of Payment Card Accounts.

The audit reviewed Direct Payments arranged by Disabled Children and Young People's Service (DCYPS).

Risk Assurance – Limited

Control Assurance – Limited

Key Findings

Government regulations and GCC's own internal procedures set out the requirements for the monitoring of Direct Payments where GCC has set a higher level of frequency for monitoring. Internal Audit was informed that Direct Payments are not monitored within the first three months of being made in line with GCC's internal procedures. CSF was unaware of this requirement.

There are two types of Direct Payment:

- One-off payments to a family to provide services such as occasional respite care; and
- Ongoing payments to provide ongoing support such as a Personal Assistant.

There is a Service Level Agreement in place to clarify the roles and responsibilities of CSF in relation to Direct Payments. In addition there is a Direct Payment flowchart that outlines roles for the set up and monitoring of Direct Payments across the DCYPS, CSF and the Business Service Centre.

Internal Audit found that the registering of DCYPS Service Users for a Payment Card Account was strong as once the DCYPS Administration Team receives the completed and signed paperwork they verify against the minutes of the DCYPS Management Panel decisions. Where appropriate they then request a Payment Card Account from PFS. This information is then passed to CSF who arrange for either the one-off payment or the first four week payment of an ongoing payment to be made to the family/carer. Once the family has provided CSF with either a timesheet or invoice that shows agreed support has been received and paid for, CSF arrange for the ongoing payments to be triggered.

Although the above process is robust with adequate separation of duties, Internal Audit found that the process is not always followed and CSF were unaware of several Direct Payment Service Users.

CSF has monitored ongoing Direct Payments since 2007 although only took over responsibility for monitoring Payment Card Accounts from DCYPS Administration in July 2020. CSF does not currently monitor one-off Direct Payments and Internal Audit was unable to locate evidence that these payments are reviewed elsewhere to ensure they are spent as agreed.

Internal Audit reviewed all current, open Payment Card Accounts (145) and found eight where one-off payments were made between three and 11 months previously and where there was still an unused balance on the Payment Card Account (the total unspent balance for these cards was £3,984.87).

CSF uses a 'CWD Monitoring Spreadsheet' to schedule and document ongoing Direct Payment reviews. When CSF review a Direct Payment they check for over or under spend by the family/carer as well as any unusual spend; however the spend is not compared with the agreed services to meet the Service User's assessed needs as documented in the Direct Payment Agreement.

As at the date of the audit the spreadsheet contained 190 DCYPS Service Users with a Direct Payment, of which:

- 118 (62%) were noted as having a current open Payment Card Account; and
- 99 (52%) were due a review but the review had not been fully completed. Of the 99, CSF had identified issues with 36 (36%), such as under/over spend, notified the DCYPS mailbox (between one and nine months previously) requesting advice but had not received a reply which would allow the review to be completed.

Internal Audit extracted from the Council's Financial System (SAP) all DCYPS Direct Payments and sampled 15 ongoing Direct Payments to verify that annual monitoring had taken place, and found:

- All 15 (100%) sampled Direct Payments had a signed Direct Payment Agreement on file;
- Two of the 15 (13%) had been reviewed in the last 12 months;
- Nine of the 15 (60%) had not had a review in the last 12 months, of which:
    - Four were missing from the 'CWD Monitoring Spreadsheet'. Internal Audit informed CSF of the missing Service Users and the team has now scheduled reviews. At the time of the audit CSF were unable to confirm why the Service Users were not included on the spreadsheet.; and
    - Five had not been monitored at all as they had a Payment Card Account and the review date was prior to CSF taking responsibility for monitoring Payment Card Accounts.
- Three of the 15 (20%) had a review started however CSF had identified issues with the Direct Payment balance, notified the DCYPS and were awaiting advice on how to progress. The DCYPS had been contacted between three and 12 months previously for advice and CSF had not yet received replies; and
- One of the 15 (7%) had not had the ongoing payments triggered yet as the family had not returned an invoice to demonstrate that the initial payment had been spent appropriately. CSF do not currently monitor until ongoing payments have been set up.

Prior to CSF taking responsibility for monitoring Payment Card Accounts and being granted access to the PFS System in July 2020, it was the responsibility of the DCYPS Administration Team. Internal Audit was informed by the Business Senior Administrator (DCYPS) that the required annual monitoring reviews did not take place.

The Business Senior Administrator provided Internal Audit with an extract from the PFS System of all Payment Card Accounts, including closed and temporary blocked accounts. Internal Audit analysed the 233 accounts and found that improved monitoring would further strengthen current processes for administering the accounts.

Senior Management do not receive regular formal reports that give them oversight of the number of DCYPS Service Users with a Direct Payment, how many have received a review and how much funding remains unspent on the Payment Card Accounts and/or has been reclaimed by the Council. This second line of defence should be strengthened.

Conclusion

The current monitoring of DCYPS Direct Payments does not meet the requirements of Government regulations and GCC internal procedures, primarily:

- Ongoing Direct Payments are not formally reviewed within the first three months (GCC requirement);
- One-off Direct Payment are not reviewed at all; and
- Annual Reviews do not take place consistently (Government requirement).

Internal Audit found that when DCYPS Direct Payments are reviewed and areas of concern are raised by CSF with DCYPS Social Workers or Lead Professionals, responses are not always received in a timely manner. This means that inappropriate spend by families could continue or the needs of the child are not met.

Since July 2020 CSF has taken over responsibility for monitoring Direct Payments that have Payment Card Accounts. Systems and controls that have been developed for undertaking this work should improve the monitoring and administration of Payment Card Accounts but good communication between CSF and DCYPS is essential.

Management Actions

Management have responded positively to the recommendations raised (which are in line with the conclusion observation themes).

Service Area: Adult Services

Audit Activity: Client Affairs

Background

Every day, we make decisions about our lives. Our ability to make decisions is called mental capacity. When a person lacks mental capacity to manage their finances or assets and there is no other suitable individual to do so on their behalf, the council’s Client Affairs team (CAT) is able to apply to the Department for Works and Pensions to act as their benefit Appointee, and to the Court of Protection to act as their Deputy for property and financial affairs. This duty requires the team to undertake a breadth of administrative tasks / duties.

Prepaid Cards

Prepaid Financial Services (PFS) offers a card account facility to the council. In January 2020 the CAT adopted the use of these as a method to distribute an individual's personal spending money provided that the individual is capable of managing their own finances using a card authorised by a personal identification number (PIN).

If an individual is unable to manage the use of a card and PIN, where appropriate, a card can be issued to a third party (such as a carer) in order to gain access to the individual's personal spending money on their behalf.

As at August 2020, the CAT manage the financial and property affairs of circa 550 individuals, of these circa 40 have been issued with a Prepaid Card.

Motability Vehicles

A person who is eligible to receive a Disability Living Allowance / Personal Independence Payment mobility, at the highest rate, can forfeit payment of the benefit and instead have the use of a Motability vehicle.

As at August 2020, circa 18 individuals have opted for the use of a Motability vehicle.

It is acknowledged that the service is in the process of digitising its processes and some recent process changes have been made due to the changed way of working brought about by the pandemic.

Scope

To review the effectiveness of the control environment in relation to the:

- Risk management arrangements to ensure these are in compliance with the council's Risk Management Policy Statement & Strategy 2018-2021;
- Management and monitoring of Prepaid Cards; and
- Administrative arrangements for an individual to have use of a Motability vehicle that may also be driven by a third party, i.e. a carer.

Risk Assurance – Satisfactory

Control Assurance – Satisfactory (Prepaid Cards) / Limited (Vehicles)

Key Findings

Risk Management

The service's risk management arrangements should be further developed to ensure these are aligned to the council's Risk Management Policy Statement & Strategy 2018-2021.

Prepaid Cards

The introduction of Prepaid Cards has been a positive initiative for both the service and for individuals.

For the service, it offers resource efficiencies and oversight of access to personal monies. Individuals who are assessed as being able to manage the use of a Prepaid Card benefit from direct access to managed amounts of personal spending monies, promoting an element of greater independence for the individual.

Policy and procedural guidance is in place and is subject to periodic reviews / refresh. These documents are accessible to team members.

The findings emanating from the review of this area has highlighted opportunities for the introduction of a number of enhancements to the current documented procedures in order to provide more detailed guidance for staff and further strengthen the control environment for administering Prepaid Cards. Including but not exclusive to the following:

- Requests / approval for a Prepaid Card to be set up;
- Issue of the Prepaid Card;
- Replacement / cancellation / closure;
- Authorisation of Standing Orders and BACS payments;
- Separation of duties within the administration and monitoring functions; and
- Monitoring arrangements of card usage and status.

Four cases were selected for audit testing, the results confirmed compliance overall with the agreed procedures for account set up; receipt of card; identity checks, and Standing Orders and BACS transactions that had been processed during the period May to September 2020 for the respective sample of individuals.

Motability Vehicles

A policy is in place and is subject to periodic review. This is accessible to view via the council's website and intranet.

Procedural guidance is also in place and is accessible to staff via the shared folder. The current guidance is brief and would benefit from a review and refresh to include the proposed enhancements to the current control environment for administering Motability leases as a result of the findings emanating from this review, including:

- Standardisation of prime records to be viewed and additional verification checks that are required in order to complete driver checks;
- Minimum requirements to be stated for periodic review of the stated prime records and re-performance of driver verification checks;
- Development of declaration forms to be utilised to collect key information required to support the process for approval of a permitted driver; and the permitted driver's acknowledgement / agreement of the insurance policy terms and conditions, and their responsibilities;

- Document retention requirements to be considered and referenced within the guidance to aid future compliance with the General Data Protection Regulations (GDPR); and

- Enhancements to the current annual review template in relation to the re-performance of driver checks is required to aid the assurance process that details of nominated drivers are confirmed and remain up-to-date, and continue to meet the pre-requisite checks of an approved permitted driver.

Four cases were selected for audit testing, the results identified:

- Motability Agreement: For all four cases an agreement is in place and a copy is held on the service's Money and Property Management System (CASPAR);

- Insurance Certificate: For all four cases an insurance certificate for the duration of the lease is in place and a copy is held on CASPAR;

- Full and valid UK or EU licence and declaration of any accidents / losses / motoring convictions, fixed penalty notices or any licence endorsements in the last five years, or which are currently pending:

  - For all four cases, driver checks in the form of a full and valid UK or EU driving licence were undertaken however there is an inconsistent approach to the validation process with a mix of prime records being used in the form of either card only, paper only, card and paper (note: the paper counterpart to the photocard driving licence was abolished on 8th June 2015) and use of the GOV.UK website;

  - There is also an inconsistent approach to the validation process for the declaration of any accidents / losses / motoring convictions, fixed penalty notices or any licence endorsements in the last five years, or which are currently pending:

    - For one of the four cases, whilst this information had been requested, as at October 20 this information has not been received / verified since inception of the agreement, however a Motability 2 letter has been issued confirming that the nominated individuals are council approved permitted drivers;

    - For one of the four cases, the case worker advised that they were not aware of any accidents / losses/ motoring convictions, fixed penalty notices or any licence endorsements in the last five years, or which are currently pending but that they rely on the driver to inform them.

- It was also noted that in two instances a photocopy of the driver licence had been retained on the shared folder (contravention of GDPR).

Annual Review:

All four individuals had received an annual review, these were completed during the period December 2019 to July 2020.

However there is an inconsistent approach to the driver verification check undertaken at this time, therefore assurance that the pre-requisite permitted driver checks remain is limited.

Conclusion

The service needs to further develop their risk management arrangements to ensure that these are in compliance with the council's Risk Management Policy Statement & Strategy 2018-2021. Internal Audit has made one medium recommendation to address the identified improvement area.

The current control framework for the management and monitoring of Prepaid Cards could be further strengthened. One high priority recommendation has been made to promote separation of duties within the administration and monitoring functions; and three medium priority recommendations to promote greater transparency over the initial request / approval for a Prepaid Card, authorisation process for financial transactions, monitoring usage and status of Prepaid Cards, and the requirement for more detailed and up-to-date guidance.

Similarly, the control framework for administering Motability vehicles could be further strengthened. Six high priority recommendations have been made to:

- Ensure that procedural guidance is sufficiently detailed and refreshed to include the proposed agreed internal control changes as detailed within the management report;
- Permitted drivers are informed of and acknowledge the conditions of the respective insurance policy and understand the role of the permitted driver and known liabilities;
- Promote greater assurance that pre-requisite driver checks are more robust, verifications checks are applied consistently, and are re-performed on a periodic basis; and
- Ensure compliance with GDPR requirements.

In light of the above:

- Satisfactory assurance can be provided that the risk identification arrangements operating within the area reviewed are operating as intended; and
- Satisfactory assurance can also be provided that these risks which are considered to be material to the achievement of the services objectives for this area under review are adequately managed and controlled for Prepaid Cards however, only limited assurance can be provided for Motability vehicles.

Management Actions

Management have responded positively to the recommendations made.

Summary of Satisfactory Assurance Opinions on Control

Service Area: Corporate Resources

Audit Activity: Disposals from the public sector estate (land and buildings)

Background

Asset disposal categories can include (but are not exclusive to) ICT, land, buildings/ property, and vehicle disposal. Internal audit review of disposal of assets is delivered via a cyclical audit review programme. This review considered the corporate disposal of land and buildings which are managed by Asset Management and Property Services (AMPS).

When land or assets are no longer required, they can be sold and proceeds spent on capital expenditure or to repay debt. Proceeds can also currently be spent on transformation projects. Phases 1 and 2 of the Meeting the Challenge Programme generated £105m from the disposal of surplus assets. The capital receipts target for phase 3, April 2018 to March 2021 is £33m. It was reported to Cabinet in March 2020 that sales from April 2018 to date achieved receipts of £11,671,295 of which £7.175m related to shortfall in phase 2 receipts.

Scope

The audit reviewed the effectiveness of the asset disposal governance arrangements, including the decision making processes for the disposal and / or transfer of the Council's surplus property taking into account the requirements of the Council's Policy for the Disposal of Property, the Corporate Asset Management Plan 2019-24 and other relevant policies. This included review of the following:

- Identification of surplus properties and subsequent authorisation of disposal;
- Ensuring that value for money is achieved in the method of sale of property and any price set;
- Ensuring compliance with section 123 (2A) Local Government Act;
- Ensuring that all sale proceeds are received and banked in a timely manner; and
- Ensuring that disposals are correctly recorded in the Council's asset register.

Risk Assurance – Substantial

Control Assurance – Satisfactory

Key Findings

There is a Policy for the Disposal of Property which was last updated in 2016. This policy does not cover the requirement to obtain approval from the Secretary of State for the sale of school land or buildings or the requirement under Section 123 (2A) of the Local Government Act 1972 to advertise the sale of open land.

Cabinet approved a Strategic Estate Plan for rationalisation of rural estate holdings to achieve in the order of £60m capital receipts in April 2016.

A sample of three sales was examined in depth. This showed that procedures in the Policy for the Disposal of Property had been followed:

- Land or properties that are no longer of use to the Council are referred to AMPS. Full reports are presented to the Property Board and agreement for disposal granted, including method of disposal.
- Sales are agreed by Cabinet, however, it was noted that sales can take a number of years to complete but the date that the sale has been agreed by Cabinet is not included within the six monthly updates.
- Independent valuations are obtained where land is tenanted and the tenant has expressed an interest in purchasing the land.
- E-mails sighted from agents indicated that highest offers had been accepted.
- Income was recorded within the accounts within a few days of a sale.
- An e-mail confirming the disposal was sent to Strategic Finance and the asset register working papers had been correctly updated.

Although it is not a requirement of the policy, obtaining quotes from agents for the sale of the land or property could only be fully demonstrated for one sale from the sample of three.

Where the 'undervalue' in the sale of land or property is estimated to be more than £250,000 or 20% of its market value this should be approved by Cabinet. None of the sales within the sample fell into this category, however, land was recently transferred to Stroud Valleys Canal Company for £1. Approval had been given by Cabinet in 2004 to transfer various parcels of land to British Waterways, now superseded by various charities, one of which is Stroud Valleys Canal Company.

Under section 123 (2A) Local Government Act where open land is to be disposed of the Council is required to publish a notice in a local newspaper. None of the sales in the selected sample fell in to this category. An e-mail confirming that this had been completed was sighted for sale of land in Moreton-in-Marsh.

Conclusion

- Land and property is agreed as surplus by the Property Board and disposal is then agreed by Cabinet.
- The sample of sales examined during the audit review had been through agents, quotes had only been obtained from agents for one of the three sales.
- E-mail evidence indicated that the best offers had been accepted.

- Income is received in a timely manner.
- Information is sent from AMPS to Strategic Finance to ensure that disposals are correctly recorded in the Council's asset register.

Three recommendations have been made to update the Policy for the Disposal of Property to ensure that legal requirements are followed, to add the date of Cabinet approval to enable members to question delay in the disposal of land or property and to ensure that the Council receives value for money in the choice of agent.

Management Actions

Management have responded positively to the recommendations made.

Service Area: Corporate Resources

Audit Activity: Database Administration and Security (Oracle – SQL) - Limited Assurance Follow Up

Background

Effective database administration and security is critical to protecting key information assets and the data they contain, ensuring that information assets are appropriately secured and for preventing unauthorised access to or the loss of critical information assets.

The original Database Administration and Security (Oracle - SQL) internal audit was completed in 2016/17 and the final report issued on 14th September 2017. The audit resulted in a limited assurance opinion for risk identification maturity and a limited assurance opinion for control environment. Fourteen audit recommendations were raised (five High and nine Medium priority) and accepted by management.

Scope

The Database Administration and Security (Oracle - SQL) follow up review is to provide assurance that the agreed actions from the 2016/17 Database Administration and Security (Oracle - SQL) internal audit have been appropriately implemented and that the original levels of assurance can be revised and reported to the Audit and Governance Committee. Where the original recommendations were found to be not/partially implemented, Internal Audit evaluated the residual risk and made recommendations to mitigate that risk where required.

Audit follow up was completed in June 2020 and the initial audit findings were reported in draft to management in July 2020. Additional service update and supporting audit trail was then required to conclude the audit and ARA remained active in key contact communication to support this. Final audit trail and update was obtained in December 2020.

Risk Assurance – Satisfactory

Control Assurance – Satisfactory

Key Findings

Audit testing identified that extensive work had been undertaken to address the findings from the original internal audit report. Discussion with relevant officers and review of Active Directory and database settings and content as at June 2020 confirmed that:

- Access to the Database Administrator (DBA) Role is restricted to valid and authorised Oracle administrative accounts;
- All Oracle administrators are assigned valid and uniquely identifiable database accounts;
- The documented Gloucestershire County Council (GCC) Password Policy had been approved and implemented following the original audit;
- Password Ageing and Password History settings had been invoked on Oracle database accounts;
- Restrictions are invoked for failed login attempts across GCC Oracle databases;
- The Password Verify Function is enabled on all Oracle production databases to enforce password complexity and minimum password length;
- All production database servers are subject to regular internal vulnerability scanning;
- Auditing is enabled on all GCC business critical Oracle database platforms;
- A temporary Password Management system has been deployed to centrally capture and administer all database super user accounts and passwords with a more permanent solution planned;
- Password security and account lockout security settings have been invoked on all live Standard Query language (SQL) Server databases;
- Guest accounts have been disabled on all SQL Server databases; and
- All GCC SQL Server databases reside on vendor supported software.
- The Nessus scanning tool has been implemented across all GCC servers and the Oracle Database Security Assessment Tool has been implemented on Oracle databases to scan for vulnerabilities.

It is noted that at the point of audit follow up, the Global Information System (GIS) database was in the process of being replaced. The specification of the replacement GIS database has been set to meet the original audit recommendation requirements. Due to this position, the relevant recommendations have not been marked as outstanding and an ICT review of the replacement GIS system will be proposed for the 2021/22 internal audit plan.

The above actions have led to the following confirmed position against the original audit report recommendations raised:

Original Recommendation Priority	Original Recommendations Raised	Position at June 2020 Internal Audit Follow Up		
		Implemented	Partially Implemented	Not Implemented
High Priority	Five	Five	-	-
Medium Priority	Nine	Seven	Two	-

The position of the two partially implemented recommendations is as follows:

- Oracle access rights were confirmed as reviewed at the time of the original audit for relevant databases, however the number of Eric (the Council's Adult Social Care database) Oracle accounts that have not been used since 2017 would indicate that the Oracle access rights had not be reviewed since. A further recommendation has been made that Oracle access rights are regularly reviewed.

- A temporary solution has been implemented relating to the deployment of a Password Management system to centrally capture and administer all database super user accounts and passwords, whilst a more permanent solution was identified to address the recommendation. A more permanent solution has now been identified and a further recommendation relating to implementing this solution has been made.

Three further new Medium priority audit recommendations have been raised to support strengthening of the current Database Administration and Security (Oracle - SQL) control environment, relating to:

- Disabling the Oracle SYS and SYSTEM DBA accounts, to reduce the risk of unauthorised access and/or disclosure of sensitive customer data;

- Evidenced ongoing review of the Council Password Policy; and

- Increasing the length of time that the audit log information for the Capita One database is retained for to enable the possibility of being able to undertake a forensic investigation in the event of a data breach.

Conclusion

The 2016/17 Database Administration and Security (Oracle-SQL) internal audit report made a total of fourteen audit recommendations (five High priority and nine Medium priority). Audit follow up review and testing has confirmed that twelve recommendations (five High priority and seven Medium priority) have been fully implemented and that the two remaining Medium priority recommendations have been partially implemented. This position has significantly reduced the risks identified within the original review, although some residual risk will remain until the final two recommendations have been fully implemented.

Three additional Medium priority recommendations have been made to support further improvement of the control environment.

Management Actions

Management have responded positively to the recommendation made within the report.

Service Area: Children's Services

Audit Activity: Health Assessments

Background

The corporate parenting responsibilities of local authorities include having a duty under section 22(3)(a) of the Children Act 1989 to safeguard and promote the welfare of the children they look after, including eligible children and those placed for adoption, regardless of whether they are placed in or out of authority or the type of placement. This includes the promotion of the child's physical, emotional and mental health and acting on any early signs of health issues.

The local authority that looks after the child must arrange for them to have a health assessment as required by The Care Planning, Placement and Case Review (England) Regulations 2010. The Initial Health Assessment (IHA) must be done by a registered medical practitioner and completed within 20 working days of the child or young person coming into care. IHAs are undertaken by a contracted assessment provider on behalf of Gloucestershire County Council (GCC).

Scope

This audit reviewed the effectiveness of the control and monitoring framework in place to provide assurance to management that IHAs are completed and recorded in line with statutory requirements for children coming into care for the first time.

Risk Assurance – Substantial

Control Assurance – Satisfactory

Key Findings

Process

GCC has a comprehensive guide for practitioners to support all front line practitioners and managers within Gloucestershire Children's Services in promoting the health and well-being of children in care, specifically in relation to Initial and Review Health Assessments. Internal Audit reviewed the procedure notes and confirmed that it contained process notes for the key elements surrounding the completion of an IHA as suggested by the statutory guidance.

Prior to the start of the audit, Children's Services undertook a trial process within the Gloucester locality for the completion of IHAs to reduce the time taken to book an IHA with the contracted health assessment provider. This has resulted in a streamlined process for the completion of IHAs and an increase of IHAs completed within the 20 working day deadline from 33% in September 2019 to 79% in May 2020 within the Gloucester Locality. The updated process is to be rolled out to all localities in stages, with supporting guidance updated to reflect this.

The statutory guidance requires local authorities to ensure that, as a minimum, the child's main carer completes the carer's two-page version of the Strengths and Difficulties Questionnaire (SDQ) for the child in time to inform his or her health assessment. Whilst processes are in place for this to be completed, prior to the start of the audit, it had been identified by the service area that the current controls and monitoring arrangements were not operating as intended and therefore SDQs had not been completed as required.

To improve the current process for the completion of SDQs, flowcharts and web monitoring reports have been drafted and are awaiting trial, to ensure they are appropriate to effectively complete and record the SDQ by the child or young person main carer as a minimum. An escalation process is also being implemented, managed by the Team Administrators, to ensure completion in line with statutory requirements.

From June 2020 a checklist has also been introduced into the process to aid completion of all the statutory requirements when a child enters care including progressing the IHA. The checklists are to be signed by the Head of Service five working days post completion of the IHA confirming completion of the case in respect of the IHA process.

Sample Testing

Internal Audit selected 13 CYP out of 332 children requiring an IHA between July 2019 and May 2020 to ensure that the process as intended had been completed including ensuring appropriate consents had been obtained and recorded within LiquidLogic and that the IHA had been fully completed and signed off in a timely manner. Due to the known issues with the completion of SDQs this was not tested. It was found that:

- 1 CYP no longer required an assessment and therefore no IHA had been completed;
- 12 consents to carry out assessment forms had been received by the contracted health assessment provider prior to the IHA. All 12 had physical signatures as required by the statutory guidance. However, only three out of 12 of these (25%) were recorded within LiquidLogic as required by the procedural guidance, with the remaining nine held by the contracted assessment provider;
- 12 fully completed IHAs where available on LiquidLogic; and
- A signed consent form from those with parental responsibility, providing authority for health colleagues to access their medical records could be found in only three out of 12 applicable cases (25%). The absence of this consent does not prevent the IHA (or subsequent Review Health Assessments) from proceeding but health professionals cannot access parental medical records without this consent and this may have

implications in terms of identifying a child's health needs. The GCC Guidance on the completion the consent forms is clear about the need to gain these consenting signatures.

Monitoring Arrangements

Monitoring arrangements are in place and working effectively for the completion of IHAs via a LiquidLogic web report. A four-day escalation process has been trialled within the Gloucester locality which is monitored by the Administration Team to ensure that the completion of the necessary paperwork required by the contracted assessment provider is in place and does not cause a delay within the process. This process is due to be rolled out to the other localities.

From June 2019 to June 2020, significant improvement has been seen in the overall completion of required IHAs in accordance with the required 20 working day statutory deadline, with an increase from 32% to 75% of IHAs completed. This has also seen the number of IHAs completed within the deadline per month at the highest recorded level of 21.

Conclusion

Significant improvements have been made to the IHA process and monitoring arrangements. This has seen a substantial improvement in the completion of IHAs in accordance with the required 20 working day deadline from June 2019 to the date of the audit with further improvements expected with the adoption of the IHA process that was trialled by the Gloucester locality.

Prior to the undertaking of the audit, issues with the completion and monitoring of SDQs had been identified by the service area. Corrective actions to remedy the concern have been drafted, with trialling of the process occurring imminently. Due to this, satisfactory assurance has been provided for the control environment excluding the pending implementation of the adjusted SDQ process and monitoring procedures by the service area.

Management Actions

Management have responded positively to the recommendation made by Internal Audit on improving monitoring arrangements for the completion of the consent form to access parental medical records.

Summary of Substantial Assurance Opinions on Control

Service Area: Corporate Resources

Audit Activity: Breach Reporting

Background

A personal data breach is a breach of security leading to the accidental or unlawful destruction, loss, alteration, unauthorised disclosure of, or access to, personal data. This includes breaches that are the result of both accidental and deliberate causes.

When a personal data breach has occurred, Gloucestershire County Council (the Council) must establish the likelihood and severity of the resulting risk to people's rights and freedoms as defined by the General Data Protection Regulation (GDPR). If it is likely that there will be a high risk or is likely to be a risk to individuals' rights and freedoms then the Information Commissioner's Office (ICO) must be formally notified.

Information Management Service (IMS) supports the Council on all aspects of information management, including governance, security, records and compliance; as well as advice, help and support in the event of an information security incident or data breach.

In the 2019 calendar year there were 854 incidents reported to the IMS of which the ICO were made aware of 11 incidents. For the period 1st January 2020 to 30th June 2020 there were 524 incidents of which the ICO were made aware of three incidents.

Scope

This audit review sought to determine whether Gloucestershire County Council is in compliance with the General Data Protection Regulation and the ICO requirements for personal data breach reporting.

The scope for this audit only looked at areas the IMS are responsible for and therefore school data breaches were not reviewed.

Risk Assurance – Substantial

Control Assurance – Substantial

Key Findings

- The Council's intranet 'Staffnet' provides accessible and extensive policies and guidance to support staff in the identification, prevention and reporting of personal data breaches. Internal Audit have made two recommendations to enhance these policies in the areas of informing staff of the progress of incident investigations, and, obtaining written confirmation from recipients who have received confidential material in error. The Council also uses the MetaCompliance system which monitors when staff have read and understood key policies including the Data Protection Policy and the Information Security Policy.

- To ensure consistency and transparency the IMS use an 'Assessing the Severity of an Information Security Breach' guidance document which ensures that personal data breaches are accurately severity risk rated and documented. To determine a severity rating the IMS take into account up to 11 factors including the scale of the breach and whether the individuals affected are likely to have been placed at risk.

- Severity ratings are defined as:

  - Noted: where no breach has occurred or the breach does not meet the threshold for reporting to the ICO or other regulators;

  - Low: unlikely to be reportable to the ICO or other regulators;

  - Moderate: likely to be reportable to the ICO or other regulators;

  - High: reportable to the ICO or other regulators; and

  - Very High: reportable to the ICO or other regulators.

- Data analysis of personal data breach incidents where the date of incident occurred between 1st April 2019 and 31st March 2020, found that 70% of data breaches were given an initial severity rating of 'Noted', this number rose to 80% after the IMS had investigated. Further data analysis showed there were no occasions of incidents initially rated as 'Noted' being finally rated as 'Moderate' or higher.

- Internal Audit tested 15 personal data breaches whether the incident occurred between 1st April 2019 and 31st March 2020 to verify that the investigations and findings met the expectations of the ICO. Internal Audit found that:

  - Internal Audit replicated the assessment of the breaches using the ICO self assessment tool and found that for all 15 breaches the ICO tool agreed with the IMS decision;

  - 11 of the 15 sampled personal data breaches had been investigated and not reported to the ICO. Internal Audit agree with the finding of the IMS and that that they did not need reporting;

  - Two of the four personal data breaches reported to the ICO were not reported within the expected 72 hours however this was outside the control of IMS; and

  - Four of the six personal data breaches with a final severity rating of Moderate/High/Very High and not reported to the ICO, the reason for not reporting was not documented. Therefore Management have agreed that incidents with an initial or final severity rating of Moderate, High or Very High will have a fully completed 'Information Security Breach Initial Report' saved into the incident folder which will include the reasons for not reporting to the ICO.

- From the review of sampled breach incidents Internal Audit finds that the IMS initially treat all reports of personal data breaches with equal urgency, however, following assessment a significant amount of documentation is obtained for all severity ratings.

As 80% of cases had a final breach severity rating of 'Noted' then this would result in a significant amount of IMS time, where in most cases a breach has not occurred. Therefore, Management have agreed that the process will be reviewed and amended for cases that have an initial severity rating of 'Noted' to see where further efficiencies can be made. Ongoing reviews of the amended process will take place to ensure risk mitigation.

- Data Breaches are reported six-monthly to the Information Board as well as the Corporate Overview and Scrutiny Committee.
- The IMS document and monitor recommendations and actions in a 'Breach Action Plan Tracker'; and the six-monthly report to the Information Board includes a section titled 'What we have done to mitigate the risk of future information security incidents'.

Conclusion

Internal Audit finds that the IMS provide a thorough, supportive role to Council employees to facilitate understanding of what is personal data and how it must be protected, as well as with the identification and reporting of data breaches when they occur.

The IMS have tools in place to support the ICO requirement for breach detection, investigation and internal reporting procedures.

Sample testing of data breaches investigated by the IMS found no discrepancies; and although Internal Audit has made four recommendations (as referred to in the Key Findings section above) these are to further streamline and strengthen the existing control framework.

Management Actions

Management have responded positively to the recommendations made.

Service Area: Corporate Resources

Audit Activity: Treasury Management

Background

Treasury Management is concerned with keeping sufficient but not excessive liquid assets available to meet the Council's spending needs, while managing the risks involved. Surplus funding is invested until required, while a shortage will be met by borrowing in order to avoid excessive credit balances or overdrafts in the bank current account. The revenue cash surpluses are offset against capital cash shortfalls to reduce overall borrowing. Due to decisions taken in the past, the Council (as at November 2019) had £276.6 million borrowing at an average interest rate of 4.76% and £346.1 million treasury investments at an average rate of 1.27%.

Scope

As there is significant assurance given by other providers (notably external audit) this audit focused solely on the transfer process as transfers are normally in the region of £10m each. Thus assurance will be provided that the transfer process is robust with adequate oversight, separation of duties and formal sign off.

Risk Assurance – Substantial

Control Assurance – Substantial

Key Findings

Transfer Process

The process is currently split into three separate roles consisting of a daily dealer, first authoriser and second authoriser with roles assigned according to a monthly rota. The dealer and first authoriser are chosen from the same pool of staff, some of whom are trained in both roles however they cannot perform both roles on the same day. The second authoriser is chosen from a different, smaller group of staff with higher level authority.

The purpose of the daily dealer is to input and update the Council's current financial position. This then allows the first authoriser to assess whether any transfers need to be made, taking into account income and expenditure as well as any loan repayments and investment maturities. The current instruction for the team is that a balance of approximately £50,000 should be left in the account each night.

Once an investment need has been established, the dealer updates a series of spreadsheets with key required information. The transfer can then be set up for payment on the HSBC.net system.

The first authoriser checks over the information within the spreadsheets and completes the first stage of authorisation on the system. The second authoriser is then provided with a snapshot of all relevant transfer information for that day and can complete the final stage of authorisation.

Testing

A sample of 44 investments from the period of April 2019 to December 2020 was selected for review to confirm whether the Council's procedures had been complied with. Internal Audit performed walkthroughs of the chosen investments and found that:

- Investment need was in line with the completed cash flow forecast/statement;
- Supporting audit trail was available to verify the deal for the 24 BACS transfers to a call account, money market fund or fixed term deposit;
- Of the 20 CHAPS transfers tested, all required request forms were recorded on the shared drive and 17 approval emails were saved; and

- All transfers were appropriately verified on the online system.

Overall, the investment transfer process is robust and works sufficiently. There are a number of spreadsheets to update which rely solely on the user entering the information correctly. This increases the risk in this area however key, useful information is retained and no errors were found during testing.

Segregation of Duties

Prior to April 2020 investment transfer paperwork was produced and signed manually. For all samples tested before this date, Internal Audit viewed reports downloaded from HSBC.net. With the team now working remotely, this part of the process has become electronic and Internal Audit were able to view this paperwork for testing and verify if the segregation of duties had taken place.

The Treasury Management team all have unique log in information to perform their tasks on the HSBC system. The software settings implemented only allow a user to complete what is necessary, therefore if a member of staff sets up a transfer payment as the daily dealer they are then unable to authorise that same payment.

Internal Audit observed that for all 44 transfers sampled there was appropriate segregation of duty, however there were seven instances where a person performing the duty did not comply with the rota. Of these, six instances were where the second authoriser differed to the rota however the member of staff to perform these duties was still from the pool of senior members of staff with the high level authority required for this task. Internal Audit was advised that these instances occurred due to clashes in busy schedules and the need to meet Treasury Management deadlines. Subsequently, Internal Audit performed additional testing by checking the schedules of the authorisers and can confirm that this was the case for all six instances where the authoriser had changed. The other instance occurred where the daily dealer differed to the rota. The person who performed the dealer duties that day was from the correct pool of people.

As a result of the findings Internal Audit did not provide a recommendation for improvement.

Conclusion

The Treasury Management team have clearly defined roles and responsibilities in their tasks and this audit review found that appropriate procedures and levels of control are in place. The use of the HSBC system enforces the segregation of duties appropriately and ensures complete transparency when setting up transfer payments. Since the team have moved to operating remotely positive efforts have been made to ensure a clear audit trail remains in place. It is noted that some approval emails were not saved when testing the CHAPS transfers and the team should be mindful to keep retaining these for the audit trail.

Management Actions

None required.

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: Grant Certification (Council Wide)

Audit Activity: Lost Sales Fees & Charges - Claim 1

Background

Covid-19 has impacted local authorities’ ability to generate revenues in several service areas as a result of lockdown, government restrictions, and social distancing measures, related to the pandemic. The Ministry of Housing, Communities, and Local Government (MHCLG) has introduced a one-off income loss scheme to help compensate for a proportion of the irrecoverable and unavoidable losses from sales, fees and charges income generated in the delivery of services in the financial year 2020/21.

There are a total of three claims over the periods of April 2020 to July 2020; August 2020 to November 2020; and December 2020 to March 2021. The three claims are subject to a reconciliation process that is to be completed after the submission of the third claim and is due to account for losses claimed for in the early part of the scheme that may ultimately be recoverable, and others that might ultimately be irrecoverable when recoverability was originally considered possible.

Scope

To review the Lost Sales, Fees and Charges claim 1 (April 2020 to July 2020) and provide assurance that the claim had been submitted in line with the guidance from the MHCLG.

Key Findings

- The records supplied by the Gloucestershire County Council Strategic Finance team identified that applicable loss income in 2020/21 under the Lost Sales, Fees and Charges scheme claim 1 totalled £2,537,000.

- Internal Audit selected and reviewed three service areas within the claim (EEI, Corporate Resources, and Children and Families) accounting for £2,240,000 of the applicable losses to ensure that the budget had been correctly calculated, all lost income was in accordance with the three principals of the scheme, within the relevant period under the claim (April 2020 to July 2020) and was as shown within the Council’s financial management system (SAP).

- Income budgets had been correctly accounted in the claim for EEI, Corporate Resources and Children and Families.

- The income for Traded Services (as part of Children and Families) included within the claim was based on estimates, using information from the 2019/20 financial year and therefore the actual irrecoverable losses from April 2020 to July 2020 could not be confirmed by Internal Audit. The Finance Business Partner responsible for Traded Services confirmed that as part of the reconciliation to be undertaken after claim 3 of the scheme, the actual income and losses for Traded Services will be calculated and any differences between the estimates and actuals will be claimed or refunded as required.

- Actual income received for the claim period, as shown for within the Council's financial management system, had been correctly accounted for in line with the schemes guidance for EEI and Corporate Resources.

- Internal Audit confirmed that the parameters of the formula for the scheme had been correctly applied to the applicable losses claimed for in the period April 2020 to July 2020. GCC claimed the amount of £1,292,806 after the required deductions (in line with the claim criteria) had been made to the original calculated loss of £2,537,000.

Conclusion

The Council submitted a Lost Sales, Fees and Charges claim for £1,292,806 under the scheme for April 2020 to July 2020 (claim 1).

Audit review confirmed that for claim 1 of the Lost Sales Fees Charges for the sample of claims reviewed, the claimed amounts of lost income were in accordance with the government guidance with the exception of the Traded Services claim which was calculated using 2019/20 actuals with estimates of losses to calculate the loss of income.

The actual income and losses for Traded Services will be calculated in line with the schemes guidance as part of the claim 3 reconciliation and any differences between the estimates used for this claim and actuals will be claimed or refunded as required.

Management Actions

Actions required regards Traded Services loss estimates are known and are due to be actioned in the claim 3 reconciliation process. No additional management actions are required as a result of the audit review.

Service Area: Grant Certification (Adults Services)

Audit Activity: Disabled Facilities Grant

Background

The Disabled Facilities Grant (DFG) is for the provision of adaptations to disabled people's homes to help them to live independently in their own homes for longer. This funding is part of the Better Care Fund (BCF), allocated to County Councils by the Ministry for Housing, Communities and Local Government (MHCLG) to be further distributed to District Councils as the local housing authorities.

Gloucestershire County Council received an allocation of £6,030,346 in 2019/20 from the Better Care Fund Disabled Facilities Capital Grant under the grant determination 2019/20 No 31/3710.

Scope

The Chief Internal Auditor is required to return to the MHCLG a declaration by 31th October 2020 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 Disabled Facilities Capital Grant Determination (2019/20) No 31/3710 have been complied with.'

The declaration deadline was extended by the MHCLG to the 20th November 2020 due to the Covid 19 global pandemic.

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 2019/20, with consideration of relevant internal audit findings from prior years.

Key Findings

- The Council received funding of £6,030,346 in 2019/20 under the Disabled Facilities Capital Grant Determination [31/3710] scheme.
- GCC and the district authorities agreed on the level of funding for each district alongside a pooled budget held by county to provide equipment for disabled service users across the county. This was formally agreed between the districts, GCC and Gloucestershire's Clinical commissioning Group through the Better Care Funding plan for Gloucestershire.
- Total grant expenditure by districts and GCC for 2019/20 was £5,573,840.71.
- The total carry forward for the grant into 2020/21 is therefore £3,581,432.29 when including the carry forwards of the previous financial years prior to 2019/20.

Conclusion

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

The remainder of the Disabled Facilities Grant funding (£3,581,432.29) has been carried forward into 2020/21.

Management Actions

No management actions required.

Service Area: Children's Services

Audit Activity: High Needs Block – Positional Statement and Deferral

Background

The High Needs audit was included in the Gloucestershire County Council (GCC) 2020/21 Internal Audit Plan but has been deferred to 2021/22. The intention was to complete the work during Quarter 4 of 2020/21 after the appointment of a new Director of Education in early 2020/21 who could direct the scope of the audit. However, following appointment and then turnover of the Acting Director of Education post in Quarter 3 2020/21, a new Director of Education is not expected to be appointed until early 2021/22.

The High Needs Block encompasses Independent Places, Special School places, Alternative Provision Schools (APS) and Education Health and Care plans (EHCP). The pressure on High Needs budgets is a nationally recognised one with significant budget overspend not being uncommon amongst many Local Authorities, including Gloucestershire.

The key risks are as follows:

- Overspend of the High Needs Block within the Dedicated Schools Grant;
- Increased demand for services;
- Educational outcomes for children and young people not improved; and
- Ineffective commissioning.

Scope

The objective of the audit will be to take account of the work of the High Needs Programme and focus on providing assurance over systems and processes within specific areas of spend of the High Needs Block as agreed by the new Director of Education.

Key Findings/Deferral Rationale

At the mid-year Internal Audit plan revision stage, the Acting Director of Education suggested that the High Needs audit should be deferred for the following reasons:

- The Education Service had recently embarked on a full programme of work around this area and as part of that would also be seeking external support/challenge to areas that would normally expose GCC to scrutiny;
- Internal Audit assurance had already been obtained for the following key areas: the Special Educational Needs and Disabilities (SEND) decision making process, independent placements and travel allowances; and
- It would enable the service teams to focus on high priority Covid-related activity which is anticipated to be a considerable pull on resources over the next six months.

The decision to defer the High Needs audit was also supported by the Director of Policy, Performance and Governance, the Director of Partnerships and Strategy and the Director of Finance.

The Head of Education, Strategy and Development confirmed that the High Needs internal audit should be deferred to 2021/22 for the following reasons:

- The Central government SEND review is due to be published in March 2021;
- By end of June 2021 the 2020/21 outturn figures will be known;
- Confirmation of the 2021/22 funding will have been received;
- New leadership will be in place; and
- Recommendations from the recent EHCP review will have been implemented.

Conclusion

Having given consideration to all the factors involved, Audit Risk Assurance's (ARA) Chief Internal Auditor in post at the time of preparing this report approved the deferral of the High Needs audit to 2021/22.

Service Area: Grant Certification (Children's Services)

Audit Activity: Troubled Families Grant Claim 1

Background

The Families First (payment-by-result) programme was introduced in a renewed drive to help improve the outcomes for troubled families.

The Department for Communities and Local Government (DCLG) has produced a Financial Framework for local authorities. This document makes clear that payment- by-result (PBR) is the subject of self-declaration, and therefore the purpose of this audit was to provide assurance that the Families First grant conditions and criteria had been met by the families to support the PBR grant claim.

Scope

To provide assurance that those families forming the PBR claims made to the date of the audit met the relevant criteria and that there was sufficient evidence to support the outcomes recorded.

Key Findings

As at 25th September 2020 there were 101 PBR claims prepared for submission relating to the period April to September 2020. Internal Audit testing was completed on 12 claims (12% of the population) to ensure appropriate coverage of the eligibility criteria and the six localities.

Internal Audit testing confirmed:

- Of the PBR claims sampled all met the criteria outlined by the Troubled Families Grant.
- There were systems and processes for how families and their eligibility markers (i.e. education/crime/anti-social behaviour; progress to work; and continuous employment (and off out-of-work benefits)) were being collated and verified.

Conclusion

Internal Audit is satisfied that as at 25th September 2020 the process undertaken by the Troubled Families team of assessing, collating and verifying families against the eligibility markers and related outcomes was working effectively and in accordance with the requirements of the scheme.

Management Actions

No management actions are required.

Service Area: Children's Services

Audit Activity: Foster Carer Bandings and Payments

Background

A County Councillor received an initial and subsequent complaint from a constituent concerning foster carer Banding reviews and payments. The complaints were referred to Internal Audit for review due to the nature of the complaints indicating that there were process issues and where audit trails were less than transparent.

Scope

Internal Audit was asked to provide a response to the following concerns:

- Banding assessment reviews: there were issues with the constituent being informed that they had been put onto a higher Band but later told that it was not the case until their annual review and subsequently that also changed; and
- Banding overpayments: there were concerns whether Gloucestershire County Council (GCC) had proper systems in place for identifying overpayments to foster carers that had de-registered as GCC foster carers.

Key Findings

The reviews that were undertaken were not full audits and as such opinions on risk management and the control environment were not given.

For the Bandings issue, GCC's assessment process achieved the correct outcome and the constituent's complaint was not upheld. However, the processes followed to review, approve and apply new Bandings were not robust or particularly transparent. The management actions below detail the process improvements that have been/will be made.

For the Banding overpayments issue, the constituent was incorrectly overpaid after de-registering as a GCC foster carer due to a lack of controls in place to cease making payments to de-registered foster carers, or to identify when overpayments had been made. The management actions below detail the process improvements that have been/will be made.

Management Actions

The Head of Service confirmed the following to Internal Audit in relation to Banding reviews:

- A new process flowchart has been shared with the whole fostering service and has been discussed in team meetings and in individual supervision sessions when foster carers are discussed;
- When the fostering policy is due for update the flowchart will be added to the policy with a link to the local resources;

- A further document will provide clear guidance about the Band criteria and expectations of each Band. The flowchart will also be a link within the full Band guidance and will be uploaded onto the local resources on Tri-x (procedures that underpin social care practice and safeguarding responsibilities); and
- The flowchart has also been made available to foster carers on the secure website.

The Head of Service confirmed the following to Internal Audit in relation to Banding payments:

- The foster carer payments to the constituent (now a de-registered GCC foster carer) have been stopped;
- An invoice for £6,729.48 was raised to recover the overpayments that were made to the constituent;
- An exercise has been undertaken to identify any overpayments that may have been made to other de-registered/withdrawn foster carers but no further overpayments were identified/made;
- A Children and Young People finance officer will attend the induction of new Social Workers to provide an overview of finance-related matters so that the importance of Change Sheets can be covered;
- The induction pack for new Social Worker starters in the Fostering Service has been updated and it includes processes for fostering placements. The Head of Service has agreed that process maps and flowcharts will be included in practice guidance for Social Workers so that they can be referred to subsequent to any induction training undertaken;
- Refresher training on LiquidLogic (Children's case management system) will be offered which will focus on fostering placements; and
- The Panel team within Fostering will undertake a periodic review of all foster carers that have been de-registered and ensure that the payments have been ended. This will be an additional management oversight control applied as a second line of defence in the event that the operational controls are not completed as required.

Conclusion

Internal Audit is satisfied that the management actions will help to mitigate uncertainty within the process for reviewing foster carer Bandings and provide future audit trails/evidence of decisions taken.

Internal Audit is also satisfied that corrective actions have been taken to stop future payments to the constituent and to recover any overpayments that have been made, including any that may have been paid to other de-registered foster carers.

Due to the lack of controls in place to detect overpayments to de-registered foster carers, Internal Audit is satisfied that actions have been/will be taken to strengthen the control environment, both in the first and second lines of defence.

Service Area: Grant Certification (EEI)

Audit Activity: Bus Subsidy Ring-Fenced (Revenue) Grant

Background

On 4th April 2019 a letter was issued by the Department for Transport (DfT) confirming the payment of £458,365 to Gloucestershire County Council (GCC) as a grant to cover the period 1st April 2019 to 31st March 2020. The purpose of the grant is to provide support to local authorities in England towards expenditure lawfully incurred or to be incurred by them.

The Bus Service Operators Grant (BSOG) may only be used for the purpose of supporting bus services (including community transport services under a section 19 permit), or for the provision of infrastructure supporting such services in that authority's, or neighbouring authority's, area. The letter stated that the DfT reserve the right to request data/information from local authorities and other Local Decision Bodies on the way in which devolved funds have been used and the cost of the services/infrastructure bought with the funds.

Scope

The Chief Executive and Chief Internal Auditor are required to return to the Department for Transport a declaration by 30th September 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 Authority Bus Subsidy Ring-Fenced (Revenue) Grant Determination 2019/20 have been complied with.'

Key Findings

- The Council received funding of £458,365 under the Local Authority Bus Subsidy Ring-Fenced (Revenue) Grant Determination [31/3644] scheme.

- The total expenditure in 2019/20 for tendered bus services was £3,007,575.73.

- Internal Audit sample tested 13 lines of expenditure totalling £149,524.26 (33% of grant funding) and found that the expenditure was appropriate under the grant determination [31/3644] and the amounts recorded matched to the supporting invoices.

- The grant determination stated that a survey provided by the DfT was to be completed in line with condition 3 of the grant determination. Internal Audit contacted the DfT on the 25th September 2020 to confirm when the survey would be made available for completion to allow for the sign off of the grant.

- On the 1st October 2020 the DfT confirmed to GCC that the survey had been removed due to Covid-19 and therefore would no longer form part of the grant conditions.

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 2019/20 declaration has been signed and submitted to the DfT.

Management Actions

No management actions are required.

Service Area: Grant Certification (EEI)

Audit Activity: Flood Resilience and Pothole Action Fund

Background

Department of Transport (DfT) in 2019/20 made £993,213 available to Gloucestershire County Council for the purpose of repairing pot holes and protecting local roads from severe weather. This funding came under the Local Transport Capital Block Funding (Pothole Action Fund). Gloucestershire County Council received this funding under the grant determination: No 31/3221, which determines that 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 Department for Transport a declaration by 30th September 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 (Pothole Action Fund) Grant No 31/3221 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 2019/20, with consideration of relevant internal audit findings from prior year.

Key Findings

- The Council received funding of £993,213 in 2019/20 under the Local Transport Capital Block Funding (Pothole Action Fund) grant scheme.
- In 2019/20 a total of £993,213 was spent against the Local Transport Capital Block Funding (Pothole Action Fund) grant scheme.
- Internal Audit has reviewed a sample of transactions covering 71.6% of the 2019/20 expenditure population and confirmed that the sampled expenditure was in accordance with the relevant DfT grant conditions.
- The grant funding was fully expended within 2019/20 with no carry forward into the 2020/21 financial year.

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 2019/20 declaration has been signed and submitted to the DfT.

Management Actions

No management actions are required.

Service Area: Grant Certification (EEI)

Audit Activity: Safer Roads Fund

Background

On 1st August 2017 a letter was issued by the Department for Transport (DfT) stating the allocation of the Safer Roads Fund Grant for 2017/18: No 31/3103. The grant allocation for Gloucestershire County Council for the year was £1,800,000. A further £360,000 was received in 2018/19.

Following expenditure within 2017/18 and 2018/19, a funding carry forward occurred of £217,408.64 into 2019/20.

The Safer Roads Fund may only be used 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 the Chief Internal Auditor are required to sign and return to DfT a declaration by 30th September 2020 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 Safer Roads Fund (2017/18) No. 31/3103 have been complied with.'

Key Findings

- A balance of £217,408.64 was carried forward into 2019/20 from the previous financial year.

- The records supplied by the Strategic Finance Accountant confirm that at the year-end £217,408.64 of the Safer Roads Fund Grant for 2019/20 was expended. Internal Audit reviewed a sample of transactions covering 100% of the expenditure and confirmed that expenditure was in accordance with the relevant grant conditions.

- No further funding has been carried forward into 2020/21.

- The capital expenditure for the Safer Roads Fund Grant is monitored by the Capital Accountant who has confirmed that this relates fully to the purchase of capital items, and was accounted for as such in the Council's financial system.

Conclusion

The records supplied by the Strategic Finance Accountant confirm that expenditure against the Safer Roads Fund in 2019/20 totalled £217,408.64. Therefore no further funding has been carried forward into 2020/21. Internal Audit concludes that the conditions of the Grant Determination for 2019/20 have been fulfilled.

Management Actions

No management actions are required.

Service Area: Community Safety (GFRS)

Audit Activity: Cultural Review – Position Statement and Deferral

Background

The GFRS Cultural Review was included in the Gloucestershire County Council (GCC) 2020/21 Internal Audit Plan but has been deferred to 2021/22. The intention was to complete the work during Quarter 4 of 2020/21 so that the outcome of the audit would support GFRS in preparation for the Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) return visit that was due in early 2021/22.

The Cultural Review would also provide assurance in relation to GFRS's Senior Leadership Team priorities, namely to stabilise the service, support staff to act with professionalism and pride and to have leaders that are accountable.

The key risks are as follows:

- Staff leave the organisation;
- High levels of sickness impacting resilience and workloads;
- Staff do not see change resulting in failure to engage with refreshed service priorities;
- Reputational damage; and
- Ministerial intervention.

Scope

The objective of the audit is to provide assurance that actions emanating from previous audits/reviews/surveys of culture are being implemented and to evaluate the outcome/impact of the actions to identify the direction of travel. Specifically, the audit will focus on the following areas:

- Lack of trust in values, vision and behaviours of the previous leadership team;
- Visible and transparent pathway for change, fully documented and available to all staff; and
- Managers to be seen to demonstrate the new values through their behaviours and rebuild trust.

Conclusion

Having given consideration to all the factors involved, Audit Risk Assurance's (ARA) Chief Internal Auditor in post at the time of preparing this report approved the deferral of the GFRS Cultural Review to 2021/22.

Summary of Special Investigations/Counter Fraud Activities

Special Investigations/Counter Fraud Activities

To date the Counter Fraud Team (CFT) within Internal Audit has received nine new referrals in 2020/21, and continued to work on six cases from previous years. In addition to the referrals that require further investigation by the CFT, advice has been provided to various clients which has allowed management to deal with the issues/risks promptly and prevent the matters escalating into an investigation. For example, liaising with a provider in respect of a potential duplicate invoice paid by the Council which on further investigation turned out to be an error with invoice numbers and therefore a payment due to the provider; and advice provided on the use the Council's new travel expenses system, Concur.

Three of the brought forward cases plus four of the new cases referred in 2020/21 have now been completed, of which two have previously been reported to Audit and Governance Committee.

The service areas of the cases referred to Internal Audit within 2020/21 to date are categorised as follows: Adults (3); Childrens (3); Community Safety (1); and Economy, Environment and Infrastructure (2).

Previous years' referrals closed case

Of the three closed cases from previous years, two have already been reported. The third case involved concerns relating to a joint funded package with the NHS (Clinical Commissioning Group) and centred on the level and cost of care/support being provided by a company owned by the family thus creating a potential conflict of interest. Greater scrutiny of the family involvement and costs incurred has been introduced by relevant services within 2020/21 and therefore no further action is required at this point in time.

Current year (2020/21) referrals

Of the four closed cases from the current year, two have already been reported to Committee.

Of the two new closed cases one involved an individual who had shielded during the first national lockdown. On return to work the individual provided documentation to support the application to shield. However, concerns were raised by the line manager and an investigation by the CFT established that the documents had not been provided by a medical practitioner. Disciplinary action has been instigated and the individual is no longer employed by the Council.

The other closed case involved concerns that Council grant funding provided by the Council (relevant to a community based grant issued in a previous year) had not been spent in accordance with the grant funding criteria. Investigation by the CFT established that the Council grant funding had been provided as a one off contribution towards the overall project costs (alongside other non GCC project funding streams) and that the Council grant criteria is being met. The project is still ongoing albeit with some planned changes and therefore no further involvement by the CFT in the matter is required.

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.

15th to 21st November 2020 was International Fraud Awareness Week. As in previous years, Gloucester County Council signed up as a supporter of this week. During the week, information on some of the more topical scams and areas of increased fraud risk due to the Covid 19 pandemic were shared with the Council's employees.

National Fraud Initiative (NFI)

Internal Audit continues to support the NFI which is a biennial data matching exercise administered by the Cabinet Office. The data collections for the 2021/22 exercise have been uploaded to the Cabinet Office. The data matching reports are due to be released from 28th January 2021. The timetable can be found using the following link GOV.UK.

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.