Gloucestershire COUNTY COUNCIL

ARA AuditRiskAssurance

Gloucester City Council | Stroud District Council | Gloucestershire County Council

PROGRESS REPORT ON INTERNAL AUDIT ACTIVITY

JULY 2023

1. Introduction

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

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

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

i. The progress against the Internal Audit Plan 2023-24;

ii. The outcomes of the 2022-23 and 2023-24 Internal Audit activity delivered up to July 2023; and

iii. Special investigations and counter fraud activity.

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

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

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 low to medium exposure to business risk;

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

2. Summary of 2022-23 and 2023-24 Internal Audit work delivered up to July 2023

Audit	Assurance Level	Supporting Paragraph
Local Authority Maintained Schools (LAMS)	Limited Limited Limited Acceptable Acceptable Acceptable	2.1
Panel Arrangements (Children's Services)	Acceptable	2.2
Section 117 – Aftercare Arrangements	Acceptable	2.3
Youth Justice Service (YJS) (Children's Services)	Acceptable	2.4
Grant Certification (Service Areas: EEI, Adults)	Grants Certified	2.5
Supporting Families (Service Area: Children's Services)	N/A	2.6

Summary of Limited Assurance Opinions

2.1 Local Authority Maintained Schools (LAMS)

i. Assurance Levels:

Three schools: Acceptable; and
Three schools: Limited

ii. Recommendations arising from the audits have been prioritised as:

High Priority: 28
Medium Priority: 13
Low Priority: 1
Rejected: 0

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

ARA has consistently allocated 7% of the productive plan days to LAMS audits. They were delivered over the 2022-23 academic year resulting in audits being carried forward into the 2023-24 financial year.

Internal Audit's activity within schools is prioritised based on risk. Due the financial risk of the academisation of schools, the Director of Children's Services requested that all schools with an actual deficit at the start of 2022-23 should be audited. As such, 14

Primary Schools and one Special school were selected for audit. At the time of writing, six audits were finalised, six were at draft report stage and the remaining three were scheduled for completion by mid-July 2023.

The themes selected to support the financial risk of academisation were Governance and Budgetary Control, Purchasing, Income (including breakfast and after-school clubs) and Staffing and Payroll. The Assurance levels, Recommendations and Key Findings sections reflect the outcomes from the six finalised school audit reports only.

2.1.2 Key Findings

i. Governance and Budgetary Control: financial information not provided to governors; Finance and other policy reviews outstanding; quality of minutes vary; declaration of interest forms incomplete; Terms of Reference out of date; annual budget not approved in a timely manner; Schools Financial Value Standard not completed on time or reviewed and approved by governors.

ii. Purchasing: no pre-approval of orders; commitments not entered onto the financial system; lack of payment authorisation; different systems in use to pay invoices; no reconciliation of invoices paid; non-compliance with policy; incomplete contract register.

iii. Income: outstanding debts not being effectively managed or reported; income paid to incorrect account and not transferred to GCC; no reconciliation of income received.

iv. Staffing and Payroll: non-compliance with the claims process; no review of payroll information.

Collaborative working

Within 2022-23 ARA continued to work with the following service areas in the Council to ensure a joined-up approach when delivering Internal Audit services to schools:

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

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

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

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

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

vi. School Improvement – for information exchange and to obtain support and advice for schools causing concern;

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

viii. GCCPlus Traded Services – to further develop an Internal Audit traded service for Academies and LAMS.

Publication of audit findings

The common findings from the 2022-23 school audits will be shared with all the LAMS once the carry forward audits have been completed during 2023-24. 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.

2.1.3 **Management Actions**

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

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 2022-23 audit recommendations will be presented to the July 2024 Audit and Governance Committee.

Summary of Acceptable Assurance Opinions

2.2 **Panel Arrangements (Service Area: Children's Services)**

i. Assurance Level for this report: Acceptable; and

ii. Recommendations arising from this review have been prioritised as:

High Priority:	0
Medium Priority:	5
Low Priority:	0
Rejected:	0

2.2.1 **Scope** - The Gloucestershire Sufficiency Strategy: Right Placement First Time 2018-21 outlined a plan to implement more joint oversight from all stakeholders across Health, Education and Social Care. The aim was to ensure effective assessment, planning, funding and review of all joint-funded placements and packages of care.

Internal Audit reviewed the adequacy and effectiveness of the arrangements in place for the operation of the panels that were set up to achieve the above objective. This included whether the various panels could be streamlined whilst ensuring that robust processes for planning, reviewing and funding placements and packages of care remained in place.

2.2.2 **Key Findings**

CYPMARP (Children and Young People Multi Agency Resource Panel)

i. The examples below demonstrate a number of instances where the operation of the Panel differed from the ToR.

ii. The expectations of the Sufficiency Strategy were that the Personal Budgets and Exceptional Needs Group (PBENG) should be amalgamated into the new multi-agency resource Panel (CYPMARP) but this has not taken place. The current trend for PBENG is to join up more with Adult Continuing Health Care and to build relationships. This enables Managers in Adults to be sighted on transitions and to agree any continuation of a package already in place (the role of the Transitions Operational Panel). The key focus is the agreement of continuing care eligibility and funding for joint packages of care. This suggests there may still be a role for PBENG but in a different format to its current ToR.

iii. The CYPMARP ToR states that the Chair will be the Assistant Director of Children and Families Commissioning but it was chaired by the Head of Service for Integrated Placements Commissioning.

iv. The Attendance section in the CYPMARP ToR does not specify whether deputies are required to attend in the absence of the nominated members of the Panel. It is also not clear on the combination of Commissioners (budget holders) that should be present and the Clinical and Professional Advisers that should inform decisions.

v. An issue arose at the CYPMARP Panel meeting that was attended by Internal Audit whereby it was not always clear what was being requested from the Panel. A Virtual School case was also incorrectly referred to Panel. The ToR specifies that a referral form needs to be signed off by a Head of Service and Section 6 includes 'standards of service'. Both these elements of the ToR, if applied, should result in correct and effective referral to Panel. This indicates that the requirements of the ToR are not known or applied by all parties.

vi. The tracker used by CYPMARP to monitor cases does not include end dates and this element of each package of support is therefore not automatically considered at Panel.

vii. The CYPMARP support officer is not able to update children's case file notes as they do not have access to LiquidLogic, Children's case management system, due to the service area in which they work. There is therefore an expectation that meeting participants will be responsible for agreed actions and make appropriate notes on the children's records. Health notes also need to be recorded on the children's Health records. Currently there is no process in place to ensure that this expectation is being fulfilled.

Risk: There could be confusion as to the purpose of the Panel and its objectives, leading to suboptimal outcomes.

Recommendation: Management should review the CYPMARP ToR to ensure they reflect the Panel's objectives, specifically:

i. Management should review the role of PBENG and either continue to progress its amalgamation with CYPMARP or retain it as a standalone Panel but with different ToR;

ii. Management should confirm which post holder should act as Chair and Deputy Chair for CYPMARP and amend the ToR accordingly;

iii. The Attendance section in the CYPMARP ToR should specify whether deputies are required to attend in the absence of the nominated members of the Panel. Clarity should also be provided in terms of the combination of Commissioners (budget holders) that should be present and the Clinical and Professional Advisers that would inform the decisions;

iv. Training on the requirements of the CYPMARP ToR should be provided to Locality Managers and Heads of Service. Training should also be refreshed whenever any new or amended Panel operational procedures are put in place;

v. The CYPMARP ToR should be enhanced to include a requirement or process that will ensure all actions from the Panel meetings are appropriately recorded on the children's records; and

vi. The tracker used by CYPMARP should include end dates so that they can be considered at Panel as part of any decisions that are made around packages of support.

Transitions Operational Panel and the Transition to Adulthood Oversight Group

i. ToR have been developed for both these Panels but they are not available on Staffnet as links from the 'How to' guide.

ii. There is no mention of the Transition to Adulthood Oversight Group in the Sufficiency Strategy.

iii. At the time of the audit the Transitions Operational Panel had not yet completed a performance review due to the ToR only being drafted in February 2022.

Risk: Inaccessibility of Panel operational procedures for those that need to follow them; Ineffective Panel operation; Panel operation not aligned to Sufficiency Strategy.

Recommendation: The ToR for the Transitions Operational Panel and the Transition to Adulthood Oversight Group should be made available on Staffnet as a link from the 'How to' guide.

The Transition to Adulthood Oversight Group should be included in the Sufficiency Strategy if it is retained as a standalone operational Panel alongside the other Panels.

16+ Panel and the High Risk Cost and Unregulated Panel

i. The High Cost Panel in the Sufficiency Strategy does not include reference to unregulated placements which are now part of its remit.

ii. There are Panel 'Introductions' in the 'How to' guide but no separate ToR have been developed for these two Panels.

Risk: Sufficiency Strategy revisions may not take account of changes in Panel operations; Ineffective Panel operation; Poor case management.

Recommendation: The title of the High Cost Panel in the Sufficiency Strategy should be updated to the High Risk Cost and Unregulated Panel.

ToR should be developed for the 16+ Panel and the High Risk Cost and Unregulated Panel and made available on Staffnet as a link from the 'How to' guide.

PBENG

i. The ToR for PBENG states that appeals are allowed but that they will be considered by the same Panel who made the original decision.

Risk: Potential conflicts of interest; Lack of objectivity for appeal decisions.

Recommendation: If PBENG continues to operate as a standalone Panel, the ToR should be updated to ensure that any appeals are not heard by the same Panel members that made the original decision.

Generic TOR issues

i. The ToRs that are available for the different Panels are not consistent in terms of content and have not been written in the same format. This prevents a like-for-like comparison to ensure that: the Panels are needed and have all been set up to maximum effect for the achievement of their objectives; there is no duplication of effort between the Panels; and the referral processes between the Panels are clear.

Risk: Panel operational procedures not clearly set out; ineffective operation of Panels; inconsistencies between Panels and potential duplication of effort; inter-relationships between Panels not clear; combination of Panels not achieving overarching Panels objectives; lack of oversight and approval of individual Panel ToRs; staff not aware of, nor trained in, Panel operational procedures.

Recommendation: All Panel ToRs should be re-written using consistent formatting and headings, for example:

ii. Membership, including a nominated Chair person, the requirement for deputies to attend where necessary and the required authority (budget holders) to approve funding at Panel;

iii. Quoracy;

iv. Frequency and duration of meetings should be clarified;

v. Responsibility for facilitating Panel meetings and the production of minutes which should include responsibilities and timescales for agreed actions;

vi. Clear referral criteria and the process for cases to be considered at Panel. This should include responsibility for oversight of the final selection of cases for discussion at each Panel;

vii. The use of monitoring tools, for example trackers, to identify and monitor all cases within scope for each Panel. The trackers should include end dates where appropriate; Inter-relationship between Panels, including clear criteria for cases to be referred or escalated to other Panels;

viii. Responsibilities for updating children and young people's case files, for example documenting that case management actions have been progressed and completed; and

ix. Calendar of business and forward plan; Self-assessment - each Panel should undertake a cyclical evaluation of its own performance and confirm ongoing need for the group. Self-assessment is a requirement in the ToR for the Transitions Operational Panel and would be good practice for all Panels to undertake.

A comparison of all ToRs should then be undertaken and amendments made, as necessary. This will identify any inconsistencies, duplication of effort and inefficiencies in terms of operation. It will also ensure that the inter-relationships and workflow between the Panels is clear and necessary.

Management should use the outcome from the above exercise to decide which Panels should continue to operate going forward. This could result in progressing the amalgamation of CYPMARP and PBENG or disbanding PBENG altogether as part of the overall objectives that the Panels have been set up to achieve.

The Assistant Director for Integrated Children and Families Commissioning should approve the finalised ToRs.

The approved ToRs should be communicated to all who need to be aware of them as well as being signposted to where they can be accessed for future reference.

2.3 Section 117 – Aftercare Arrangements (Service Area: Adults)

i. Assurance Level for this report: Acceptable; and

ii. Recommendations arising from this review have been prioritised as:

High Priority:	3
Medium Priority:	1
Low Priority:	0
Rejected:	0

2.3.1 **Scope** - Gloucestershire County Council (the Council) and the NHS Gloucestershire Integrated Care Board (ICB) provide aftercare in line with Section 117 of the Mental Health Act 1983. This is provided without charge to the individual. This audit reviewed whether there are effective arrangements in place for Section 117 Aftercare Arrangements.

2.3.2 **Key Findings**

i. Internal Audit was unable to confirm that spend is in line with funding agreements where Section 117 funding is split between ICB and GCC; at the time of completing this audit the required information was not made available to enable this.

ii. As expected, all Section 117 individuals had a flag on the records to indicate that the individual would not be charged for Aftercare Services;

iii. GCC is only responsible for funding individuals who were resident in Gloucestershire prior to detention. Internal Audit found that those individuals sampled had a Gloucestershire address prior to detention.

iv. The Section 117 MHA Aftercare Policy states that a review should take place approximately once every six months, post discharge. Internal Audit found that this does not always occur.

Risk: Non-compliance with statutory regulations. Risk of harm to individuals or their carers. Reputational damage to the Council.

Recommendation: Ensure that individuals subject to Section 117 receive regular reviews in line with the Section 117 MHA Aftercare Policy. These should be evidenced on Liquidlogic (adults database).

v. The Section 117 MHA Aftercare Policy states that a joint funding split will be agreed through a locality funding panel. Internal Audit found that these panel decisions were not always uploaded onto Liquidlogic.

Risk: Poor transparency of decision making.

Recommendation: Ensure that joint funding decisions for Section 117 individuals are evidenced on Liquidlogic.

vi. The Council’s Cabinet and the Corporate Overview and Scrutiny Committee receive Section 117 information as part of the Adult Social Care Mental Health provision. This is in narrative form and does not include performance or financial information that would support them to effectively monitor performance such as

timely care reviews.

Risk: Poor oversight of performance. Risk of harm to individuals or their carers. Reputational damage to the Council.

Recommendation: Consideration to the type of reports that would enable Council Management to effectively monitor performance. A reporting framework should then be implemented.

vii. Council Management do not currently receive financial reports that would support them to effectively review, manage and monitor costs for commissioned services. Strategic Finance are currently preparing a funding report on S117 Aftercare Services for future reporting to the Joint Commissioning Partnership Executive (JCPE).

Risk: Poor oversight of funding spent on S117 Aftercare Services. Risk of harm to individuals or their carers (due to care packages not being appropriately funded). Reputational damage to the Council.

Recommendation: Ensure that JCPE regularly receive a funding report on S117 Aftercare Services.

2.4 Youth Justice Service (YJS) (Children's Services)

i. Assurance Level for this report: Acceptable; and

ii. Recommendations arising from this review have been prioritised as:

High Priority:	1
Medium Priority:	1
Low Priority:	1
Rejected:	0

2.4.1 **Scope** - the aim was to assess whether the YJS are operating in accordance with the 'Standards for Children in the Youth Justice System 2019' (the Standards). The specific areas reviewed included:

i. First Time Entrants (FTE);

ii. Re-offending;

iii. Use of Custody (including resettlement); and

iv. Disproportionality.

Internal Audit also reviewed progress with the implementation of the Improvement Plan that was developed by the YJS and is overseen by Gloucestershire's Youth Justice Partnership Board. This was in response to Her Majesty's Inspectorate of Prisons (HMIP) inspection report, published in January 2020, where the YJS was rated as 'Requires Improvement'.

2.4.2 Key Findings

There are no specific process requirements within the Standards in relation to First Time Entrants, Re-offending and Disproportionality. Instead, they provide a more holistic approach as to how these areas should be managed. As such, the expectation would be that the YJS should have Standard Operating Procedures for the management of these areas but they were not in place.

Risk: Key processes are not documented, increasing the likelihood of errors or non-compliance with the Standards; Inconsistency of practice; Lack of business continuity and reference materials in the event of staff turnover.

Recommendation: Standard Operating Procedures should be developed for all relevant areas where the Standards do not detail specific process requirements.

First Time Entrants

i. Between 1st January 2022 and 1st October 2022 there were 34 FTE.

ii. A sample of four FTEs was selected for testing purposes. The YJS FTE process as described was followed correctly and was in accordance with the 'spirit' of the Standards. All four young people had their assessment completed within one month and thorough management oversight was applied throughout.

iii. All FTEs are monitored on a monthly basis where the suitability of decision making is reviewed. The production of monthly performance reports was one of the actions within the Improvement Plan. The outcomes are reported to the Youth Justice Board (YJB) for the purposes of identifying any barriers. Quarterly reports are also provided to commissioners and the Youth Justice Management Board (YJMB) which allows further scrutiny.

Reoffending

iv. A young person would be classed as someone who has re-offended if the second offence was committed within a 12-month period of the first offence.

v. Due to the time elapsed between FTEs and re-offenders being recognised, Internal Audit testing focused on a prior period where records were already available. Testing was completed on both individuals who had re-offended in the quarter from October 2020 to December 2020.

vi. Both young people had updated assessments and appropriate management oversight had been applied throughout the re-offending process.

Disproportionality

vii. In accordance with the Equality Act 2010, the YJS should have due regard to eliminating discrimination, advancing equality of opportunity and foster good relations between different people when carrying out their activities. All children should be treated fairly and in accordance with their individual needs.

viii. Disproportionality is an area that remains under development and is a focus for improvement. The YJS is reviewing stop-and-search data and police arrest data which will inform an upcoming research project.

ix. Management confirmed that diversity, unconscious bias and identity training has recently been delivered to all staff within the YJS.

x. All assessments are quality assured by management and each month two cases are subject to a deep dive. This includes how identity has been considered and addressed.

xi. Disproportionality analysis is included in quarterly reports to the YJMB for the purposes of oversight and scrutiny. The last report presented in April 2022 found that consideration of identity is evident in the assessments that were audited.

Use of Custody (including resettlement)

xii. The process begins with the young person being taken into custody (12 - 17 years of age). They are placed in one of three custodial settings (not to be confused with adult prison), namely a secure children's home, a Youth Offending Institute or a training centre.

xiii. Between 1st September 2021 and 30th September 2022 there were five cases of resettlement. Internal Audit selected a sample of three cases for review against the Standards and the described resettlement process. It was difficult to locate the necessary evidence on the Integrated Youth Support System (IYSS) due to the naming convention of the files. However, confirmation can be provided that all three cases had been processed correctly and appropriate management oversight had been applied throughout.

Risk: Inefficient use of resources; Information searches may prove ineffective.

Recommendation: The naming convention of files in IYSS should be altered to allow more efficient navigation within the system and enable information to be located more easily.

Improvement Plan

xiv. The Improvement Plan is subject to quarterly monitoring within the YJS. The outcome is reported to the YJMB for further scrutiny of progress against the plan. The Improvement Plan is monitored separately to the annual Youth Justice Plan.

xv. At the time of the Internal Audit in October 2022, the latest copy of the Improvement Plan was dated March 2022 (no updates were provided over the summer). There were 15 actions out of a total of 44 that had either not been completed or were only partially complete.

xvi. Discussions with YJS management identified that there are numerous ways in which progress against the actions in the Improvement Plan can be evidenced. These include increased training and personal development throughout the team,

a new audit process for the moderation of assessments, significantly improved management oversight and detailed minute-taking at meetings. Supervisor notes are now being created and feedback is being obtained from families the YJS have worked with to further inform improvements that need to be made.

Risk: Inefficient use of resources monitoring two independent plans.

Recommendation: Any outstanding actions on the Improvement Plan should be incorporated into the annual Youth Justice Plan going forward and submitted to the Youth Justice Board for approval**.**

Summary of Consulting Activity, Grant Certification or Support Delivered where Assurance Opinions are not provided

2.5 Grant Certification (Service Areas: EEI, Adults, Community Safety)

2.5.1 **Scope** – As part of the annual audit plan, the following individual grant certifications have been completed:

i. Growth Hub;

ii. Community Capacity; and

iii. Fire and Rescue Authorities Grant.

Each audit reviewed whether the conditions of the relevant grant determinations had been complied with during 2022-23.

2.5.2 **Key Findings**

i. Internal Audit review confirmed that expenditure during 2022-23 had been monitored by Strategic Finance and appropriate records maintained;

ii. Internal Audit tested a sample of expenditure which was in accordance with the grant conditions; and

iii. Internal Audit gained appropriate assurance that the conditions of the grant determinations had been met. No recommendations arose from the ARA review. Therefore, declarations were signed and submitted to the appropriate Department.

2.6 **Supporting Families (Service Area: Children's Services)**

i. Assurance Level for this report: An assurance level was not provided for this activity; and

ii. No recommendations arose from this review.

2.6.1 **Scope** - Within the Supporting Families Programme there are ten eligibility criteria areas. Within each of these areas there are various indicators to show achievement of eligibility.

Families need to meet at least three of the 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.

The Supporting Families Guidance indicates that Internal Audit should verify claims prior to them being submitted. This audit was to satisfy this requirement for the period January to March 2023.

2.6.2 **Key Findings**

i. Internal Audit selected a sample of 15 of the PBR claims to test compliance against the criteria;

ii. Appropriate evidence was available for all the cases tested. Evidence such as case notes were attached to the individual records supporting that the PBR had been achieved; and

iii. 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 2023.

3. Counter Fraud Update – Summary of Counter Fraud Activities

Current Year Counter Fraud Activities

3.1 To date in 2023-24 there have been five new referrals received by the ARA Counter Fraud Team (CFT).

3.2 Two referrals have been closed without any investigative action required. Both were resulted via the provision advice and signposting to policies and appropriate teams.

3.3 A third referral, concerning Blue Badge misuse, was resolved following initial investigations. The badge has been cancelled.

3.4 Two referrals remain ongoing. One relates to potential Blue Badge misuse. The second relates to concerns around inflated and duplicate invoices. Outcomes will be reported to Committee on completion.

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

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

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

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

Previous years' cases

3.9 In addition, the CFT continued to work on eight cases carried forward from prior years. One case which related to potential Direct Payment misuse has now been closed. The Adult Social Care team is working with the family to resolve the issues and no further CFT involvement is required.

National Fraud Initiative (NFI)

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

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

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

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

National Anti-Fraud Network (NAFN)

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

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

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