Progress report on
Internal Audit Activity
2021-2022

ARA
AuditRiskAssurance

Gloucestershire
COUNTY COUNCIL

(1) Introduction

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

The Internal Audit service is delivered in conformance with the International Standards for the Professional Practice of Internal Auditing.

(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 Council 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. 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 Head of ARA should provide progress reports on Internal Audit activity to those charged with governance. This report summarises:

I. The progress against the 2021/22 Internal Audit Plan, including the assurance opinions on the effectiveness of risk management and control processes;

II. The outcomes of the 2021/22 Internal Audit activity delivered during the period September 2021 to December 2021; and

III. Special investigations and counter fraud activity.

(4) Progress against the 2021/22 Internal Audit Plan, including the assurance opinions on risk and control

The schedule provided at **Appendix 1** provides the summary of 2021/22 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 2021/22 Internal Audit activity undertaken during the financial year to date. This includes, where relevant, the assurance opinions on the effectiveness of risk management arrangements and control processes in place to manage those risks. **Appendix 2** also reflects the dates where a summary of the activity outcomes have been presented to the Audit and Governance Committee.

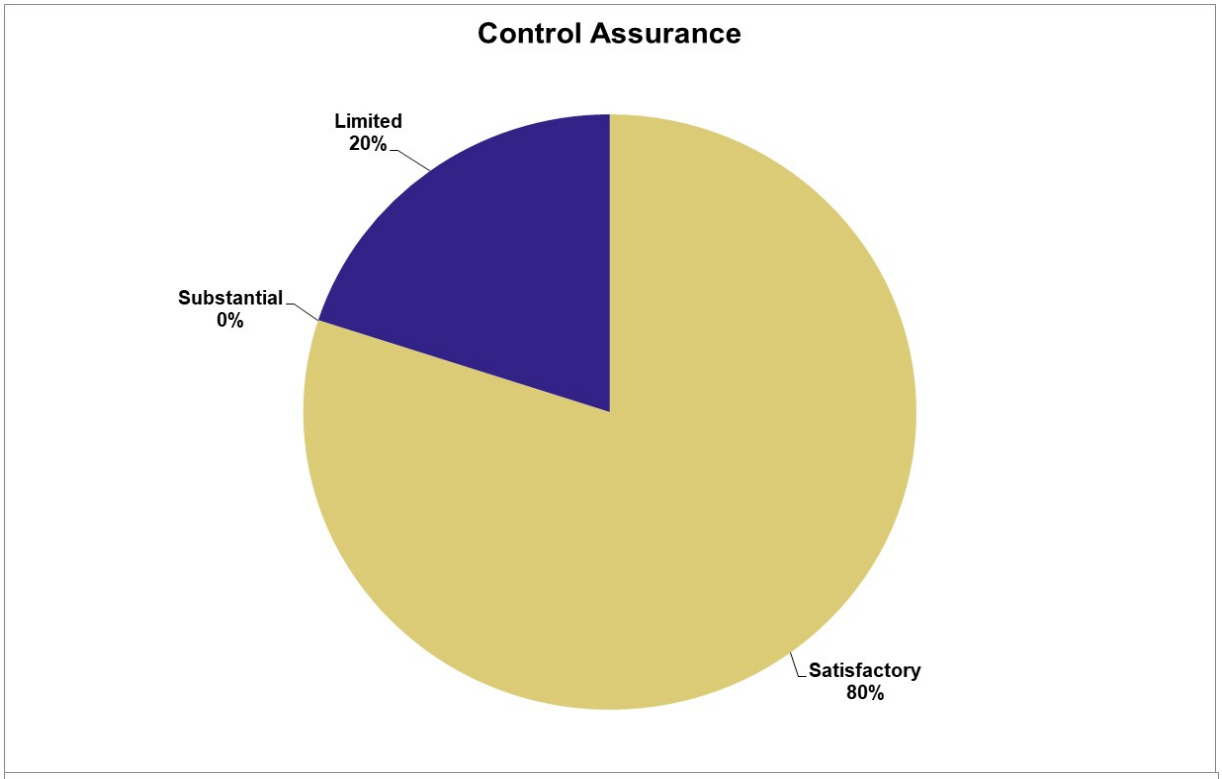
Explanations of the meaning of the assurance opinions are shown below.

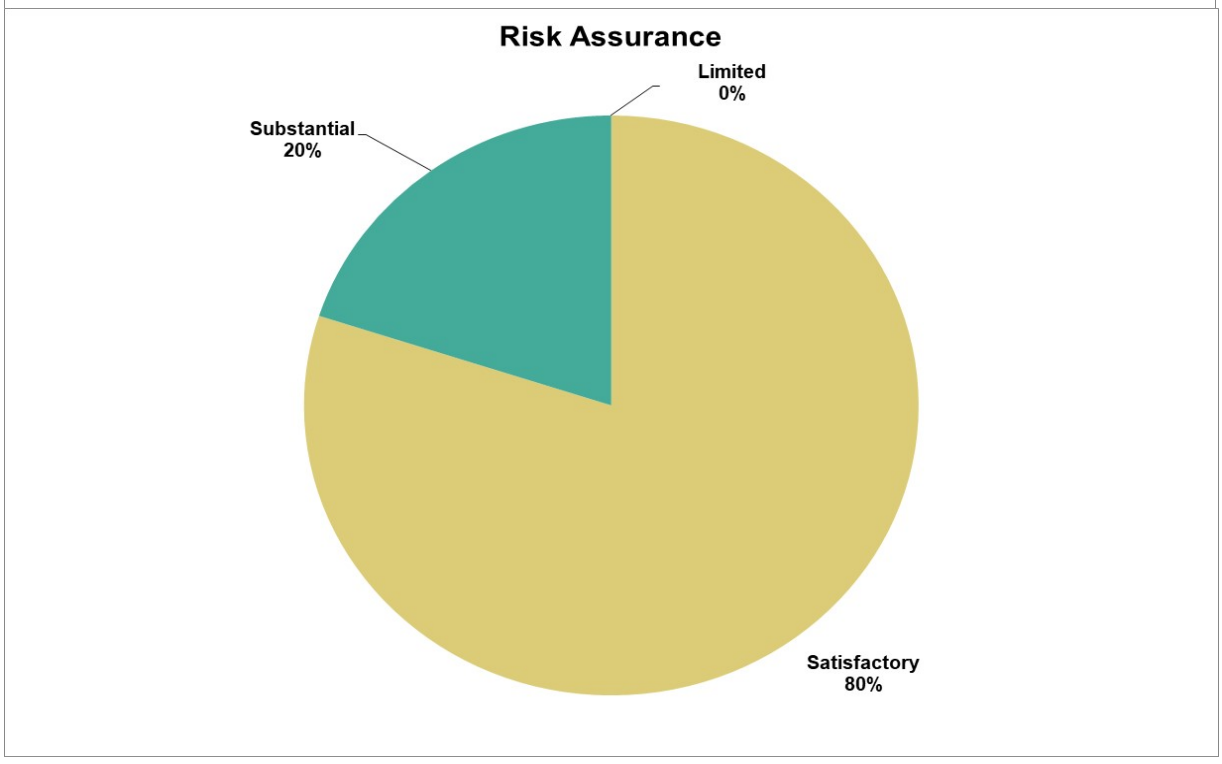
Assurance Levels	Risk Identification Maturity	Control Environment
Substantial	**Risk Managed** Service area fully aware of the risks relating to the area under review and the impact that these may have on service delivery, other service areas, finance, reputation, legal, the environment, customers, partners, 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, customers, 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, customers, 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 below pie charts show the summary of the risk and control assurance opinions provided on the 2021/22 Internal Audit activity undertaken from April 2021 to December 2021. Five 2021/22 Internal Audit activities within this period have resulted in assurance opinions.

It is noted that the majority of ARA activity delivered to December 2021 has not generated an assurance opinion, due to being a grant, consultancy or resource support activity. The outcomes from these areas are not included in the pie charts.





(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 September 2021 to December 2021, no limited assurance opinions on control have been provided on completed audits from the Internal Audit Plan.

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 2021/22 period to December 2021 Internal Audit have made **29** recommendations in total to improve the control environment. **12** of the recommendations are High priority recommendations and **17** are Medium priority recommendations.

100% of Internal Audit recommendations have been 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 September 2021 to December 2021, no limited assurance opinions on risk have been provided on completed audits from the Internal Audit Plan.

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) Activity Completion Rate

In line with prior year, the ARA target is to complete and achieve 85% of the Annual Internal Audit Plan. This target includes appropriate consideration of any Plan changes within the year.

During the 2021/22 period to December 2021 ARA has finalised 30 activities, which will increase as the year progresses.

Appendix 2 details 23 activities as in progress or draft report issued as at December 2021. In addition, **Appendix 2** confirms that Terms of Reference have been issued proactively for a number of audit and consultancy activities due for delivery within quarter 4 2021/22.

Appendix 2 items identified as 'Planned' remain a required ARA activity, based on up to date risk assessment and consultation as at December 2021. The target is for these activities to have commenced or progressed within year.

It is forecast that the 85% target will be achieved by the point of the Annual Report on Internal Audit Activity 2021/22.

(5) ARA Activity Breadth – 2021/22 Internal Audit Plan and Other

Members approved the Internal Audit Plan 2021/22 at the 25th March 2021 Audit and Governance Committee meeting.

The approved Internal Audit Plan 2021/22 contains a breadth of ARA activity across the Council's Department and Service areas. Activity types include:

i. Internal audit;

ii. Counter fraud activity and fraud or irregularity case review;

iii. Consultancy review or advice;

iv. Grant certification or review;

v. Data analytics review; and

vi. Resource support for priority areas.

All the above activity types generate an ARA outcome or conclusion, however only the internal audit activity stream will result in assurance opinions on risk and control.

When compared to prior years, the Internal Audit Plan 2021/22 includes a higher level of non-assurance opinion activity. This is due to the following factors:

i. An increased level of grants certification and review requirements, as a result of receipt of Covid-19 relevant grant funding streams by the Council;

ii. Roll out of the ARA Data Analytics Strategy, increasing the number of specific data analytics review activities;

iii. The changing risks and needs of the Council, evident through the Internal Audit Plan 2021/22 planning and consultation process. This has resulted in increased consultancy review and advice activities to enable agile and added value outcomes from ARA work; and

iv. Appropriate application of PSIAS requirements, which supports consideration and delivery of consultancy review within Internal Audit Plans.

The above weighting of ARA activity will impact Internal Audit Progress Report **section 4** and **Appendix 2** contents. The quarterly profile of ARA activity (including consideration of grant certification deadlines) will also impact the volume of activity reported to Committee per Internal Audit Progress Report.

Any update to the Internal Audit Plan 2021/22 content will be reported to Audit and Governance Committee through the Internal Audit Progress Reports. New activities to date within 2021/22 include four additional grants requiring Internal Audit certification by specified deadlines. The new grant activities are confirmed through **Appendix 2**.

Appendix 2 also reflects any wider non-Plan activities completed by ARA, to ensure Audit and Governance Committee awareness. As reported to Committee in September 2021, an example of this activity type is:

i. The ongoing work by ARA to build a commercial service offer to Academies, including the completion of an Academy pilot internal audit. The commercial offer will ensure appropriate consideration of income generation, service experience, resilience and capacity with the underlying understanding that the Academies activity should not negatively impact the level or quality of ARA service delivery to our current partners.

Completed 2021/22 Internal Audit Activity delivered between September 2021 and December 2021

Summary of Satisfactory Assurance Opinions on Control

Service Area: Corporate Resources

Audit Activity: Disposal of Assets (Vehicles) - Limited Assurance Follow Up

Background

The Disposal of Assets (Vehicles) Internal Audit report was issued on 29th July 2020 and resulted in a limited assurance opinion for both risk and control. The report contained six audit recommendations (four High priority and two Medium priority), which were agreed by management for implementation. Due to the outcome of the original review, a limited assurance follow-up internal audit was required.

Scope

The scope of this follow up review was to extract the 2019/20 Disposal of Assets (Vehicles) Internal Audit report recommendations and agreed management actions, then undertake appropriate audit review and testing to verify their implementation.

The audit review considered all vehicles disposed of by the Council including those assigned to Gloucestershire Fire and Rescue Service (GFRS), as all such disposals should be undertaken by the Council's Integrated Transport Unit (ITU).

The review considered all vehicles disposed of between March 2020 and June 2021.

Risk Assurance – Satisfactory

Control Assurance – Satisfactory

Key Findings

i. The asset disposal policy and asset disposal procedures were formally approved by the Director of Finance in March 2021, following evidenced consultation with relevant parties within GFRS and Economy, Environment and Infrastructure. Full roll out to officers was then completed on Staffnet and through subsequent Talksmart (all staff e-mail) updates.

ii. Six vehicles were identified as potentially disposed of within the review period. Audit review confirmed:

- One of these had been the result of an accident and subsequent vehicle write off;
- One vehicle was highlighted as no longer required by the service and transferred within the Council in line with Council policy and following the recommendation from the previous audit review; and

- The four remaining vehicles were confirmed as true income generating disposals.

iii. From the four vehicles disposed of, reviewed and tested by Internal Audit:

- A signed disposal authorisation form was sighted for each;
- Refund of vehicle tax was only relevant for two vehicles within the population. Informing DVLA of the sale for one had been delayed, due to Covid restrictions and closure of the auction house (outside of the Council's control);
- Maintenance costs were reviewed for the disposal population. One vehicle had maintenance expenditure prior to disposal and audit trail was provided confirming appropriate rationale for the maintenance work (to enable the asset to be brought into a sellable condition);
- Offering the vehicle to other Council services prior to disposal was only relevant to two vehicles within the population. This action was confirmed as completed for one of the two vehicles; and
- Insurance Services had been made aware of all disposals. It is noted that for one disposal and due to notification timing and audit trail, the insurance end date was recorded as a few days prior to sale of the vehicle. This caused a minor gap in the vehicle's insurance cover. It was confirmed that the vehicle was in the care of the contracted auction house for this period.

Conclusion

Due to the low number of vehicle disposals within the audit review period, the follow-up internal audit reviewed the entire sample population. However, the low disposal volume restricts the level of assurance that can be provided to confirm that the Internal Audit recommendations made have been implemented and fully embedded.

The 2019/20 Disposal of Assets (Vehicles) Internal Audit report made a total of six audit recommendations. Internal Audit follow-up review and testing has confirmed that positive progress has been made for all recommendations, with four recommendations fully implemented.

The recommendations relevant to offering vehicles to other services prior to disposal and ensuring Council vehicles remaining insured until ownership is transferred have been confirmed as partially implemented. Application of and compliance with the March 2021 asset disposal policy and procedures should ensure their full implementation.

Management Actions

There were no new recommendations made following this audit review. As referred to within the conclusion, compliance with the March 2021 asset disposal policy and procedures should ensure the full implementation of the two remaining partially implemented recommendations.

Service Area: Corporate Resources

Audit Activity: Payroll Standing Data

Background

Payroll is one of the main areas of expenditure for Gloucestershire County Council (GCC) with 4,600 staff employed as of March 2021 with an overall value of £133,424,501 for 2021. GCC have an obligation to maintain good governance of county resources and therefore need to ensure processes are in place to monitor and safeguard these assets. Ensuring that the standing data of employees is accurate and free of errors is essential to sound financial control of this area.

Payroll for GCC staff is administered by the Business Service Centre (BSC) Payroll team.

Scope

The audit reviewed the processes in place for changes to standing data within the payroll system. Specifically, to:

i. Review the adequacy of the current processes used by the BSC for changes to payroll standing data;

ii. Test to confirm that identified cases of changed standing data had been through the correct process and a valid authorisation; and

iii. Confirm any instances where data was changed outside of the prescribed process to identify the justified reasoning behind the change.

Internal Audit used data analytics to review GCC payroll data at a point in time to identify staff who had standing data changed.

Outside of the audit scope were all other payrolls administered by BSC, this audit therefore excluded Teachers, and Police payrolls.

Risk Assurance – Satisfactory

Control Assurance – Satisfactory

Key Findings

There were two identified ways that standing data can be amended for a member of staff. This was either through an E-form accessible via SAP using their unique log in or via a manual process completed by the Payroll team. The manual process is divided into two categories of changes. The first is where the employee is advising that their details (bank or personal) require change. The second is where an advice is sent directly from a bank stating that their customer has changed their account, and which comes in the form of a compiled report to the Council.

All staff with SAP access should use the E-form for bank and personal detail changes, with only staff unable to access SAP using the manual process for standing data changes.

Internal Audit identified that there were approximately 4605 staff employed by GCC at the time of the audit with 3984 staff having a license to access SAP ESS. Testing found a total of 49 bank detail changes made via E-form and 56 completed manually by the Pay and Conditions team. For Personal Detail changes there were 497 E-form changes and 90 manual changes completed.

Payroll standing data changes via E-form were sample tested to confirm if there was evidence to substantiate that the individual had completed the E-form for bank detail and personal detail changes. Evidence was provided for all the instances selected and confirmed that the changes had been made through the E-form.
It was identified through the manual process that there was a hard copy form to be completed for bank detail changes, however there was no standardised form for staff without SAP access wishing to change other personal details. Instead, the individual would write a letter or send an email to the BSC Contact Us requesting that changes be made.

For hard copy changes made by the Pay and Conditions team a sample selected identified evidence of necessary bank details forms completed. However, for personal detail changes, it was just the information provided on an email that was used as no form exists. It was confirmed through this that there was no verification process implemented for manual changes being made for bank or personal details. However, in all sampled instances there was documentation provided to Internal Audit of requests to change details being received by the team to evidence the reason for a change to the standing data of an employee.

From the sample testing undertaken, there were no changes to payroll standing data made via E-form or manual process identified, that were outside of the prescribed processes that required follow up by Internal Audit.

Draft E-forms which had not been submitted were also reviewed by Internal Audit, this identified weaknesses in the process as there was a backlog of draft forms dating back to 2014. With no current process within the SAP team to identify these or remedy the cause for them they remain pending on the SAP system.

Conclusion

There was a defined process for the amendment of payroll standing data for GCC and GFRS staff via SAP. The majority of staff have SAP access with their own unique login details allowing them to make individual amendments to their own personal details where required. However, for those staff without SAP access there are areas where the process did not have as strong control or standardised process. This included personal detail changes not having a standardised form for submission and no current verification process for manual changes which could allow for unauthorised changes to be made. Internal Audit was able to see supporting documentation for all changes to payroll standing data sampled provided by the SAP Team and Pay and Conditions Team.

Management Actions

Management have responded positively to four recommendations made, including control improvement on verification of manual changes and follow up of completed draft E-forms. The target date for their full implementation is September 2022.

Service Area: Children's Services

Audit Activity: Recruitment, Retention and Development of Foster Carers

Background

As of 31st March 2021, Gloucestershire County Council (GCC) had a total of 204 active fostering households who were caring for 71% (up from 69% in 2020) of children who are living in foster care.

In the 'Right Placement First Time' Sufficiency Strategy 2018-2021 GCC stated 'we want to be in a position where 75% to 80% of children and young people are placed with our own GCC carers. We also want to be in a position whereby we have some vacant capacity in order to be able to have some choice and effectively match the needs of those children being referred with the right carer/s.'

The Strategy recognised that GCC struggles to place certain groups within the in-house fostering service. The document states this is due to 'a lack of capacity, and also the lack of skills required to meet specialist needs'. The Strategy listed those groups that GCC finds harder to place in-house and acknowledged that there is therefore a reliance placed on Independent Fostering Agencies (IFA). The provision of this service is subject to the Southwest Regional Framework.

Scope

The audit scope comprised the following elements:

i. Review of the strategy and overall plan to be employed to ensure there would be an increased number of in-house foster carers available to achieve the 80% target by 2021. This included an assessment of issues such as the suitability of the promotional activities performed and the associated resources allocated;

ii. Assessment of the adequacy of the monitoring of progress towards reaching the target;

iii. Review of the plan and activities employed to train and develop the existing in-house foster carers to meet the specialist service user groups identified in the Sufficiency Strategy, plus any actions taken to retain existing in-house foster carers; and

iv. Evaluation of the procedures and controls within the recruitment process to ensure that the capability of in-house foster carers will be in line with the current and forecast requirements of GCC. Recruitment processes should also be adequately designed in order to identify unsuitable applicants. In-house foster carers are not employees of GCC and are thus not subject to the processes and controls operated by Human Resources.

Also, it should be noted that this audit was suspended for a period of six months from March 2020 to August 2020 due to the Covid-19 pandemic and from December 2020 to May 2021 as an external review of the foster care service was ongoing.

Risk Assurance – Substantial

Control Assurance – Satisfactory

Key Findings

The Sufficiency Strategy 2018-2021 identified a clear strategy for foster care provision that involves a mid-term increase in in-house provision (to 80% in three years). It is reasonable to conclude that the effectiveness of the strategy was materially impacted by Covid.

The GCC Fostering Outcomes and Action plan has 14 themes which now link to the strategies identified in the Fostering Strategic Plan. The Action plan now has specific targets, measures of success and progress to date. Recruitment also has its own action plan so the effectiveness of these specific measures can be assessed.

The marketing techniques and actions adopted are in line with the profile that this activity has within the context of the strategy and the allocated budget, namely circa 2% of total cost. An increase in the marketing budget would allow for specific markets to be targeted. It would also allow further development of innovative and digital marketing techniques and collaborations with local partners and employers both in the public and private sector.

Quarterly management information (MI) is produced detailing how long it takes for successful applicants to reach each milestone. This is sufficient to be able to confirm successful achievement of the statutory eight-month timescale for approving foster carers (suspended during Covid-19). There is an enquiry monitoring spreadsheet which records considerable detail including the reasons for any applicant withdrawing from the application process. There is also monthly marketing MI produced regarding detailed numbers at each contact stage and the key marketing activities undertaken.

There is a strategic plan for training and development that aligns to the goals of GCC that has an associated action plan with tangible outcomes and a record of progress. The training that carers receive is monitored with specific focus on the first year of training and fulfilment of the relevant statutory requirements. Only one of 24 carers reviewed had not completed the statutory training and extra support was being given to this person. Records of carers course bookings are also kept for completeness however in 20% of cases tested during the pandemic LiquidLogic (Children's case management system) was not updated in a timely manner despite a monthly reminder being issued.

There is a detailed process map which shows the process for recruiting foster carers up to the allocation of an assessment date. This process includes a doctor's and Employer references, Disclosure and Barring Service (DBS) checks for all members of the household and six personal references prior to an assessment which must take place within four months of allocation of a date. Due to Covid-19 the process map was revised to include a fast-track process. This revised process was also tested and was found to be followed.

Internal Audit tested 24 of the 314 foster carers recruited between 2012 and 2021. All sampled cases had received DBS checks on appointment. The follow-up DBS checks required after three years were tested for six foster carers and two were found not to have a record of these follow-up DBS checks on LiquidLogic.

Conclusion

The strategy, systems, processes and controls used to recruit and train foster carers are, in the main, adequate.

Consideration should be given to extending the time for any future strategies to take effect to recognise the impact of Covid and also the inherent time taken to ensure all applications are processed in accordance with legal requirements.

These factors continue to mean that the impact of the strategy will be felt for a number of months following the end of this current financial year.

Whilst significant efforts have been made to streamline the recruitment process and the performance of GCC in approving applicants is comparable to or above similar-sized councils, this cannot be regarded as a limiting factor in achieving the targets. The recruitment process is legally compliant and is being followed.

However, once recruited, processes should be introduced to ensure that LiquidLogic is regularly updated for training foster carers have received and to record any subsequent DBS checks required.

The biggest risk to the achievement of the targets for recruitment is the lack of resources employed to advertise and market foster caring for GCC as a career.

Management Actions

Delivery of this ARA activity was completed over a longer term than originally planned, due to the impact of Covid-19. Internal Audit greatly appreciated the support from key contacts to appropriately conclude the Recruitment, Retention and Development of Foster Carers review.

The audit raised two high recommendations concerning increasing the marketing budget and ensuring follow up DBS checks are performed three years after recruitment. It also raised one medium rated recommendation concerning introducing a process to ensure training records on LiquidLogic are up to date.

Management proactively ensured that the Internal Audit recommendations were implemented during the course of the review. The recommendations have now been closed as a result.

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

Service Area: Adult Services - Grant Certification

Audit Activity: Community Testing Grant

Background

The Community Testing Grant is specifically to support Councils with costs incurred in providing Covid-19 testing within communities. The grant is allocated and monitored by the Department of Health and Social Care.

In February 2021 Gloucestershire County Council (the Council) successfully tendered for the provision of a Community Testing Funding Grant with expected total costs of £1,269,242.60.

The initial grant covered eligible expenditure incurred between 1st January 2020 and 31st March 2021. In total the Council received £304,624 from the Community Testing Funding Grant during this period, which was the value of total incurred costs.

Scope

The audit scope was to provide assurance that, in all significant respects, the conditions of the Grant Determination have been complied with. The period under audit review was 2020/21.

Key Findings

i. The review confirmed that the 2020/21 'Final True up payment: Community Testing Financial and Operational Template' was in accordance with the Department of Health and Social Care grant determination offer letter;

ii. Audit trail provided confirmed that the sum of £304,624 had been received by the Council and ring fenced within the general ledger, through coding to the Community Testing Funding cost centre 305757; and

iii. Internal Audit reviewed a sample of transactions covering 15% of the 2020/21 expenditure population and confirmed that the sampled expenditure was in accordance with the grant conditions.

Conclusion

Based on discussion with officers and a review of records maintained by the Council, Internal Audit has gained assurance that the conditions of the Grant Determination have been fulfilled. As such the 2020/21 declaration has been signed and submitted to the Department of Health and Social Care.

Management Actions

No management actions were required.

Service Area: Adult Services - Grant Certification

Audit Activity: Disabled Facilities Grant

Background

The Disabled Facilities Grant 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. It is allocated to County Councils by the Department for Levelling Up, Housing and Communities (DLUHC), formally the Ministry for Housing, Communities and Local Government (MHCLG).

Gloucestershire County Council (GCC) received an allocation of £6,842,353 in 2020/21 from the Better Care Fund Disabled Facilities Capital Grant under the grant determination 2020/21 No 31/5267.

Scope

The audit scope was to provide assurance that, in all significant respects the conditions of the Grant Determination have been complied with. The period under audit review was 2020/21.

Key Findings

i. Audit trail confirmed the Council's receipt of £6,842,353 in 2020/21 under the Disabled Facilities Capital Grant Determination No 31/5267.

ii. GCC and the district councils agreed on the level of funding for each district alongside a pooled budget held by GCC 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.

iii. Total grant expenditure by districts and GCC for 2020/21 totalled £5,113,842.56.

iv. Funding spent by GCC in 2020/21 amounted to £2,739,166.20. £2,521,004.20 of this related to capitalised community equipment. Internal Audit tested 15 invoices from the capitalised community equipment spend (£132,145.06 – 5% of category expenditure) and confirmed that the expenditure was in accordance with capitalised expenditure requirements.

v. Unspent grant is ring fenced and carried forward into the next financial year. The total carry forward for the grant into 2021/22 was £5,309,942.73, when including the carry forwards and adjustments of the previous financial years.

Conclusion

Based on declarations provided by District Councils and having undertaken a review of records maintained by GCC, ARA have gained reasonable assurance that the conditions of the grant determination have been fulfilled.

As such the 2020/21 declaration has been signed and submitted to the DLUHC.

Management Actions

No management actions were required.

Service Area: Children's Services - Grant review

Audit Activity: Troubled Families (now Supporting Families) - review 1

Background

The Families First (payment-by-result) programme was introduced in a renewed drive to help improve the outcomes for troubled families. As of April 2021, the programme changed from the Troubled Families Programme to the Supporting Families Programme.

Within the Supporting Families Programme there are six eligibility criteria areas: Education; Crime and anti-social behaviour; Worklessness or risk of financial exclusion; Children who need help; Domestic Abuse; and Health.

Families need to meet at least two of the above eligibility criteria areas to enable them to be included in the programme. For a payment-by-result (PBR) claim to be made, the family needs to have either met all the relevant outcomes that relate to each criteria area they were experiencing, or to have found and maintained paid employment.

The former Ministry of Housing, Communities and Local Government (MHCLG) issued updated guidance on the Supporting Families Programme in April 2021. This guidance indicates that Internal Audit should verify claims prior to them being submitted.

Scope

The audit scope was to provide assurance that:

i. Those families forming PBR claims during the review period met the criteria outlined by the claim type; and

ii. There was sufficient evidence to support the outcomes recorded.

The period under review by Internal Audit was July to September 2021.

Key Findings

i. As at 30th September 2021 there were 196 PBR claims. The claims related to the period July to September 2021 and had been assessed by the Supporting Families Team as having met the criteria outlined by the Supporting Families Grant.

ii. Internal Audit selected 20 out of the 196 (10.2%) PBR claims to test compliance against the criteria. This covered all six possible eligible criteria categories and all six Council localities (Gloucester, Cheltenham, Tewkesbury, Forest of Dean, Stroud and Cotswolds). Internal Audit ensured that the sample testing was across the category criteria, as well as the continuous employment criteria.

iii. No issues were identified through the Internal Audit sample testing. Appropriate evidence was available for all sampled cases.

Conclusion

Based on discussion with officers and a review of records maintained by the Council, Internal Audit is satisfied that the process undertaken by the Supporting Families Team is in accordance with the requirements of the scheme for the period July to September 2021. The following processes were also found to be working effectively - assessing, collating and verifying families against the eligibility markers and related outcomes.

Management Actions

No management actions were required.

Service Area: Economy, Environment and Infrastructure - Grant Certification

Audit Activity: Bus Subsidy (Revenue) Grant

Background

On 30th April 2020 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 2020 to 31st March 2021. The purpose of the grant was to provide support to councils in England towards expenditure lawfully incurred or to be incurred by them.

The determination requires that councils report on how they have made use of the devolved funds and any decision-making processes that are followed. This is undertaken by completing and submitting a short survey issued by the DfT. This information should be published on the Council's website.

Scope

The audit scope was to provide assurance that, in all significant respects the conditions of the relevant grant determinations have been complied with within the period. The period under review by Internal Audit was 2020/21.

Key Findings

i. The Council's total eligible expenditure in 2020/21 for tendered bus services was £4,215,678.49.

ii. Internal Audit sample tested 19 lines of expenditure totalling £130,440.78 (equivalent to 28.5% of grant funding). It was found that the sampled expenditure was appropriate under the Bus Subsidy (Revenue) grant determination [31/5013] and the amounts recorded matched the supporting invoices.

iii. The grant determination requires a survey provided by the DfT to be completed and published on the Council's web site. The survey link was not received by the Council until 15th October 2021 and contained an extended deadline of 31st October 2021. The Auditor confirmed that the survey had been completed by the Integrated Transport Unit (ITU) and uploaded to the Council website on the 27th October 2021 within the extended deadline.

Conclusion

Based on discussion with officers and a review of records maintained by the Council, Internal Audit has gained reasonable assurance that the 2020/21 expenditure was in accordance with the requirements of the grant determination. Therefore, the declaration has been signed and submitted to the DfT.

Management Actions

No management actions were required.

Service Area: Economy, Environment and Infrastructure - Grant Certification

Audit Activity: Local Transport Capital Funding

Background

On 11th May 2020 Gloucestershire County Council (GCC) received a letter from the Department for Transport (DfT) to advise that capital funding was to be made available across three grant streams to support local transport in Gloucestershire.

The combined grant allocation across the three grant streams was £20,200,000. There was also a brought forward balance of £13,197,021.12 from 2019/20 which was included within this review of spend.

Scope

The audit scope was to provide assurance that, in all significant respects the conditions of the relevant grant determinations have been complied with within the period. The period under review by Internal Audit was 2020/21.

Key Findings

i. £13,197,021.12 of grant funding was brought forward from the 2019/20 Local Transport Capital Funding allocation. An additional £20,200,000 was received from the grant allocation in 2020/21, bringing the total grant balance under review to £33,397,021.12.

ii. None of the 2020/21 Local Transport Capital Funding grant allocation was used during the year. Strategic Finance provided evidence from SAP (GCC's financial management system) confirming the £20,200,000 carry forward as identified in the general ledger.

iii. The expenditure for the Local Transport Capital Funding grant is monitored by the Capital Accountant who confirmed that in 2020/21, £5,721,728.68 of the carry forward from 2019/20 was expended. An additional £2,373,503.26 was spent by the Council on transport capital projects during the period, but funded by other relevant time-limited sources.

iv. Internal Audit selected and reviewed a sample of 17 lines of expenditure with a total value of £967,375.66 (16.9%) of the £5,721,728.68 spent from the 2019/20 carry forward. All sampled expenditure was confirmed as in accordance with the relevant DfT grant conditions.

Conclusion

Based on discussion 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. Therefore, the declaration has been signed and submitted to the DfT.

Internal Audit can confirm the remainder of the Local Transport Capital Funding (£27,675,292.44) has been carried forward into the 2021/22 financial year.

Management Actions

No management actions were required.

Service Area: Children's Services

Audit Activity: Social Work Academy

Background

Gloucestershire Children's Services Social Work Academy (the Academy) opened in May 2019. It is a professional development centre for qualified and unqualified staff working in children and families' social work, from students and newly qualified social workers to Heads of Service. The Academy also supports a range of entry routes into social work and related professions.

The Academy is for both new and existing staff and the aim is to ensure the standard of working practice is consistent across Gloucestershire Children's Services. To enable that, the Academy's aim is to provide the tools, training and development needed.

The Academy also aims to promote and enable effective recruitment and retention of social work staff. A career pathway is provided for individuals, which outlines the opportunities for progression within Children's Social Care. The individuals will be supported to progress through the pathway.

Scope

The scope of this review was to provide assurance over the effectiveness of the following four key areas within the Academy's operations. The review therefore sought to establish:

i. Whether the Academy is maximising its reach of potential users;

ii. The reasons for delays in completion of training programmes;

iii. The stability of the infrastructure (administration and ICT); and

iv. The effectiveness of the Academy's electronic Learner Management System, Moodle.

The activity report was prepared on the basis of consultancy rather than audit and therefore no opinions were given.

Key Findings

The information which informed the findings of the audit was obtained through email and surveys completed by Academy staff and current students.

Maximising the reach of the Academy

i. Whilst there are a number of teams within Children's Social Care who use the Academy, there are others who are unaware of the training opportunities it offers. Email is the most common way that individuals hear about training opportunities, although not everyone receives them.

Completion of training programmes

i. The main reasons given for not attending training courses were work commitments and pressures put on other staff to cover the attending officer's workload. Managers should be aware of training that their staff are undertaking and this should enable them to arrange cover in advance of the training. However, it is recognised that there will be circumstances where this is not always possible. It is understood that any non-attendance is followed-up by the Academy with the individual and their line manager.

The stability of the Academy's infrastructure

i. The quality of video and audio of the Academy's Learner Management System, Moodle and Big Blue Button, can often be poor, which impacts on the delivery of the training; and

ii. Academy staff commented that they did not receive training on how to use the system, especially with regard to designing and delivering courses to others. Students also said that a dedicated system administrator they could refer to or a helpline would be beneficial.

The effectiveness of Moodle and Big Blue Button, the Academy's electronic Learner Management System

i. Some students occasionally had problems logging into Moodle and Big Blue Button and also had difficulty finding their way around the system; and

ii. Students commented that they would like bespoke training for particular areas, a wider variety of training courses to be on offer, easily accessible links to books and advance notice of a full year of programmes.

Conclusion

There are some individuals who do not receive details of courses available and are therefore missing out on training opportunities.

The lack of support on using the Learner Management System was highlighted as a concern, by both students and Academy staff. Some form of helpline or ongoing support would be beneficial, together with training for staff from a trainer's point of view.

Seven recommendations have been made, to provide solutions to the anomalies raised in the consultancy report. These include (but are not exclusive to) consideration of a communications and marketing strategy to ensure maximum exposure of the training offer; extending the advertising term for training; ensuring appropriate Moodle training for all relevant staff; and set up of more than one Moodle system administrator to enable service support resilience.

Management Actions

Management has responded positively to the recommendations made.

Service Area: Community Safety

Audit Activity: Business Fire Safety

Background

Business fire safety is covered by the Regulatory Reform (Fire Safety) Order 2005 (the Order). The Order applies to all non-domestic premises in England and Wales, including the common parts of blocks of flats and houses in multiple occupation (HMOs).

The role of the Fire Service is to ensure that the responsible person for the property has carried out their duties as required by the Order. This requires them to complete a fire safety risk assessment and implement and maintain a fire management plan. To confirm these are in place, an audit is undertaken by the fire safety team at Gloucestershire Fire and Rescue Service (GFRS).

In June 2019 GFRS was subject to an inspection by Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS). The subsequent report issued by the HMICFRS inspectors judged that business fire safety was an area of concern, giving it an 'inadequate' rating. This meant that the HMICFRS inspectors found serious critical failings of policy, practice or performance.

One area highlighted by the report was that the service had difficulty maintaining and interpreting its data, meaning GFRS may not be using it to effectively prioritise risk.

Scope

It was agreed with GFRS management that Internal Audit would undertake a consultancy review to establish whether fire safety risk processes had been reviewed and updated.

Key Findings

i. The details of non-domestic premises in the county are recorded by GFRS on a system called Community Fire Risk Management Information System (CFRMIS). There is a nationally agreed standard form for all audits which aligns to the information required to be input to CFRMIS. Following an audit, the GFRS regulator will input the information into the system and a reinspection time and risk level for the premises is automatically generated. Providing that the information being input into CFRMIS is correct, assurance can be provided that the premises are being risk assessed in line with the national standards.

ii. There is no overarching Business Fire Safety Strategy, although a policy is in place which explains how GFRS will work with businesses to ensure they meet their legal obligations.

iii. There are no documented process notes or procedures for undertaking the fire safety audits or for how to use the management information system.

iv. There is only one data-coordinator in the team who has responsibility for the day-to-day management of CFRMIS. This poses a risk with regard to business continuity to cover sickness and leave.

v. The data in the system is not being reviewed, which means there is no certainty that the information is current and up to date.

vi. Management have recognised that the current situation is not ideal. One solution being considered is to use a data management company to provide GFRS with a regular list of current non-domestic premises.

vii. A number of new regulators have been employed, although not all of them are fully trained yet, which limits the types of premises they can audit.

viii. As at 5th October 2021, there were 962 premises classified as high risk on CFRMIS. Of these, 630 audits have been completed with 332 still to be undertaken. It has been estimated by GFRS that it will take approximately six months to complete the outstanding audits.

ix. There are plans for each regulator to be evaluated every six months, on how they undertake the process and to ensure all of them follow a consistent approach. Any learning points will be disseminated to all of the team.

Conclusion

There is no guarantee that the information in the management information system is up to date and correct. Management understands that there are limitations with the current data and are pro-actively seeking a solution.

A number of new regulators have been employed and once they are all fully qualified the number of audits which can be undertaken will increase.

Documented processes for undertaking an audit, as well as for the use of CFRMIS should be produced.

There is a need for a second individual who has the same access rights to CFRMIS as the current data-coordinator, to provide cover for holidays and sickness.

Management Actions

The consultancy review did not raise formal audit recommendations.

Service Area: Corporate Resources

Audit Activity: Procurement Sourcing Pools

Background

Sourcing pools were introduced in Gloucestershire County Council in 2007. Their role is to:

i. Provide guidance to shoppers about their product categories and general shopping procedures;

ii. Challenge and confirm transactions in shopping carts and limit shopping carts;

iii. Contribute to the approved vendor list; and

iv. Approve or decline new vendor requests.

The sourcing pool role is primarily one of challenge and approvals of shoppers spend. Therefore, the consultancy review will focus on their ability as currently constituted to fulfil this role.

There are 13 sourcing pools in place. These accounted for £341,259,520 of total spend in 2020/21.

Scope

The purpose of the consultancy activity was to understand, assess and advise on the current use of sourcing pools, specifically:

i. To understand the current structure and reporting lines for sourcing pools and their relationship to product codes;

ii. To understand the allocation of approved suppliers to the sourcing pools, the oversight of that allocation and the purpose of the approved list;

iii. To assist with mapping all processes for sourcing pools in order to understand how they work in SAP (the Council's financial system);

iv. To ascertain what policies, procedures and guidance is provided to sourcing pools to define and assist them in carrying out their roles; and

v. To investigate what specific training is available to sourcing pools staff to assist them to carry out their roles.

Procurement that is not administered by the sourcing pools was outside the scope of this consultancy activity.

Key Findings

The following observations are based on the main themes of:

i. Time spent on sourcing pool activity and activities performed;

ii. Executive Ownership and Escalation Processes;

iii. Empowerment and the ability to challenge spend;

iv. Processes and Guidance; and

v. Training.

These were discussed in open online forums with all sourcing pools represented.

The challenges and issues experienced were found to be the same for all sourcing pools with the exception of ICT. ICT procurement is effectively managed 'in house' with a specific team completing the 'end to end' process of raising quotes, purchase orders and goods receipting requested from within the ICT team. Requests for IT equipment from the wider business are sent via the Service Now portal and are usually common IT stock items, so do not require bespoke purchasing procedures.

The only other identified significant difference that is apparent across the Council is that shopping with GFRS is on the basis of licenses rather than being operated on an 'open to all' basis via SAP.

The time spent on sourcing pool activity is normally between half a day and a whole day per week per person. Sourcing pool staff complete a number of key activities but spend a considerable portion of their time helping and advising budget holders and shoppers. There are a high number of retrospective orders and if these are raised correctly, they do not appear in sourcing pools. There is the possibility that these retrospective orders are being used to circumvent the purchasing process. A disproportionate amount of time is spent dealing with these.

Individual sourcing pools seem to operate in silos to the point where feedback was received that there was no cover for individual staff members sourcing pool responsibilities if they are off sick.

There is no clear, unambiguous executive ownership of 'Sourcing Pools' at Executive level. Neither is there a clear escalation process both within sourcing pools and to management. Sourcing pool staff do not believe they are appropriately empowered to challenge spend.

From the feedback from sourcing pool staff there is a lack of knowledge of the correct process and specifically knowledge of the 'Sourcing Pools' role in the process.

This lack of knowledge of the process is particularly pertinent for budget holders. There also seems to be a wider lack of knowledge of the basics of the process by shoppers. Shoppers and budget holders tend to ring sourcing pools for advice rather than try Staffnet first, this may be because the information on Staffnet is not easy to find or understand. Consequently, sourcing pools often deal with queries that could be answered by reference to Staffnet.

There is no structured training of sourcing pool staff. Formal training seems to only exist when a new person starts as part of handover. Individual sourcing pools make their own arrangements which reinforce the perception of them operating in 'silos'. There are different levels of expertise, response times which coupled with the 'handing down' of different working practices due to a lack of formal training, cause further inconsistencies between sourcing pools and 'silo working'.

Conclusion

The key decision to be made first is what role sourcing pools should perform.

If their role is one of offering advice, guidance and processing, then the current process is adequate. The challenges that sourcing pools face can be largely overcome through a better structure to avoid silo working. Also, a better understanding of the process by budget holders and shoppers as well as improved communication to both of these groups.

If the sourcing pool role is one of a control mechanism, then the process will require redesign to remove budget holder approval prior to sourcing pool involvement. This will enable them to be sufficiently empowered to challenge all spend (including retrospective orders).

Management Actions

The consultancy review did not raise formal audit recommendations. It is noted that management have responded positively to the consultancy report.

Service Area: Corporate Resources

Audit Activity: The Whistleblowing Framework

Background

Gloucestershire County Council (the Council) is committed to operating in the best way possible with honesty and integrity and has a zero-tolerance stance to all forms of fraud, danger, corruption, malpractice or maladministration.

The Council's Whistleblowing Policy applies to all employees, Members, Gloucestershire Fire and Rescue Service, apprentices, consultants, contractors, volunteers, interns, casual workers, partners and agency workers, whether full-time or part-time. Schools should have their own whistleblowing policy.

The Whistleblowing Policy sets out the arrangements for expressing and reporting any concerns, how this will be managed, confidentiality and external contacts. The whistleblowing charity Protect has developed a benchmark framework to help entities reach best practice when it comes to whistleblowing standards.

Currently, the benchmark framework has 34 standards consisting of around 200 benchmarking questions across the key areas of Governance, Engagement and Operations.

In 2017 Protect reviewed and assessed the Council's whistleblowing arrangements and issued a report that utilised a red, amber or green (RAG) formula, resulting in six green ratings, five amber ratings and three red ratings.

The Director of Policy, Performance and Governance is the Council's Monitoring Officer and responsible for the Whistleblowing Policy and procedures.

Scope

To support a review and assessment of the operation of the Council's current whistleblowing framework against Protect's Benchmark framework. The aim was to improve on the 2017 assessment scores documented in the Protect report, and eliminate all red RAG rated concerns.

Key Findings

i. Internal Audit met with Protect's Business Development Director to discuss their benchmark framework and Standards.

ii. Internal Audit developed a Whistleblowing Toolkit in Microsoft Excel that would allow the Council to self-measure itself against the 34 Standards of Protect's benchmark framework.

iii. The Monitoring Officer has been given the Whistleblowing Toolkit by Internal Audit as well as a demonstration on how to use it.

iv. The Whistleblowing Policy states for concerns 'we hope you will feel able to raise it first with your manager or team leader'. ContactUs provided Internal Audit with a list of 465 line managers with licenses on the SAP Portal (these are line managers that approve leave). Internal Audit conducted a survey of these line managers to gauge their understanding of the Council's Whistleblowing procedures.

v. The full survey responses have been shared with the Monitoring Officer.

vi. Although the majority of line managers indicated they knew what information to record, it was clear that the Whistleblowing Policy should:

   - Clarify what and how information should be recorded to ensure consistency and security of information;
   - State when whistleblowing information can be deleted, in line with document retentions schedules;
   - Include a flowchart clearly showing the whistleblowing process for staff and managers; and
   - Support potential Whistleblowers by providing examples of what would be classed as whistleblowing versus a grievance.

vii. Through discussions with the Monitoring Officer Internal Audit noted that:

- There is no oversight of all whistleblowing allegations when the Monitoring Officer is not notified. This could be resolved by the implementation of a secure and confidential Whistleblowing System for the documentation of all allegations whether founded or unfounded; and
- When the Monitoring Officer is unavailable there is no deputy who feels confident in managing the Council's whistleblowing procedures.

viii. Internal Audit met with the Council's Counter Fraud Team as they have a Whistleblowing Data Management System (Opus). The Counter Fraud Team have advised that they can provide a 'webform' on the Council's staff intranet which would allow line managers and staff to 'log' whistleblowing allegations onto Opus. Opus will then create a unique reference number for each 'log' and reports can be generated that would provide the Monitoring Officer oversight of all whistleblowing allegations.

Conclusion

Following the ARA consultancy work, the Director of Policy, Performance and Governance now has:

i. The tools to measure the Council's whistleblowing procedures against Protect's Benchmarking standards;

ii. An understanding of the procedures required to be in place to avoid any red RAG rated concerns by a Protect assessment;

iii. An understanding of the current issues faced by line managers when managing a whistleblowing allegation; and

iv. Awareness of the Opus Data Management System.

Management Actions

The consultancy review did not raise formal audit recommendations.

Summary of Special Investigations and Counter Fraud Activities

Current Status

The ARA Counter Fraud Team (CFT) has received fourteen new referrals in 2021/22 to date and continued to work on eight cases brought forward from previous years.

The service areas of the cases referred to Internal Audit within 2021/22 to date are categorised as follows: Adults (5); Children's (2); Corporate (1); County Wide (1); Community Safety (2); and Economy, Environment and Infrastructure (3).

Eight of the fourteen in year referrals have been closed. Four of those closed cases have previously been reported to the Audit and Governance Committee. The four recently closed referrals are as follows:

i. The first case related to allegations that a retained fire fighter was not accurately recording their call out times with their secondary employer and GFRS. Audit trail of the individual's shifts together with the hours recorded was reviewed. It was found that GFRS internal controls for call out recording and monitoring were accurate and there was no case to answer on this occasion. The secondary employer has confirmed they will look to improve their record keeping process;

ii. In the second case a routine annual Financial Assessments and Benefits (FAB) assessment by the FAB team identified that an individual, in receipt of services funded by the Council via a Direct Payment, had failed to declare all of their savings. Individuals with savings exceeding the capital threshold of £23,250, as in this case, are considered to be self-funding and therefore not eligible to claim Council funded services. The individual has repaid in full the £22,240 claimed in error;

iii. The third closed case was a referral in respect of a Direct Payment (DP). The DP was to cover the costs of a Personal Assistant (PA). Concerns were raised suggesting that the DP was being paid to family members living at the same address as the claimant (which is against the DP agreement) and that the agreed hours were not being provided. Adult Services reviewed the details of the support being provided and following discussions with the family found that there was insufficient evidence to withhold any payments. Based on the outcome and Adult Services confirmation, the case was closed; and

iv. The final case was linked to the receipt of potential safeguarding concerns in respect of a service provider. The CFT passed on the concerns received to the Multi Agency Safeguarding Hub (MASH). It was subsequently established that the Monitoring Officer had also received the allegations and had been in touch with the Council's Commissioning and Brokerage teams to investigate the concerns. At this time there is no requirement for any CFT involvement, but the Council will continue to look into the concerns raised to ensure that no individuals are at risk.

In respect of the eight prior year cases, five have been previously reported to Audit and Governance Committee. Of the three remaining prior year cases, two have now been closed:

i. The first closed case was the result of a whistleblowing allegation. It was alleged that staff within a specific service area were regularly not present on site on a Friday afternoon. An investigation by the CFT confirmed this to be the case, although there were a number of mitigating factors to take into account - some of which were the result of confusion around the Covid-19 guidance at that time. A further independent review was undertaken, following which a number of changes to working practices have been introduced; and

ii. The second case was the result of a complaint. The complainant alleged that there had been non-compliance with Council Policy in respect of contract procurement. As a result of the investigation, a number of recommendations were raised with the aim of strengthening the Council's existing internal controls. In addition, further work around the Council's contract procurement, recording and management will be undertaken, to raise awareness of Contract Standing Orders and Procurement policies and reiterate the requirement for compliance with these policies.

The outstanding open cases will be reported to the Audit and Governance Committee on their conclusion.

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.

Any fraud alerts received by Internal Audit from the National Anti-Fraud Network (NAFN) and other credible entities are passed onto the relevant service areas within the Council, to alert staff to the potential fraud.

Gloucestershire County Council is a supporter of International Fraud Awareness Week (IFAW) which this year took place between 14th and 20th November. During this week there were log in screen pop ups together with articles on Staffnet providing counter fraud awareness including fun quizzes and articles on how to stay safe and avoid becoming a victim of the fraudster.

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 were uploaded to the Cabinet Office between October and December 2020. The data matching reports resulting from the data upload were released from mid-January 2021 onwards.

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

Examples of data sets produced include insurance, payroll, creditors, pensions, blue badges and concessionary bus passes. Not all matches are investigated but where possible all recommended matches are reviewed by either the appropriate service area or in some cases Internal Audit. Any irregularities identified will be reviewed by the CFT.

To date and of the total 12,215 matches, 2,498 matches have been reviewed and 29 are being investigated. However, it should be noted that some teams may be reviewing the matches offline and have yet to update the NFI site. The areas reviewed so far include pensions, payroll to payroll and duplicate creditors. No specific issues have been reported as identified.