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. This states Council's '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 recognise 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 PSIAS 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 and final position on the Internal Audit Plan 2021/22, including the assurance opinions on the effectiveness of risk management and control processes;

ii. The outcomes of the delivered Internal Audit Plan 2021/22 activity; 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 activities 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 Plan activity undertaken. This includes, where relevant, the assurance opinions on the effectiveness of risk management arrangements and control processes in place. **Appendix 2** also reflects when activity outcomes have been presented to the Audit and Governance Committee.

Explanations of the meaning of the assurance opinions provided up to February 2022 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.

ARA activity reports have changed from March 2022 and the assurance opinion approach has been updated.

One assurance opinion is now provided per activity. Four opinion outcomes are possible against the following criteria:

i. Substantial assurance – all key controls are in place and working effectively with no exceptions or reservations. The Council has a low exposure to business risk;

ii. Acceptable assurance – all key controls are in place and working but there are some reservations in connection with the operational effectiveness of some key controls. The Council has a medium to low exposure to business risk;

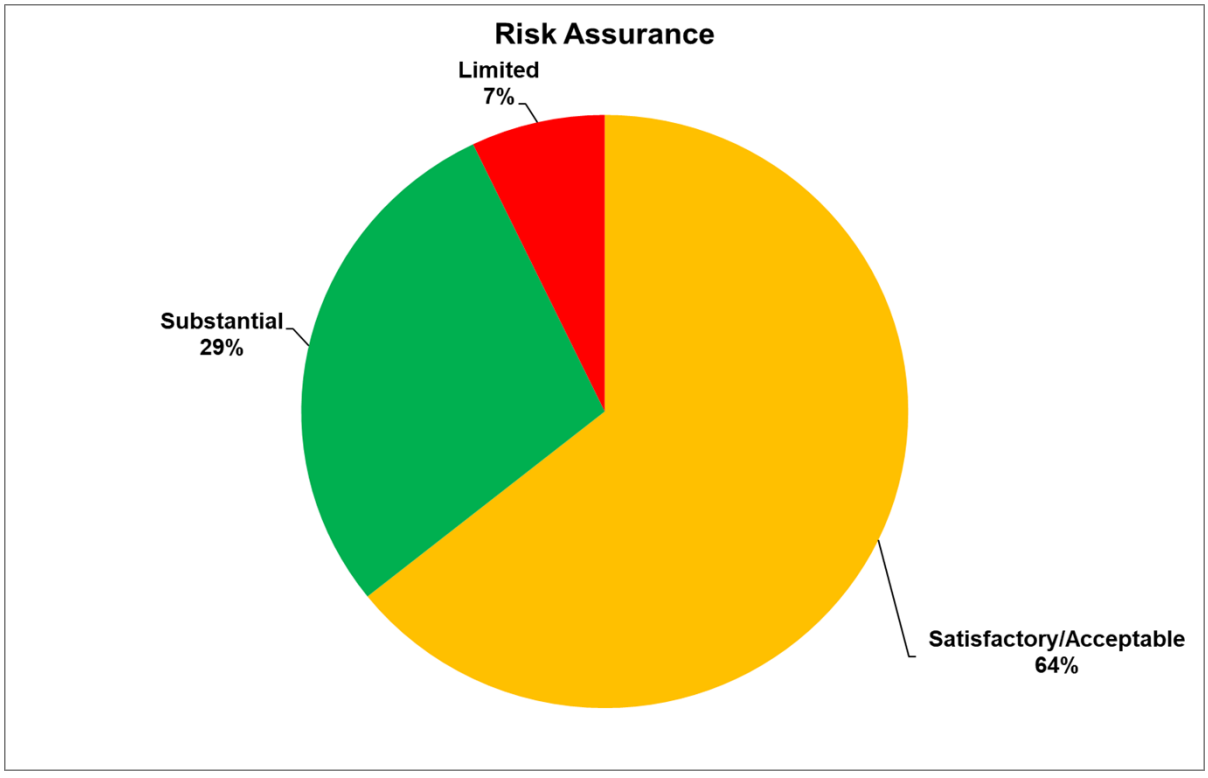
iii. Limited assurance – not all key controls are in place or are working effectively. The Council has a high to medium exposure to business risk; and

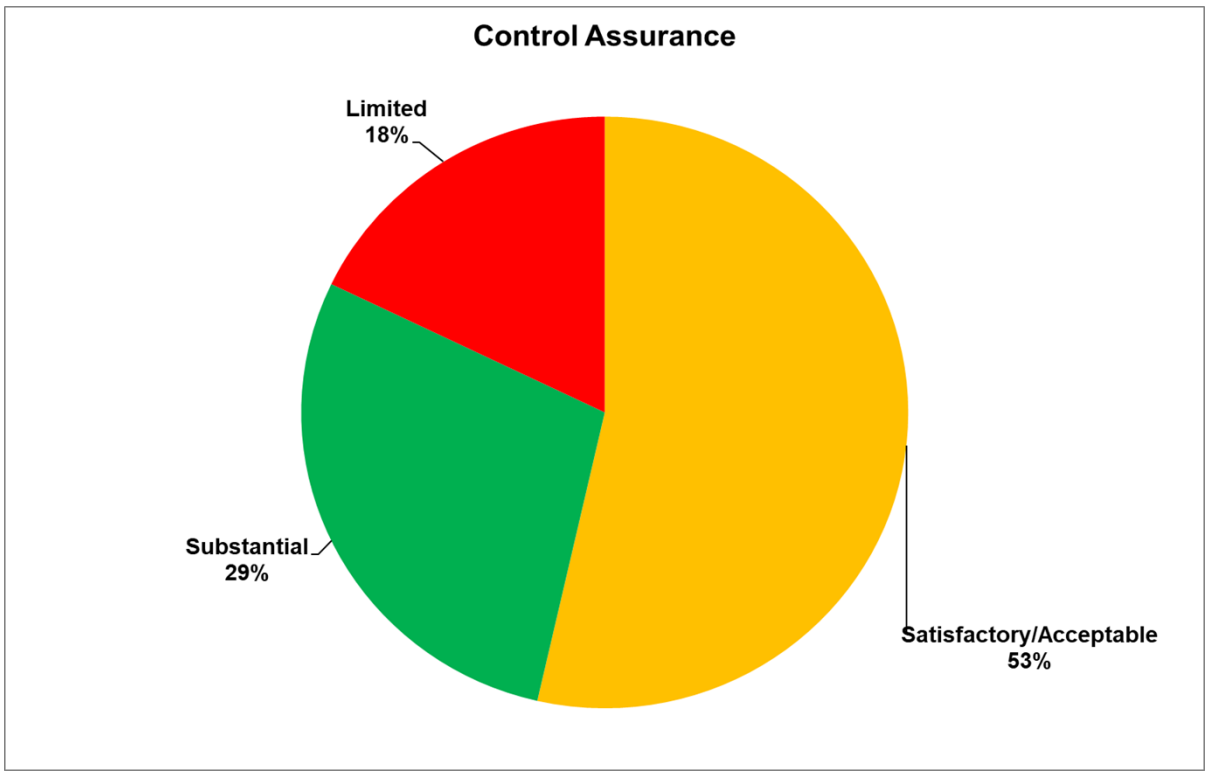
iv. No assurance – no key controls are in place or no key controls are working effectively. The Council has a high exposure to business risk.

Due to the timing of change and the transition from one approach to another, the ARA outcomes in **Appendix 2** will reflect both types of assurance within 2021/22.

(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 in relation to the completed Internal Audit Plan 2021/22 activity.





For the purpose of the pie charts, the two assurance approaches within 2021/22 have been amalgamated. There were nil 'No assurance' opinions in 2021/22.

(4b) Limited Control Assurance Opinions

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

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

Four limited assurance opinions on control have been provided on concluded Internal Audit Plan 2021/22 activity during the period March 2022 to June 2022.

These relate to school 4 and school 10; Section 17 spend including No Recourse to Public Funds - Limited Assurance Follow Up; and Traffic Signals – Asset Management and Replacement.

Where a limited assurance opinion is given, a follow up audit will be considered and undertaken to provide assurance that the agreed actions have been implemented by management.

(4d) Satisfactory Control Assurance Opinions

Where Internal Audit activities record that a satisfactory assurance opinion on control and recommendations have been made, the Committee can take assurance that improvement actions have been agreed with management.

(4e) Internal Audit Recommendations

Through delivery of the Internal Audit Plan 2021/22, Internal Audit have made a total of **93** recommendations to improve the control environment. This is compared to 96 recommendations raised in 2020/21.

For 2021/22 29 of these were high priority, 61 were medium priority and 3 were low 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

Two limited assurance opinions on risk have been provided on concluded Internal Audit Plan 2021/22 activity during the period March 2022 to June 2022. These relate to school 4 and school 10.

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.

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

Members agreed the Internal Audit Plan 2021/22 at the 25th March 2021 Audit and Governance Committee meeting. The Internal Audit Plan 2021/22 delivers a range 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 of these activity types generate an ARA outcome or conclusion, however only the Internal Audit activity stream will result in assurance opinions.

When compared to prior years, the Internal Audit Plan 2021/22 includes a higher level of activity where an assurance opinion is not given. This is due to the following factors:

i. An increased level of grants certification and review requirements, as a result of Covid-19 relevant grant funding streams received by the Council. The ARA output on these activities is sign off of the respective grant return;

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

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. Within 2021/22, audit opinions were not provided on these types of activity.

The above weighting of ARA activity will impact upon the 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 via the Internal Audit Progress Report.

Additional activities which were not originally within the 2021/22 Internal Audit Plan include (but are not exclusive to) five additional grants requiring certification by specified deadlines; and consultancy advice request on the Procurement Toolkit. The new activities are confirmed within **Appendix 2**.

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

i. The ongoing work by ARA to build a commercial service offer to Academies and Local Authority Maintained Schools, including the completion of an Academy pilot internal audit.

Concluded Internal Audit Plan 2021/22 Activity during the period March 2022 to June 2022

Summary of Substantial Assurance Opinions on Control

Service Area: Children's Services

Audit Activity: School Admissions

Background

Gloucestershire County Council (GCC) delivers the Coordinated Admissions service for entry into schools across Gloucestershire. The Coordinated Admissions service places children into schools during the normal round of admission. GCC does not coordinate in-year admissions, for which applications are made directly to individual schools.

GCC coordinates around 15,000 allocations each year for over 200 schools across Gloucestershire. The Capita ONE software package is used to support the delivery of the Coordinated Admissions service. This is a specialist piece of software containing individual modules to support service delivery across Children's Services.

There are limits on the number of admissions per school (the Published Admission Numbers, PANs). PANs mean that not all applicants can be offered a place at their preferred school and oversubscription criteria are formally applied.

The relevant statutory guidance underpinning the Coordinated Admissions service is the School Admissions Code.

Scope

The objectives of the review were as follows:

i. To assess whether GCC's guidelines and procedures were comprehensive and in accordance with the requirements of the School Admissions Code;

ii. To evaluate whether processes and procedures were operating satisfactorily, with school places correctly assigned in a timely manner; and

iii. To determine whether the arrangements in place were sufficient to minimise the risk of school catchment area fraud.

The period covered by the review was September 2020 to September 2021, allowing review of the admissions cycle for entry into the 2021/22 academic year.

The full appeals process, governed by the School Admissions Appeals Code, was not reviewed as part of this audit.

Risk Assurance – Satisfactory

Control Assurance – Substantial

Key Findings

The key findings of the review are listed below:

i. GCC's Coordinated Admissions service operates in full compliance with the elements of the School Admissions Code (2021) relevant to their remit;

ii. All Internal Audit sampled applications and allocations tested were correctly processed and had outcomes in line with GCC guidance (and the School Admissions Code, by extension);

iii. GCC's public-facing guidance is satisfactory. However, internal guidance (covering operational tasks and processes) should be more fully developed. This is compensated for at present by the depth of experience within the Coordinated Admissions Team;

iv. A risk register capturing the key risks to the delivery of the Coordinated Admissions service is not currently in use and should be developed;

v. 'Register of Staff Interests' forms are not routinely completed. It is important that both real and perceived conflicts are documented. GCC has a defined process in place for returning completed forms to the Monitoring Officer and this should be applied;

vi. A checklist, or similar, should be developed to record the outcome of key operational actions;

vii. The key requirements set out in the Traded Service - Service Level Agreements (SLAs) with schools are not directly monitored and this should take place; and

viii. There is no protocol in place for access to specific information from the Electoral Register and this should be investigated. It may require discussion and coordination with the relevant district, city, and borough councils in Gloucestershire. The Digital Economy Act 2017 may provide the necessary provisions for information-sharing.

The Coordinated Admissions Team has correctly identified that data exchange issues with other councils would be best resolved by a National Exchange Day. This has been raised within the 'Local Authority to Office of the School Adjudicator Report' over each of the past three years. No action has been taken by the School Adjudicator to date.

Conclusion

The Coordinated Admissions Team has adapted well to the shift to remote and hybrid working arrangements. The most intensive part of service delivery takes place between December and May, which was a period where the UK was placed under a full lockdown (in 2021). Despite this disruption and the associated pressures, the Coordinated Admissions Team was able to effectively deliver a key statutory service.

Management Actions

Management has responded positively to the six Medium Priority recommendations that were made, as a result of the above Key Findings iii to viii.

Service Area: Pensions

Audit Activity: Ghost Pensioners

Background

The Gloucestershire Local Government Pension Scheme (LGPS) is administered by Gloucestershire County Council. As reported in the 2020/21 Pension Fund Annual Report, there are approximately 56,800 members, split between active contributors (19,222), pensioners (17,290) and deferred members (20,274).

A main area for fraud or misappropriation within a LGPS are ghost scheme members. Specifically within the pensioners members category, for example false or fraudulently set up pensioners who are being paid a pension.

Scope

The objectives of the audit were to review:

i. That effective procedures to identify, review, challenge and resolve potential ghost pensioners are available to relevant staff and are complied with; and

ii. That controls are in place to recover monies that have been erroneously paid or taking action against potential fraudsters.

Risk Assurance – Substantial

Control Assurance – Substantial

Key Findings

Internal Audit assessed the ghost pensioners main control from start to finish as part of this review. Internal Audit also reviewed the control environment by considering the internal controls detailed in other recent audits of pensions.

The main detective control used to identify ghost pensioners is Microsoft Access, a data mining tool where the Pensions Administration Manager extracts information off Altair (the pensions administration system) and SAP (the financial management system). This is completed to ensure the data on both systems correlate. Once the control has been performed, a list is created showing unmatched records from SAP and Altair. These are then investigated to ascertain if there is a ghost pensioner. The Pensions Administration Manager verbally confirmed that there has never been a case of an identified ghost pensioner.

Internal Audit reviewed the operation of the control and found the checks performed by the Pensions Administration Manager to be effective.

Internal Audit can provide assurance that the Pensions Administration Manager tests to check for ghost pensioners occurs twice a year with the most recent being the 6th January 2022. Internal Audit agree that twice a year is suitable for running the control.

Internal Audit found that there is a single point of failure in that the Pensions Administration Manager is the only person with the correct IT knowledge to perform the control. However, there is a separation of responsibility as the Pension Administration Manager does not create the pensioners record on Altair, this is performed by the administrative team.

Internal Audit tested 30 un-matching records from the 402 that were created from running the control. All records tested were correctly dealt with. If further investigation and escalation were required, this was actioned, and where incorrect data was input, this was corrected.

After detecting a potential ghost pensioner, the pensions team informs payroll to suspend payment until an investigation is completed. This process is robust and well controlled.

Internal Audit reviewed the control environment surrounding the main detective control to provide supporting evidence that the controls in place are effective. From when a pensioner first joins the pensions scheme to the pensions team receiving proof of death, separation of duties is established. There are good controls supported by appropriate escalation processes and frequent peer reviews and sign offs throughout the control environment.

Within the control environment there are systems and processes in place that provide assurance with the LGPS membership. These include Tell Us Once; Registrars notification of death; and the National Fraud Initiative (NFI) exercise undertaken by the department every two years that identify when pension entitlement may change.

Conclusion

Internal Audit review of the Ghost Pensioners control environment verified that the existing processes in place are operating effectively.

One recommendation has been made. The Pensions Administration Manager should train someone else to perform the control using MS Access to compare the Altair and SAP databases.

Management Actions

The recommendation has been accepted, with specific actions and will be implemented by 30th April 2023.

Service Area: Pensions

Audit Activity: Pensions Information and Cyber Security

Background

An audit of Pensions Information and Cyber Security was completed in August 2019 where the arrangements in place were assessed as providing Satisfactory Assurance.

Gloucestershire County Council (GCC) entered into a cloud hosting contract with Heywards Ltd under which Heywards host the Altair pensions system. Heywood Ltd were required to complete a GCC Information Handling Requirements request during the procurement process for the cloud hosting service. This considered both office based and server based security.

Scope

The objective of the audit was to confirm that the security arrangements recorded in the Heywood Ltd Information Handling Requirements declaration are still in place and fully operational. Also, where arrangements have changed, that these provide the same or greater level of system and information security.

Assurance Opinion – Substantial

Key Findings

Heywood's information security controls and policy remain robust and changes noted between the previous assessment and the current position have only increased or improved upon existing measures.

Heywood Ltd has now been accredited with Cyber Essentials Plus, which provides the Council with a level of assurance over Heywood's cyber security controls and stance. This is an improvement over the previous assessment, in which this was not achieved.

Conclusion

The review included documentation examination, and the evaluation and sample testing of the system and processes in place. ARA conclude that overall, the existing procedures and controls provide a Substantial Assurance level in meeting the control objectives for the area under review.

Internal Audit have not identified areas where improvements can be made to enhance the existing control environment.

Management Actions

There were no management actions arising from this review.

Summary of Acceptable / Satisfactory Assurance Opinions on Control

Service Area: Corporate Resources

Audit Activity: GCC usage of CCTV in compliance with legislation – Limited Assurance Follow Up

Background

An audit of Gloucestershire County Council's (GCC) usage of CCTV was undertaken by Internal Audit during 2020/21. The subsequent report included six high priority recommendations, and a Limited opinion was given for both the risk identification maturity and the control environment. A follow-up audit was therefore undertaken in 2021/22.

Scope

To determine the extent to which the agreed actions, arising from the previous audit report, have been implemented.

Assurance Opinion – Acceptable (equivalent to the Satisfactory assurance opinion)

Key Findings

Internal Audit review and testing found that four recommendations had been fully implemented and two recommendations (ii and vi) partially implemented. In summary:

i. The Data Protection Officer (DPO) role for GCC has been amended to include the condition that the DPO is also the Senior Responsible Officer for CCTV use across the council. A dedicated resource for CCTV has also been provided.

ii. The Information Asset Register lists all known CCTV systems within GCC, but it does not have all the information for each one. The outstanding details for each system have been requested from the Information Asset Owners.

iii. A CCTV Policy has been written by the Information Management Service (IMS) and approved by the Information Board. It is available, together with other guidance, on Staffnet. Training will also be provided.

iv. Heads of Service will now have to provide information on CCTV when completing the Annual Governance Statement, to ensure awareness of their responsibilities.

v. Asset Management and Property Services (AMPS) is responsible for arranging CCTV for GCC's corporate estate buildings. The Facilities Managers within AMPS will ensure that the information is kept up to date and that IMS is made aware of changes to any of the systems.

vi. All known CCTV owners have been made aware of the need to complete the Surveillance Camera Commissioner's self-assessment tool.

Conclusion

Overall, the progress made in implementing the audit recommendations from the original review is satisfactory. This conclusion is based on documentation examined, discussions with officers and sample testing.

Management Actions

No new recommendations were made following this audit.

Service Area: Adult Services

Audit Activity: Out of County - cross charging for sexual health

Background

Cross-charging applies when residents of a given area attend a sexual health service provided in another area (known as 'Out of Area Attendances'). The 'provider' (usually a Health Trust) will charge back the cost of providing the service to that individual to their 'home' Council.

The Department of Health and Social Care (DHSC) provided guidance in August 2018 "Sexual Health Services: Key Principles for Cross Charging". This is not legally binding. Different areas will work to slightly different principles (such as what they will pay and charge for). Some councils have produced 'position statements' to clarify their local practice. Gloucestershire has not done so to date.

Scope

This audit was to review the process for charges that have been paid to 'out of county' providers of sexual health services by Gloucestershire County Council (GCC) to ensure that:

i. Only appropriate and authorised payments are made (considering the fee rates agreement, verification of service provided and service recipient); and

ii. The process complies with the DHSC guidance.

Risk Assurance – Satisfactory

Control Assurance – Satisfactory

Key Findings

The Council has a policy for payment of invoices received from sexual health providers. Invoices relating to Genito Urinary Medicine (GUM) for Gloucestershire residents treated outside of county will be paid. In line with other Councils, GCC does not pay for out of area contraception provision, in accordance with the DHSC 2018 guidance. In order for payments to be made, backing documentation needs to be provided. This is reflected in the written guidance available for staff processing invoices received.

The policy for invoice payment is not backed up by a written position statement. To enable comparison, Internal Audit obtained position statements and charging policies for other Councils. It was noted that the policies within these were similar to that within GCC. However, a number of Councils have also set a maximum level above which payments will not be made.

Payments to individual providers are recorded to enable monitoring. This has been on two spreadsheets, one for main providers, another for all other providers. Although these spreadsheets summarise payments to each provider through the year, there is currently no comparison to previous years.

A sample of eight payments totalling £9,944.08 from a total expenditure from April to November 2021 of £42,755.97 (23.26%) was examined. Each invoice corresponded to a number of patients; the exact number cannot be confirmed from the information provided to ensure patient confidentiality. ARA review confirmed:

i. Backing documentation was sighted for each;

ii. The payment related to a patient within the correct Lower Layer Super Output Area or Postcode;

iii. All appeared to be relating to GUM, other than one payment for IUS insertion (although this may have been part of other treatment); and

iv. All payments had been recorded onto the spreadsheets of payments maintained.

It was noted that rates for services varied considerably between providers. Charges made by one provider appeared to be particularly high. It was also noted that there were delays in the receipt of backing information from some providers despite chasing by staff. This has led to a delay in making payments.

Conclusion

Audit testing confirmed that appropriate payments are made.

Four medium priority recommendations have been made to improve the controls in place. This includes opportunities for spreadsheet update to enhance monitoring; and consideration of agreements between specific councils to aid compliance with processes. Also, a position statement would strengthen the Councils stance on making payments.

Management Actions

Management have responded positively to the recommendations made.

Service Area: Pensions

Audit Activity: Hymans Employee Asset Tracking (HEAT) process

Background

As quoted within the Statement of Accounts 2020/21, the Gloucestershire Local Government Pension Scheme (LGPS) had a total of 204 employers as of March 2021 and a market value of £2,902 million. It is the responsibility of the Council, as good governance, to ensure that the pension fund is safeguarded against fraud, inappropriate payments and over-payments being made.

On a monthly basis income and expenditure from the LGPS member employers is allocated onto SAP (the Council's financial management system), through ring fenced codes per employer. This information is then provided to and used by Hymans (the fund actuary) to compile relevant calculations for the fund and member employers. This includes cessation and year-end calculations relevant to financial statement regulation requirements.

An actuarial valuation of the Pension Fund is undertaken every three years to determine funding levels and contributions going forward for the next three years. The submission of HEAT data on a monthly basis ensures the actuary has accurate and up-to-date information. The approach enables improved accuracy and transparency of employer asset calculations, as the need for actuary assumptions is reduced. Should a change be required to an employer, the actuary has the relevant up-to-date information on hand. In turn, the monthly HEAT approach does not require the investment team to provide detailed cash flow data to the actuary to make final calculations.

Scope

The purpose of the activity was to:

i. Confirm and review the current procedures and controls in place regarding the HEAT process including relevant considerations of the contract between the LGPS and Hymans; and

ii. Test to ensure that the required HEAT information was complete, accurate, provided in a timely basis, monitored, and reconciled accordingly to ensure the integrity of LGPS data being sent to the fund actuary.

Risk Assurance – Satisfactory

Control Assurance – Satisfactory

Key Findings

Internal Audit identified that there is currently a contract in place for the HEAT process between the LGPS and Hymans. The contract does not provide an outline of the operational requirements that the LGPS should meet to ensure the process functions effectively.

Discussions with the pensions officers involved in the process identified there is a template provided by Hymans that is to be completed and uploaded to their HEAT data portal on a monthly basis. Use of this template ensures that the correct data categories and formats are provided. It was agreed that the reporting for the HEAT process should be run by mid-month for the previous months data and submitted by the end of that current month.

Internal Audit completed a walkthrough of the process alongside a Senior Finance Officer within the Pensions Team. The full process is to collate the monthly figures for the following areas: employee contributions, employer contributions, transfers in (internal and external) and outflows (pension's paid, lump sums, death grants, transfers out – external, and transfers out – internal). Other information that also needs to be collated onto the template is the payroll costs, administration costs, other expenses, income received and the whole fund value.

The process of collating this information and extracting the required data from SAP is complex and time intensive. The Senior Finance Officer demonstrated through the walkthrough their knowledge and expertise of navigating the various programs and functions within SAP to extract the required data.

Four employers for the month of August 2021 were sampled within the testing which included the payroll costs, administration costs, other expenses, income received and whole fund value for the same period. The figures provided to Hymans via the template upload onto their bespoke portal were all reconciled back to the SAP system and, where applicable, State Street (pension custodian).

The completed walkthrough verified that at the end of the HEAT data collation exercise, the template is uploaded onto a portal on the Hymans website. Once completed a validation spreadsheet is produced, however this is not currently reviewed by the team.

Throughout the data collation there is no management or peer review of any of the figures that are submitted to Hymans prior to the upload.

Conclusion

Internal Audit reviewed the HEAT process to understand how it is undertaken and following that confirmed the information is complete, accurate, provided in a timely basis and reconciled. It can be confirmed that this process is performing as expected, however there is no evidence available to confirm that the process is currently monitored by management.

The testing undertaken found that the information submitted to Hymans reconciled to the information available on SAP. The monthly costs, income and overall market value for the LGPS were also reconciled back to SAP figures for the period of August 2021.

Internal Audit have suggested five recommendations where improvements can be made. These are regarding the areas of business continuity, review of data prior to upload, as well as management review and what management expects to be recorded from the process.

Management Actions

Officers and management have, throughout the audit, been receptive to Internal Audit findings and have proactively begun implementing some of the recommendations raised.

Internal Audit has raised one high and four medium priority recommendations in order to strengthen the control environment and risk management monitoring arrangements. All have been accepted by management.

Service Area: Children's Services

Audit Activity: Unregulated Placements (Fostering) Limited Assurance Follow Up

Background

Regulation 24 of the Care Planning, Placement and Case Review (England) Regulations 2010 sets out the arrangements for the temporary approval of a Connected Person as a foster carer. This should be done before making a placement. In exceptional circumstances, Gloucestershire County Council (GCC) will allow an initial Regulation 24 Viability Assessment to be undertaken within one day of the placement being made. However, the placement will remain as unregulated until such time as the Agency Decision Maker (ADM) grants temporary approval.

In 2019/20 an audit was undertaken to review the operational procedures for placing children in unregulated fostering placements. The Limited assurance opinion on control resulted in a follow-up audit being undertaken in 2020/21. A further Limited assurance opinion on control was given and this resulted in a follow-up review being undertaken in 2021/22.

Scope

The objective of the 2021/22 Limited Assurance Follow Up audit was to provide assurance that the actions agreed with management to address the High Priority audit recommendation from the two previous audits had been implemented and was effective.

Risk Assurance – Satisfactory

Control Assurance – Satisfactory

Key Findings

Results of sample testing

Testing was undertaken on all 39 unregulated placements that were made from 1st January 2021 to 30th June 2021 with the following results:

i. The 'Request for a Child to Become Looked After' form now captures the Entry to Care Panel decision which allows more scrutiny and challenge for children entering care. These forms were available in LiquidLogic (Children's case management system). However, the formal recording of the approvals were often dated after the period of care start date.

ii. The results of the Police checks were not always available in LiquidLogic and were sometimes stored elsewhere.

iii. The Regulation 24 Initial Viability Assessment forms were not always available in LiquidLogic or had not been signed by all the required parties. A contributing factor is that, during the audit testing period, the document was not yet a Form on LiquidLogic. A recommendation was made that this should be progressed. The highest area of non-compliance was that the forms were not approved by the ADM within one working day of the placement start date.

iv. The Entry to Care Checklist is now a Form in LiquidLogic and this improves the workflow and storage of the documents in the case management system. The Entry to Care Checklist was completed in the majority of cases. However, a recommendation was made for Service Managers and Heads of Service to be reminded about the specific requirements surrounding the checklist as there were some misunderstandings.

Guidance for staff and management oversight

There is a Children's Social Care Procedures Manual (Tri-X) which is available on Staffnet (GCC's intranet) with sections that are relevant to placements with Connected Persons. A high-level training video on Regulation 24 requirements was developed in November 2020 and is also available on Staffnet.

When the ADM grants temporary approval for a placement under Regulation 24, the sign-off email includes reminder instructions as to next steps and actions required.

The Entry to Care Checklist includes checks for making placements with Connected Persons.

Audit findings from this review have resulted in an 'Unregulated' form being put in place. This will be completed whenever there is an unregulated placement change within the same period of care. This will ensure that the necessary safeguarding checks will still be undertaken.

The Localities Champions work with staff across the localities. A recommendation was made for their role to be enhanced to include the reinforcement of Regulation 24 requirements.

The Strategic Lead for Children in Care has left GCC and therefore the spot checks regarding compliance with placing children with Connected Persons are no longer being undertaken. At the point of Internal Audit review, other management oversight applied to samples of case files do not automatically include checks for compliance with Regulation 24 requirements.

A recommendation was made for this to be considered as a way for management oversight to be re-instated in this area.

Conclusion

Actions have been taken to improve the control environment and the guidance that is available to staff. This could be further enhanced through ongoing training and signposting of the guidance by the Locality Champions.

Management oversight arrangements have been put in place, however the checking function previously performed by the Strategic Lead for Children in Care is no longer operating. One way of addressing this could be to ensure that samples of case files include the area of Unregulated Placements made with Connected Persons.

Management Actions

Management has responded positively to the one High Priority and three Medium Priority recommendations that were made. The recommendations focus on management oversight arrangements; development of the Localities Champion role; set up of the Regulation 24 Initial Viability Assessment for on LiquidLogic; and Entry to Care Checklist completion requirements.

Service Area: Children's Services - Education

Audit Activity: Schools

Background

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

ARA undertook a benchmarking exercise with other Councils in July 2018 which identified that the average number of audit plan days allocated to schools by the benchmark group was 7%. Since then, ARA has consistently allocated 7% of the audit plan days to local authority maintained schools audits. Despite the Coronavirus pandemic, the same level of audit days was applied to the 2021/22 audit plan. However, due to delays caused by the application of a remote audit approach, there was a larger than average carry forward balance into the 2022/23 audit plan.

Scope

Internal Audit's activity within schools is prioritised based on risk and as such 12 schools (11 Primary and one Secondary) were audited on a themed basis during 2021/22. The themes selected were Governance and Budgetary Control, Bank Reconciliation, Purchasing and Income.

Some schools had multiple themes applied to them, for example Governance and Budgetary Control as well as Bank reconciliation for schools with a bank account.

A further four schools are being audited during 2022/23 to utilise the balance of the carry forward days from 2021/22. The Key Findings section reflects the common findings and assurance outcomes from the 12 finalised school audit reports only.

Schools assurance opinions applied up to March 2022:

Risk Assurance – 2 Substantial, 4 Satisfactory, 1 Limited

Control Assurance – 2 Substantial, 4 Satisfactory, 1 Limited

Schools assurance opinions applied from April 2022:

Assurance Opinion – 2 Substantial, 2 Acceptable (equivalent to the previous Satisfactory outcome), 1 Limited

Key Findings

The key findings where improvements were required in relation to the themed audits were as follows:

i. Governance and Budgetary Control (seven schools): whistleblowing policy; Finance and other policies review; provision of financial information to the Governing Body; Finance Committee Terms of Reference; declaration of interests; register of interests.

ii. Purchasing (three schools): use of order forms; approval of orders; Her Majesty's Revenue and Customs (HMRC) employment status checks; reconciliation of invoices paid.

iii. Bank Reconciliation (four schools): written procedures; non-completion of bank reconciliations; audit trails evidencing completion and review of bank reconciliations.

iv. Income including pre-school and after-school clubs (two schools): review of Finance Policy and Charging Policy; Lease agreements; lettings agreements; invoices not raised; reconciliation of income received; disputed charges; registration of breakfast club.

Within 2021/22 ARA continued to work with the following service areas in the Council to ensure a joined-up approach when delivering Internal Audit services to schools:

i. Governor Services – to collaborate on the schools' annual assurance statements for the implementation of recommendations made;

ii. Area Finance Officers – to provide internal control advice; information exchange on individual school audits; and collaboration for the development of an Internal Audit traded service for Local Authority Maintained Schools (LAMS);

Director of Partnerships and Strategy – to provide regular progress updates in relation to the 2021/22 Children's Services audit plan including schools audits;

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

iv. Education Outcomes and Intervention – to obtain support and advice for schools causing concern;

v. Counter Fraud – to make referrals for suspected fraud and irregularity; and

vi. GCCPlus Traded Services – to further develop an Internal Audit traded service for Academies; and to initiate the development an Internal Audit traded service for LAMS.

Conclusion

The common findings from the 2021/22 school audits will be shared with all the LAMS once the carry forward audits have been completed during 2022/23. This will be via Schoolsnet (the Council's schools intranet) and the Heads Up and What's Up Gov newsletters. It will enable the schools to undertake a self-assessment against the findings identified and implement improvement actions to address the risks should they apply.

Management Actions

Individual reports were issued to each school audited for which management responses were obtained and agreed. No recommendations were made for one of the school audits.

On an annual basis, the Governing Bodies whose schools were audited are required to submit a return confirming the progress that has been made with the implementation of the recommendations. A summary report is presented to the Audit and Governance Committee providing assurance that processes are in place to manage Internal Audit identified risks and confirms update on recommendation implementation. The annual assurance report for the 2021/22 audit recommendations will be presented to the July 2023 Audit and Governance Committee.

Summary of Limited Assurance Opinions on Control

Service Area: Economy, Environment and Infrastructure

Audit Activity: Procurement of Short Term Transport Arrangements for Social Care Users – Limited Assurance Follow Up

Background

The Integrated Transport Unit (ITU) operates a Dynamic Purchasing System for procuring transport for use by children and vulnerable adults. Transport can either be short-term (which is for periods of less than two weeks) or more long-term. Officers wishing to procure transport arrangements commission it via a dedicated page on Staffnet.

During 2018/19 Internal Audit undertook a review which sought to provide assurance that transport was being procured in a timely manner and short-term contracts were not being rolled over. The safeguarding controls relating to approved transport providers were also reviewed. However, the outcomes of the review, which were presented to the July 2019 Audit and Governance Committee, only confirmed limited assurance on both risk identification maturity and the control environment.

A follow-up audit was therefore undertaken.

Scope

The objective of this audit was to provide assurance that the actions agreed with management to address the 2018/19 recommendations have been implemented and are effective.

Risk Assurance – Satisfactory

Control Assurance – Limited

Key Findings

The 2018/19 audit review included ten recommendations. The 2021/22 Internal Audit follow-up review and testing confirmed that positive progress has been made and seven of the recommendations have been fully implemented. Two recommendations have been partially implemented and one not implemented (this relates to having a completed operation risk register). Four new recommendations were made, based on findings from the follow up review.

A spreadsheet is maintained of all badges issued. However, it is not monitored to highlight badges which are due to expire and consequently need renewing or returning to GCC.

Recommendations were made to review the spreadsheet and establish which badges were out of date and to contact the appropriate transport operators. In addition, a process should be established for monitoring the expiry dates of the badges.

A process is required to monitor DBS clearances. Until this has been established, the DBS team should check each individual clearance on the anniversary date. An operational risk register should be completed, reviewed and updated on a regular basis.

Conclusion

While positive progress has been made against the original audit report recommendations, the partially implemented and outstanding recommendation areas are high risk. Hence, only limited assurance on control can be given.

The four new recommendations made in the follow-up report relate to the areas in the original report where actions were still outstanding – driver ID badge controls; monitoring of DBS clearances; and completion of an operational risk register.

Management Actions

Management has responded positively to the new recommendations.

Service Area: Children's Services

Audit Activity: Section 17 spend including No Recourse to Public Finds (NRPF) – Limited Assurance Follow Up

Background

Under Section 17(1) of the Children Act 1989, Councils have a general duty to safeguard and promote the welfare of children within their area who are 'In Need'. The term 'Section 17' is often used as a shorthand way of describing the statutory services that Council's provide to Children in Need who are looked after by their family.

During 2019/20 Internal Audit undertook a review of Section 17 funding. This was to ensure it was only provided where necessary, and that processes were robust and consistently applied across the six localities. The audit resulted in a Limited assurance opinion being given for the control environment with three High Priority recommendations and one Medium Priority recommendation being made.

Scope

The Follow Up audit was to provide assurance that the agreed management actions to address the four recommendations had been fully implemented and were operating in practice.

Risk Assurance – Satisfactory

Control Assurance – Limited

Key Findings

Monitoring of Spend

An Access to Resources Panel (Resources Panel) had been created to perform a central authorisation function for Section 17 spend exceeding £50. An E-form which is held within LiquidLogic (Children's case management system) had also been developed to support the Resources Panel in their decision making. This replaced the Service User Assistance Form (SUAF) for expenditure over £50.

Discussion with the Resources Panel Chair confirmed that Team Managers still retained responsibility for the approval for expenditure under £50 and that this would be via a SUAF. This process differed from the management update provided for Recommendation one that stated that the Resources Panel was to be used for all spend and not just spend over £50.

Further testing of Section 17 expenditure across localities identified non-compliance with Accounting Instruction No.1 whereby cumulative spend with vendors was in excess of contracting thresholds.

Use of Purchase Orders

Testing of documentation and discussions with staff confirmed that pink slips (for the authorisation of invoices without purchase orders) were no longer used by the localities. This was in accordance with Recommendation two and the corresponding management response received. However, the current process was to raise retrospective purchase orders to align them with an invoice that had already been received from a vendor. This was not in accordance with Accounting Instruction No.1 which states that retrospective orders should only be used in exceptional circumstances.

Assessment and Approval Process

A sample of 12 Section 17 expenditure items was tested by Internal Audit across the six localities to confirm that they were in accordance with the revised processes.

Of the 12, four were identified as having the following issues:

i. Actual Costs incurred exceeded the amount agreed by the Resources Panel for two of the sampled transactions (a combined overspend of £540);

ii. The request for Section 17 support was rejected by the Resources Panel on the grounds that it would not be effective. Resources Panel provided challenge that other potential avenues of support should have been considered, however the services were still provided by the locality (£480); and

iii. Instances where no evidence of spend over £50 went to the Resources Panel for approval prior to the services being provided (£2,273.20).

Internal Audit testing identified that the Business Support team undertakes monthly monitoring of expenditure by localities. However, where SUAFs are still used, there is no monthly review of the completed documents to confirm the adequacy of the information provided on the forms.

Use of Service User Assistance Forms (SUAFs)

The process for expenditure below £50 was also tested by selecting a sample of 12 records. The management response to Recommendation three confirmed that all SUAFs and associated documentation would be uploaded to LiquidLogic and that the information provided on the SUAFs would be consistent. The localities were not able to locate two of the SUAFs in the Internal Audit sample. For the 10 SUAFs that were available there was inconsistency in the level of detail provided by the social workers. There were also instances where Auriga (a facilitator for the provision of goods and services) would have been able to provide the support. However, this avenue was not pursued by the localities and no justification for this was provided.

Conclusion

From the follow-up review and testing undertaken, Internal Audit was able to identify that progress had been made towards improving the control environment for Section 17 expenditure. This was through the creation of the Resources Panel and the associated E-form on LiquidLogic for the approval and review of expenditure by teams.

However, there remained areas where the current practices within the locality teams was not aligned to the management responses or the progress update to the Audit and Governance Committee. This had resulted in the recommendations not being fully implemented where risks were still present to the achievement of the objective of providing effective support through Section 17. Internal Audit therefore made four new recommendations to further strengthen the control environment for Section 17 support and the opinion remained as Limited.

Management Actions

Management has responded positively to the four recommendations made and will seek to implement improved controls over the next 12 months to further reduce the risks identified.

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

Service Area: Council Wide - Grant

Audit Activity: COVID emergency funding grant 2020/21 and 2021/22

Background

In March and April 2020, the government provided emergency grant funding and cashflow support to assist local authorities through Covid-19 and manage the immediate and long-term impacts of the pandemic. Further allocations were made during both 2020/21 and 2021/22.

The Emergency Funding Grant is not ringfenced and in 2020/21 Gloucestershire County Council received £33,846,623 in funding, with £11,526,060 received in 2021/22.

Scope

The audit scope was to provide assurance that the framework in place within the Council ensures that the funding is monitored effectively, and expenditure is in line with Government expectations.

Key Findings

i. The framework in place to monitor and report on grant expenditure was robust.

ii. Internal Audit reviewed the Corporate Resources budget holder expenditure spreadsheets dated April 2020, November 2020, April 2021 and November 2021. Internal Audit found that all expenditure was linked to Covid-19 costs and in line with the expectations of the grant.

iii. Internal Audit reconciled two costings of £8,925 and £620,968.83 on the Corporate Resources budget holder expenditure spreadsheet for April 2020 against the figures entered on the Delta online system. Internal Audit found that they had been entered as £0.089m (April actual) and £0.625m (May projected) rather than the expected £0.009m and £0.621m. This was discussed with the Finance Manager (Projects) who stated that these errors had been noted and a more robust process implemented to prevent this type of error reoccurring.

iv. The Finance Manager (Projects) stated the Delta system provided by the Department for Levelling Up, Housing and Communities (DLUHC) in 2020/21 did not allow for changes to actual reported figures. They stated that the April 2020 error and other changes were reported but evidence was not given. The actual May figure was correct on the May return. The inability to change prior actuals was noted by the DLUHC and in 2021/22 the Delta system permitted the reporting of actuals to date rather than by month.

v. Internal Audit sampled three further payments between November 2020 and November 2021 and found that they had been accurately entered on the Delta system.

Conclusion

The review included discussions with officers and a review of records maintained by the Council. From this, Internal Audit has gained reasonable assurance that there is an effective framework in place to ensure that the grant funding is monitored effectively, and expenditure is in line with Government expectations.

Management Actions

No management actions were required.

Service Area: Children's Services - Grant

Audit Activity: Troubled Families - second review

Background

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. Within each of these areas there are various indicators to show achievement of eligibility. 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, in all significant respects; the conditions of the grant have been complied with. The period under review by Internal Audit was January to March 2022.

Key Findings

i. As at 28th March 2022 there were 163 PBR claims. The claims relate to the period January to March 2022, and have 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 163 (12.3%) PBR claims to test compliance against the criteria. This covered all six possible eligible categories of criteria listed above and all six Council localities (Gloucester, Cheltenham, Tewkesbury, Forest of Dean, Stroud and the Cotswold). Internal Audit found that all claims this quarter met all relevant outcomes that were applicable to them and that there were no continuous employment claims made.

iii. Internal Audit were made aware that by the third quarter of the financial year, Gloucestershire County Council had achieved 100% of its allocated claims. The Department for Levelling Up, Housing and Communities (DLUHC) provided advice allowing the Council to "bank" the additional claims from quarter four and submit them for payment within quarter one of 2022/23.

Conclusion

Based on discussions 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 January to March 2022. This includes assessing, collating and verifying families against the eligibility markers and related outcomes are working effectively.

Management Actions

No management actions were required.

Service Area: Children's Services - Grant

Audit Activity: Additional Home to School Transport Grant

Background

During the Covid-19 pandemic the Department for Education (DfE) provided Gloucestershire County Council (GCC) with grant funding to support Additional Home to School transport arrangements for children in education. This funding was granted to support local authorities in providing extra capacity for Home to School transport arrangements to be in accordance with social distancing measures implemented in schools and colleges.

There were a total of six tranches of funding received by GCC during 2020/21 and 2021/22 for the period September 2020 to July 2021. These grants were also subject to a reconciliation process in the autumn of 2021 to inform the DfE of any underspend from the grants.

Scope

To review the Additional Home to School Transport Grants and provide assurance that the funding had been spent in line with the guidance from the DfE. The Chief

Executive and Head of ARA also have to provide a declaration back to the DfE confirming the following:

"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 Additional Dedicated Home to School and College Section 31 Grant S31/5137, 31/5268, 31/5370, 31/5568 and 31/5671 have been complied with".

Key Findings

i. GCC were provided with six tranches of grant funding to support Home to School transport arrangements by the DfE. The first of these was received in September 2020 and the last of the six tranches received in July 2021. These allocations of funding covered the Autumn 2020 term, Spring 2021 term and Summer 2021 terms.

ii. Across the six tranches there was a total of £1,430,277 in funds received by GCC. The purpose of this was to ensure social distancing and bubbles could be in place while traveling to and from education establishments. Of the grant funding received, there was a total incurred expenditure of £1,325,626.

iii. Internal Audit met with the Principal Finance Officer (PFO) who supported the grant spend through budget monitoring. The PFO provided a spreadsheet used to monitor the grants actual expenditure. This was completed through extraction of actuals data held on the Capita system that was used to manage the home the school transportation contracts.

iv. A sample of 29 payments was selected from the monitoring spreadsheet totalling £111,664 (8.4% of overall spend). The PFO was able to demonstrate that the expenditure incurred according to the monitoring spreadsheet matched the Capita system and SAP (GCC financial management system) payment records for the sample reviewed.

v. The Integrated Transport Unit (ITU) who manage the home to school transport contracts provided copies of the invoices for the 29 sampled payments. These were reviewed and found to be in accordance with the grant determinations in being costs for providing home to school transport.

vi. The final grant determination required that in the autumn (2021) there would be a reconciliation process. This was required to be completed to identify if there were any unspent funds due to be returned to the DfE from across the grants. Internal Audit saw evidence that the ITU had completed the reconciliation return to the DfE. This had been completed using the same actuals of identified spend as the budget monitoring spreadsheet.

vii. The DfE had calculated the underspend from the grant return reconciliation provided in November 2021.It was calculated that a total of £104,651 was required to be paid back to the DfE. This however did not reconcile to the amount of £203,683 which had been calculated as the actual amount of underspend from the budget monitoring undertaken by Strategic Finance.

viii. The difference between the Strategic Finance underspend and the DfE invoice was due to an extra £100,000 of Travel Demand Grant received from the Department for Transport (DfT).
In addition, parking charges of £968 relating to the extra provisions of transport for children had been charged against the grant.

ix. The sum of £104,651 as requested by the DfE should be returned. The Travel Demand grant is outside of the scope of this audit however, Strategic Finance should ensure that this grant funding is reviewed to ensure it is used appropriately or returned to the DfT.

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 determinations have been met. Therefore, the declaration was signed and submitted to the DfE.

Internal Audit could confirm that there are no applicable carry forwards, as the grant underspend was returned to the DfE.

The Travel Demand Grant was included within the monitoring spreadsheet for the Additional Home to School Transport Grant.

Management Actions

A recommendation relating to the Travel Demand grant identified through the course of this audit was raised with Strategic Finance. Management have accepted this recommendation and will pursue this matter further.

Service Area: Adult Services

Audit Activity: Direct Payments – Investigation Follow Up

Background

A follow-up audit was undertaken to ensure that the recommendations, which emanated from a direct payment (DP) investigation, have been implemented. The original joint investigation was undertaken by Gloucestershire County Council (GCC) and the Gloucestershire Clinical Commissioning Group (CCG). It led to the prosecution of the person responsible for managing the DP on behalf of the service user.

The original investigation mainly involved the alleged provision of personal assistant (PA) hours by the sibling of the service user. It was shown that the claimed PA hours could not have been provided, due to the PA working elsewhere or being on holiday abroad.

Scope

The scope of the review was to ensure that the nine recommendations resulting from the original investigation report (final report issued September 2018) had been implemented by management.

Key Findings

i. The recommendations made previously have been positively progressed by management with four out of the nine fully implemented, two partially implemented and two being no longer relevant due to process update or wider controls in place that mitigate the identified risk. Only one of the original recommendations remains outstanding.

ii. Management reviewed two of the original recommendations and came to the conclusion that they are no longer required. One recommendation was covered by the Council's Code of Conduct for staff. Legal advice confirmed that the other recommendation was not necessary as it is already included within the Council DP Policy.

iii. Recommendation 8, which recommended that both GCC and the CCG should consider a joint internal audit for the end to end processes involved as a part of this internal assurance process, has not yet been implemented. It is noted that the 2022/23 Internal Audit Plan includes a review of Direct Payments (Adults).

iv. Issues still remain with the DP subject to the original investigation. Those recommendations that had been partially implemented related to this case had legitimate reasons for delay in full implementation.

Conclusion

The majority of the original investigation recommendations have been implemented or management has confirmed they are not required. As referred to in Key Findings, the outstanding recommendation of a joint GCC and CCG internal audit review is mitigated by the 2022/23 GCC Internal Audit Plan including an internal audit of Direct Payments (Adults). The joint review approach is still an option for consideration. There remains issues with the specific DP case and a new ARA recommendation has been made relating to appropriate confirmation/substantiation of PA working hours.

Internal Audit can confirm that there is now a much improved general control environment for DPs, specific to the implementation of prepayment personal accounts (PFS accounts) for all new DP cases. In addition, the majority of the old style DP accounts have transferred to PFS accounts. The Council, via the DP team, now have live access to PFS accounts and can monitor these accounts, noting and addressing any potential irregularity early on. Management feedback identified that this approach has also enabled recovery of unused, excessive or closed account balances. This had previously caused problems with the DP accounts being in the name of the service user or their appointee. The Integrated Social Care Manager confirmed that for 2020/21 over £1.176m was recovered by the Council, of which £1.055m related to sums recovered from PFS accounts.

Management Actions

Management responded positively to the new ARA recommendation made, confirming a December 2022 implementation target.

Summary of Special Investigations and Counter Fraud Activities

2021/22 Final Position

The ARA Counter Fraud Team (CFT) received sixteen new referrals in 2021/22 and continued to work on one case brought forward from previous years. This is compared to twelve new referrals received in prior year (2020/21).

The service areas of the cases referred to the CFT within 2021/22 were categorised as follows: Adults (6); Children's (3); Corporate (1); County Wide (1); Community Safety (2); and Economy, Environment and Infrastructure (3).

Thirteen of the sixteen in year referrals have been closed and nine have previously been reported to the Audit and Governance Committee.

The four recently closed cases are:

i. A letter was received by the CFT alleging that a family had deliberately failed to fully declare their financial position and assets during a Financial Assets and Benefits assessment. The claims were investigated by the CFT and there was no evidence found to support the allegations;

ii. An unannounced spot check of cash at one of the County's libraries identified a potential loss of cash. Investigation by the CFT found that the loss could be attributed to poor record keeping and accounting errors. A report containing recommendations to strengthen current internal controls and therefore reduce the risk of future similar occurrences was issued;

iii. Thieves targeted several parking machines across the County over a period of a couple of weeks. The thefts were reported to the police and additional monitoring of the car parks was introduced during this time. The perpetrators were not caught; and

iv. Concerns were raised on the use of a Direct Payment (DP) bank account and potential monies owed to a Personal Assistant (PA). The DP has subsequently been changed to a receipt account meaning that funds are only released on receipt of an invoice. The monies due to the PA were reviewed and payment was made.

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.

Many potential attempted frauds are intercepted. This is due to a combination of local knowledge and also the credible national communications including those from the National Anti-Fraud Network (NAFN) being swiftly cascaded to teams where more national targeted frauds are shared for the purpose of prevention.

Within 2021/22, the CFT provided support and guidance to Council staff in respect of Interviews Under Caution, court file preparation and taking witness statements where required.

National Fraud Initiative (NFI)

Internal Audit continued 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, 8,630 matches have been reviewed and closed. As a result of which, £12,891 is being recovered. It should be noted that some teams are 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.

The next NFI data upload will be October 2022.

2022/2023 Current Status

For Committee awareness, the ARA CFT has received two new referrals in 2022/23 to date and continued to work on four cases brought forward from previous years.

The service areas of the cases referred to the CFT within 2021/22 to date are categorised as follows: Adults (2).

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

Any fraud alerts received by Internal Audit from NAFN and other credible entities continue to be passed onto the relevant service areas within the Council, to alert staff to the potential fraud.