Annual report on
Internal Audit Activity
2017-2018

ARA
AuditRiskAssurance

Gloucestershire
COUNTY COUNCIL

Contents

(1) Introduction

All local authorities must make proper provision for internal audit in line with the 1972 Local Government Act (S151) and the Accounts and Audit Regulations 2015. The latter states that 'a relevant authority must undertake an effective internal audit to evaluate the effectiveness of its risk management, control and governance processes, taking into account Public Sector Internal Audit Standards (PSIAS) 2017 or guidance'.

The standards define the way in which the Internal Audit Service should be established and undertake its functions. The Council's Internal Audit Service is provided by Audit Risk Assurance under a shared service agreement between Gloucestershire County Council (host authority), Gloucester City Council and Stroud District Council and carries out the work to satisfy this legislative requirement and reports its findings and conclusions to management and the Audit and Governance Committee. The standards also require that an independent and objective opinion is given on the overall adequacy and effectiveness of the control environment, comprising risk management, control and governance, from the work undertaken by the Internal Audit Service.

Gloucestershire County Council's Internal Audit function conforms to 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 challenge, advising the organisation that satisfactory arrangements are in place and operating effectively.

Internal Audit is not the only source of assurance for the Council. There are a range of external audit and inspection agencies as well as management processes which also provide assurance and these are set out in the Council's Code of Corporate Governance and the Annual Governance Statement.

(3) Purpose of this Report

One of the key requirements of the PSIAS is that the Chief Internal Auditor should provide an annual report to those charged with governance, to support the Annual Governance Statement. The content of the report is prescribed by the PSIAS which specifically requires Internal Audit to:

- Provide an opinion on the overall adequacy and effectiveness of the organisation's internal control environment and disclose any qualifications to that opinion, together with the reasons for the qualification;

- Compare the actual work undertaken with the planned work, and present a summary of the audit activity undertaken from which the opinion was derived, drawing attention to any issues of particular relevance;

- Summarise the performance of the Internal Audit function against its performance measures and targets; and

- Comment on compliance with the PSIAS.

When considering this report, the Committee may also wish to have regard to the quarterly interim Internal Audit progress reports presented to the Committee during 2017/18 and the Annual Report on Risk Management Activity for 2017/18.

(4) Chief Internal Auditor's Opinion on the Council's Internal Control Environment

In providing the internal audit opinion it should be noted that assurance can never be absolute. The most that Internal Audit can provide is a reasonable assurance that there are no major weaknesses in risk management arrangements, control processes and governance. The matters raised in this report, and our quarterly monitoring reports, are only those that were identified during our internal audit work and are not necessarily a comprehensive statement of all the weaknesses that may exist or represent all of the improvements required.

Chief Internal Auditor's Opinion

I am satisfied that, based on the internal audit activity undertaken during 2017/18 and management's actions taken in response to that activity, enhanced by the work of other external review agencies, sufficient evidence is available to allow me to draw a reasonable conclusion as to the adequacy and effectiveness of Gloucestershire County Council's overall internal control environment.

In my opinion, for the 12 months ended 31st March 2018, Gloucestershire County Council has a **satisfactory** overall control environment, to enable the achievement of the Council's outcomes and objectives.

This opinion will feed into the Annual Governance Statement which will be published alongside the Annual Statement of Accounts.

(4a) Scope of the Internal Audit Opinion

In arriving at my opinion, I have taken into account:

- The results of all internal audit activity undertaken during the year ended 31st March 2018 and whether our high and medium priority recommendations have been accepted by management and, if not, the consequent risk;

- The effects of any material changes in the organisation's risk profile, objectives or activities;

- Matters arising from internal audit quarterly progress reports or other assurance providers to the Audit and Governance Committee;

- Whether or not any limitations have been placed on the scope of internal audit activity; and

- Whether there have been any resource constraints imposed on internal audit which may have impacted on our ability to meet the full internal audit needs of the organisation.

(4b) Limitations to the scope of our activity

There have been no limitations to the scope of our activity or resource constraints imposed on internal audit which have impacted on our ability to meet the full internal audit needs of the Council. Whilst the core Internal Audit service is provided in-house, during 2017/18, the Chief Internal Auditor has:

- Commissioned external specialist ICT audit via Warwickshire County Council's Internal Audit Framework Agreement;

- Set up joint working arrangements in relation to Internal Audit, Risk Management and Insurance Services, with the Chief Internal Auditor at Warwickshire and Worcestershire County Councils and Stratford District Council;

- Arrangements in place with Gloucestershire NHS Counter Fraud Service to provide support with investigations; and

- An agreement in place with Gloucestershire's Counter Fraud Unit to provide counter fraud support.

(5) Summary of Internal Audit Activity undertaken compared to that planned

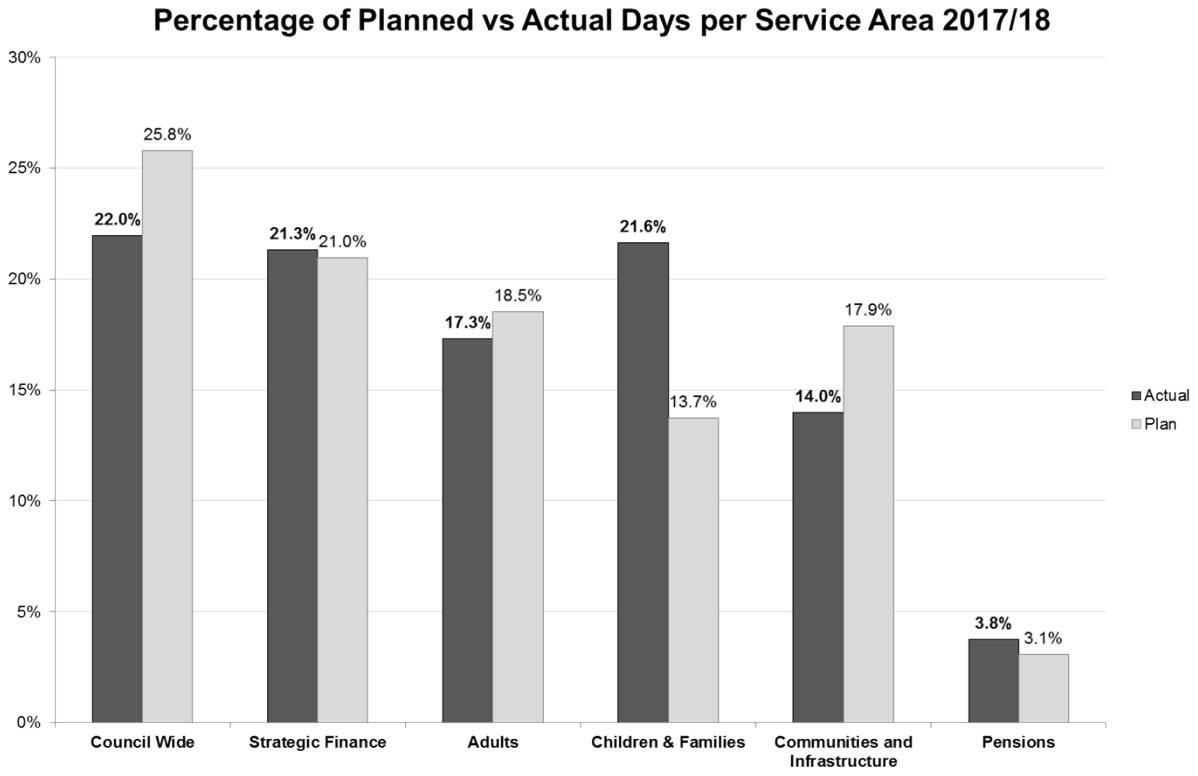
The underlying principle to the 2017/18 plan is risk and as such, audit resources were directed to areas which represented 'in year risk'. Variations to the plan are required if the plan is to adequately reflect the ongoing changing risk profile of the Council.

Since the original risk based plan was approved in April 2017 by the Audit and Governance Committee, a number of additional audit activities have proved necessary and some of the planned audits were no longer required. Plan changes are detailed in **Appendix 2** (the Summary Activity Progress Report 2017/18).

Resources also required redirecting as a result of special investigations and irregularity work, i.e. 14 new referrals during 2017/18 and continuing work on 9 referrals brought forward from previous years.

The net effect is that although the work undertaken was slightly different to that originally planned we are able to report that we achieved **92%** of the overall revised plan 2017/18, against a target of 85%.

The bar charts below summarise the percentages of planned audits per service area (i.e. Adults, Core Council, etc.) and category of activity (i.e. fundamental financial systems, corporate governance, etc.) compared with the percentage of actual audits completed.



Example rationale for the variance between 2017/18 planned and actual days per service area include (but are not exclusive to):

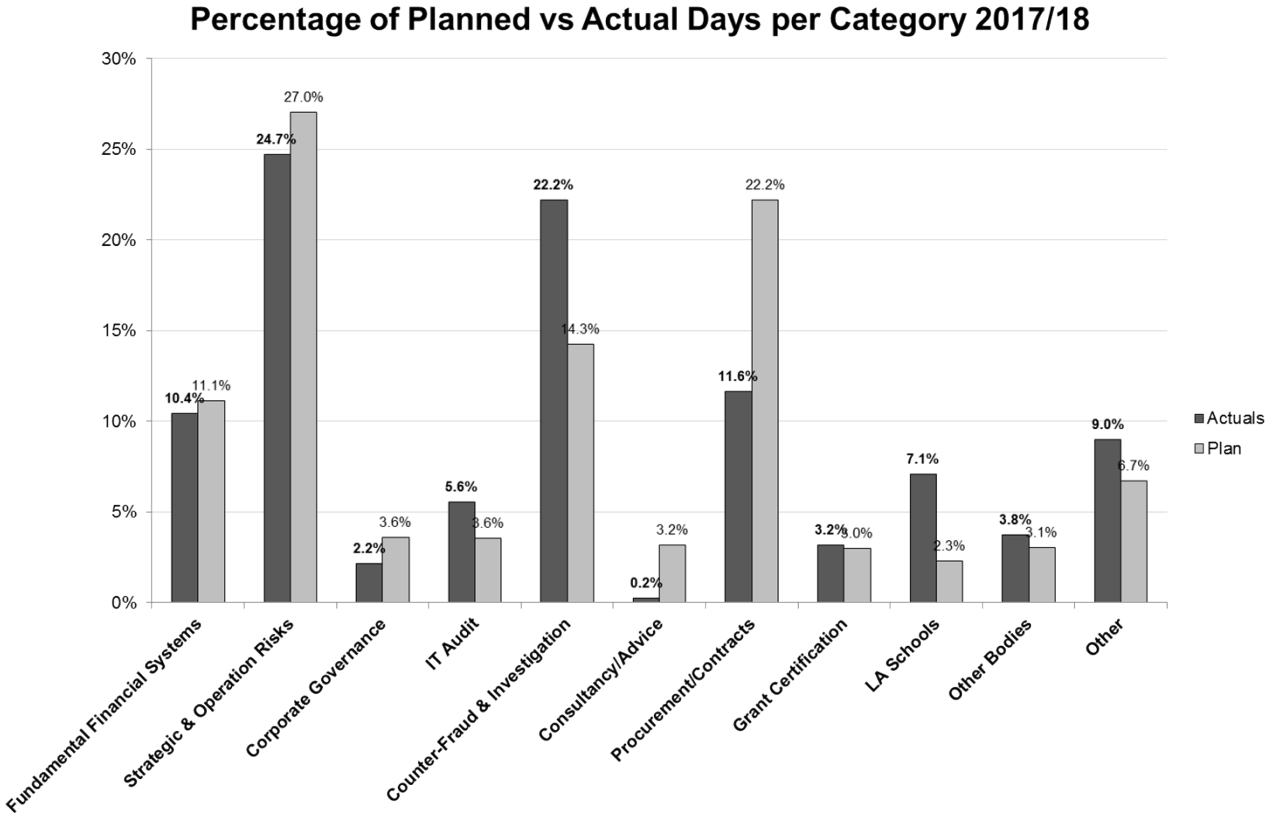
- New activity requests:
    - Cinderford Spine Road Adjudication Payment
    - Transforming Care Grant 2016/17
- Audit activity where actual days were in excess of those originally budgeted, due to the findings and outcomes of the audit work:
    - School audits
    - Review of Contract Monitoring of Schools Catering Contract
    - Approval of Payments for Agency Staff
- The impact of counter fraud and investigation actual days, following case referral by the Council or whistleblowing (i.e. actuals days have been allocated to the service area, rather than Council Wide).

- Deferral of internal audit work into the 2018/19 Plan (at request of and in agreement with client key points of contact), to ensure the work will be of added value to the Council e.g.

    - Highways and Transportation Services Contract – deferral due to significant contract changes within 2017/18 with internal audit review deferred to 2018/19 to ensure audit scope can capture the updated contract requirements

    - Information and Cyber Security (Pensions) – a new pensions system is due to be implemented within 2018/19 and the internal audit has been deferred to ensure review of the new system's relevant processes and controls

The above rationale can also be applied to the below table which confirms variances between 2017/18 planned and actual days per audit category.



(6) Summary of Internal Audit Activity undertaken which informed our opinion

The schedule provided at **Appendix 1** provides the summary of 2017/18 audits which have not previously been reported to the Audit and Governance Committee, including, very importantly, five limited assurance audit opinions on risk and control all relating to schools.

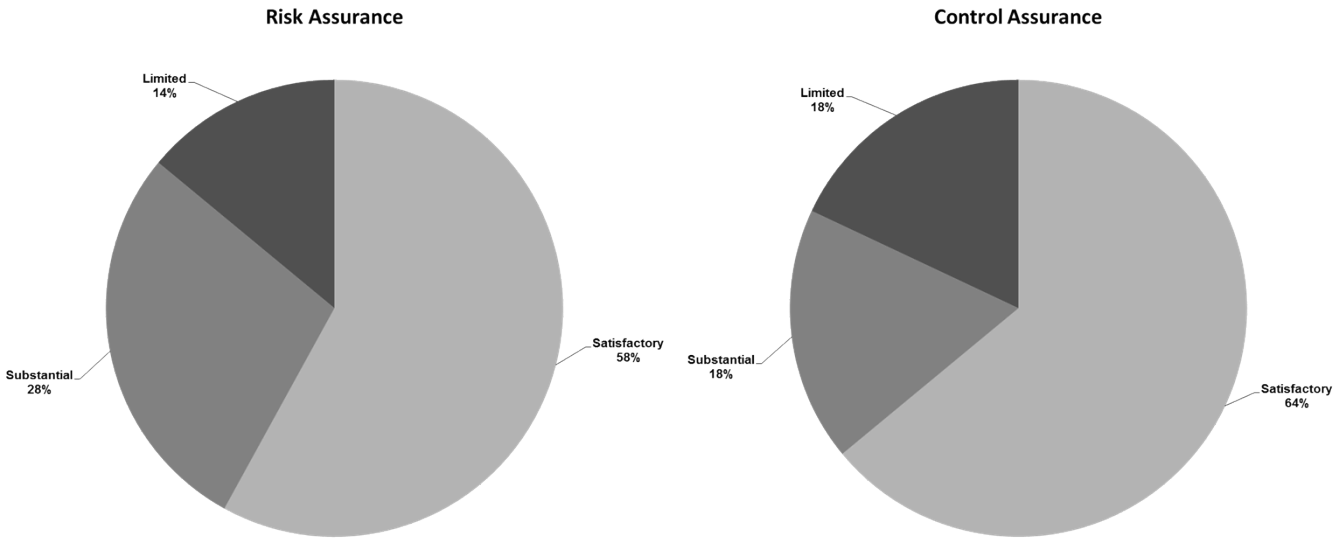
The schedule provided at **Appendix 2** contains a list of all of the audit activity undertaken during 2017/18, which includes, where relevant, the assurance opinions on the effectiveness of risk management arrangements and control processes in place to manage those risks and the dates where a summary of the activities outcomes has been presented to the Audit and Governance Committee. Explanations of the meaning of these opinions are shown below.

Assurance levels	Risk Identification Maturity	Control Environment
Substantial	**Risk Managed** Service area fully aware of the risks relating to the area under review and the impact that these may have on service delivery, other services, finance, reputation, legal, the environment, client/customer/partners, and staff. All key risks are accurately reported and monitored in line with the Corporate Risk Management Strategy.	• System Adequacy – Robust framework of controls ensures that there is a high likelihood of objectives being achieved • Control Application – Controls are applied continuously or with minor lapses
Satisfactory	**Risk Aware** Service area has an awareness of the risks relating to the area under review and the impact that these may have on service delivery, other services, finance, reputation, legal, the environment, client/customer/partners, and staff. However some key risks are not being accurately reported and monitored in line with the Corporate Risk Management Strategy.	• System Adequacy – Sufficient framework of key controls for objectives to be achieved but, control framework could be stronger • Control Application – Controls are applied but with some lapses
Limited	**Risk Naïve** **Due to an absence of accurately and regularly reporting and monitoring of the key risks in line with the Corporate Risk Management Strategy, the service area has not demonstrated an adequate awareness of the risks relating to the area under review and the impact that these may have on service delivery, other services, finance, reputation, legal, the environment, client/customer/partners and staff.**	• **System Adequacy – Risk of objectives not being achieved due to the absence of key internal controls** • **Control Application – Significant breakdown in the application of control**

(6a) Internal Audit Assurance Opinions on Risk and Control

The below pie charts show the summary of the risk and control assurance opinions provided within each category of opinion i.e. substantial, satisfactory and limited. It is pleasing to report that the Council is showing that **82%** of the activities reviewed have received a **substantial (18%)** or **satisfactory (64%)** opinion on control. Whilst **18%** of the opinions on control are limited (compared to 17% within 2016/17), this maybe related to transformational change, continued focusing of our activity on the key risks of the Council and specific requests from Directors, who are asking for areas to be reviewed where issues have arisen or where independent assurance is required.

Risk and Control Opinions 2017/18



(6b) Limited Control Assurance Opinions

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

(6c) Audit Activity where a Limited Assurance Opinion has been provided on Control

During 2017/18, nine limited opinions on control were provided. These related to:

Audited Service Area	Date reported to Audit and Governance Committee
Approval of Payments for Agency Staff	6th October 2017
Electronic Call Monitoring (ECM) - All Ages All Disabilities	6th October 2017
Section 20 – Children's Act	6th October 2017
Exempt Report	6th October 2017
Schools (5 limited)	27th July 2018

(6d) Satisfactory Control Assurance Opinions

Where audit activity records that a satisfactory assurance opinion on control has been provided where recommendations have been made to reflect some improvements in control, the Audit and Governance Committee and Corporate Management Team (CoMT) can take assurance that improvement actions have been agreed with management to address these.

(6e) Internal Audit recommendations made to enhance the control environment

Year	Total No. of high priority recs.	% of high priority recs. accepted by management	Total No. of medium priority recs.	% of medium priority recs. accepted by management	Total No. of recs. made
2016/17	46	100%	86	100%	132
2017/18	**101**	**100%**	**89**	**100%**	**190**

The Audit and Governance Committee and CoMT 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.

(6f) Risk Assurance Opinions

There were seven audits where a limited assurance opinion was given on risk during 2017/18, these related to:

Audited Service Area	Date reported to Audit and Governance Committee
Section 20 – Children's Act	6th October 2017
Exempt Report	6th October 2017
Schools (5 limited)	27th July 2018

Where limited assurance opinions on risk are provided, the relevant reports are shared with the service Risk Champions to ensure that the risks highlighted by Internal Audit are placed on the relevant service risk registers. Monitoring the implementation of the recommendations is then owned by the relevant manager and helps to further embed risk management into day to day management, risk monitoring and reporting processes.

In addition, where a limited assurance opinion is provided, the Internal Audit reports are shared with the Corporate Risk Management Team to prioritise risk management support where appropriate.

(6g) Internal Audit's Review of Risk Management

During 2017/18, **86%** of the audited areas rated the effectiveness of risk management arrangements as **substantial (28%) or satisfactory (58%)** with **14%** obtaining a limited assurance opinion (compared to 14% within 2016/17). This evidences that risk management continues to be further embedded into the Council's business activities.

Internal Audit also undertake, on a rotational basis, specific reviews purely on the effectiveness of risk management arrangements, operating across all service areas, looking at the Strategic and Operational Performance/Business Plans and associated Risk Registers, to ensure that actions recorded to mitigate risks are in place and operating as intended.

The assurance statements obtained from all Directors and Service Heads across the Council (when formulating the Annual Governance Statement), provided reasonable assurance that the majority of management apply the Council's risk management strategy and principles within their service areas. This together with our own assessment, supported by the external assessments and recognition received for numerous risk management initiatives over past years, have led Internal Audit to conclude that the risk management arrangements within the authority are reasonably effective.

(6h) Gloucestershire County Council's Corporate Governance Arrangements

The Council is required by the Accounts and Audit Regulations 2015 to prepare and publish an Annual Governance Statement. The Annual Governance Statement is signed by the Leader, Chief Executive and the Chief Financial Officer and must accompany the Annual Statement of Accounts.

In April 2016, the Chartered Institute of Public Finance and Accountancy (CIPFA) and the Society of Local Authorities Chief Executives (SOLACE) published 'Delivering Good Governance in Local Government: Framework 2016' and this applies to annual governance statements prepared for the 2017/18 financial year. Guidance notes were also published to assist Council Leaders and Chief Executives in reviewing and testing their governance arrangements against the revised seven principles for good governance.

The key focus of the framework is on sustainability – economic, social and environmental and the need to focus on the longer term and the impact actions may have on future generations.

The Council therefore:

- Reviewed the existing governance arrangements against the principles set out in the Framework;

- Developed and implemented a refreshed local code of corporate governance, based on the new principles, including an assurance framework for ensuring ongoing effectiveness; and

- Will report publically, via the Annual Governance Statement on compliance with our code on an annual basis, how we have monitored the effectiveness of our governance arrangements in the year and on planned improvement areas.

(7) Summary of additional Internal Audit Activity

(7a) Special Investigations/Counter Fraud Activities

The Counter Fraud Team within Internal Audit received 14 new referrals in 2017/18, and also continued to work on 9 cases from previous years. The category of each referral (fraud/irregularity/other) is determined per case review. One of the brought forward cases was completed within 2017/18, plus a further three have been closed at the time of writing this report. In respect of the five remaining cases further sanctions have been required and are still in progress. One of the older cases closed in 2017/18 has previously been reported to Audit and Governance Committee. All of the other three closed cases involve direct payments and the repayment of varying sums to the Council. One of these cases was taken to court jointly with the NHS where a guilty plea was entered for false accounting by the defendant and the individual was ordered to repay £17,000 to the Council/NHS.

Referrals in 2017/18

The service areas of cases referred to Internal Audit within 2017/18 were categorised as follows: Children and Families (5), Council wide (1), Adults (3), Core Council (3), and Adults/Children (2).

Eight of the cases received in 2017/18 had been closed at year end and a further four have now been closed at the time of writing this report. Four of the closed cases have previously been reported to the Audit and Governance Committee.

Of the eight cases now closed:

- Four were staff/consultant related: resulting in two disciplinaries through which one individual received a final written warning and the other resigned; a consultant's contract was terminated with the subsequent recovery of over £10,000; and an overpayment of £3,016 was repaid by a member of staff in respect of duplicate claims.
- Of the remaining four: one resulted in the repayment of £31,614 in respect of Nursery Grant funding; two cases involved poor controls around cash handling with recommendations to improve and strengthen the control environment; and the last involved the replacement of a stolen generator with a value of around £15,000, which was also reported to the Police.

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.

National Fraud Initiative (NFI)

Internal Audit continues to support the NFI which is a biennial data matching exercise administered by the Cabinet Office. The data sets required were submitted through the web portal in October 2016 and data match reports were reviewed and recommended matches investigated by either Internal Audit or the relevant service area.

Internal Audit has previously reported the overpayment of £30,186.09 in respect of a care services NFI match, which has subsequently been repaid. Matches of pensions to death data were reported in 2016/17 and £20,776 has been recovered within 2017/18.

Monitoring and Review

The Audit and Governance Committee and CoMT can take assurance that the Statutory Officers, comprising the Chief Executive, Monitoring Officer and Chief Financial Officer are regularly fully briefed on all such fraud and irregularity activity, they challenge, monitor management actions and progress to date and approve all police referrals.

Serious and Organised Crime Strategic partnership led by Gloucestershire Police

The Chief Internal Auditor is a member of the Serious and Organised Crime Strategic Partnership (SOCSP) formally known as the joint Policing Panel for Serious and Organised Crime (JPPSOC) to discuss the local multi agency approach to tackling crime/fraud. There is a clear direction from central government that a 'whole government approach' is required, with the co-ordination of the Police, statutory partners and the community and voluntary sector. It is the intention that this partnership is to set the context of Serious and Organised Crime within Gloucestershire and then mobilise the network of local partners to work together with a strong emphasis on a preventative, early intervention approach.

(7b) Local Government Transparency Code 2015

Introduction

This Code is issued to meet the Government's desire to place more power into citizens' hands to increase democratic accountability and make it easier for local people to contribute to the local decision making process and help shape public services.

Transparency is the foundation of local accountability and the key that gives people the tools and information they need to enable them to play a bigger role in society. The availability of data can also open new markets for local business, the voluntary and community sectors and social enterprises to run services or manage public assets.

Detecting and preventing fraud (taken from Annex B of the Code)

Tackling fraud is an integral part of ensuring that tax payers money is used to protect resources for frontline services. The cost of fraud to local government is estimated at £2.1 billion a year. This is money that can be better used to support the delivery of front line services and make savings for local tax payers.

A culture of transparency should strengthen counter-fraud controls. The Code makes it clear that fraud can thrive where decisions are not open to scrutiny and details of spending, contracts and service provision are hidden from view. Greater transparency, and the provisions in this Code, can help combat fraud.

Local authorities must annually publish the following information about their counter fraud work [1] (as detailed for Gloucestershire County Council (GCC)) in the table below:

Council wide fraud and irregularity activity relating to 2017/18 including Internal Audit activity

Question	GCC Response
Number of occasions they use powers under the Prevention of Social Housing Fraud (Power to Require Information) (England) Regulations 2014, or similar powers.	N/A
Total number (absolute and full time equivalent) of employees undertaking investigations and prosecutions of fraud.	1.4 FTE
Total number (absolute and full time equivalent) of professionally accredited counter fraud specialists.	1.8 FTE plus qualified staff employed by the Counter Fraud Unit as part of the shared internal audit service.
Total amount spent by the authority on the investigation and prosecution of fraud.	£63,486
Total number of fraud cases investigated (inc. b/fwd. cases).	9

In addition to the above, it is recommended that local authorities should go further than the minimum publication requirements set out above (as detailed for GCC) in the table below.

Question	GCC Response
Total number of cases of irregularity investigated (both Internal Audit and other service areas inc. b/fwd. cases).	14
Total number of occasions on which a) fraud and b) irregularity was identified (exc. b/f cases from previous years).	a) 4 b) 9 One 2017/18 case was not proven to be a fraud or irregularity.

[1] *(The definition of fraud is as set out by the Audit Commission in Protecting the Public Purse).*

Question	GCC Response
Total monetary value of a) the fraud and b) the irregularity that was detected in 2017/18, including pension overpayments identified through NFI where pensions were paid after death and deaths not notified to the Council.	a) £15,000 + unquantified amount from ongoing cases b) £46,071
Total monetary value of a) the fraud and b) the irregularity that was recovered in 2017/18, including pension overpayments identified through NFI where pensions were paid after death and deaths not notified to the Council.	a) £15,000 (inc. value of an item replaced) b) £68,439 (inc. pension overpayments identified through NFI in previous years but receipts received in 2017/18 plus other amounts received in 2017/18 relating to irregularity identified in previous years)

N.B. The Council also identified 41 cases where assets were given away/gifted/transferred to family members by service users (or their representative) requiring care. This is referred to as *deprivation of assets*. The value of the assets 'given away' in 2017/18 confirmed by the Financial Assessment and Benefits service was £1.475m; however, this is not necessarily the value of the potential loss to the Council as it would depend on the length of time that the care service would be required. In each case the value of the asset has been taken into account when calculating the service user's contribution towards the cost of their care.

Full details about the Local Government Transparency Code and its requirements can be found at: https://www.gov.uk/government/publications/local-government-transparency-code-2015

(8) Internal Audit Effectiveness

The Accounts and Audit Regulations 2015 require '*a relevant authority must undertake an effective internal audit to evaluate the effectiveness of its risk management, control and governance processes, taking into account public sector internal auditing standards or guidance'.* This process is also part of the wider annual review of the effectiveness of the internal control system, and significantly contributes towards the overall controls assurance gathering processes and ultimately the publication of the Annual Governance Statement.

The Accounts and Audit Regulations 2015 also state that internal audit should conform to the Public Sector Internal Audit Standards (PSIAS).

Public Sector Internal Audit Standards (PSIAS) 2017

These standards have four key objectives:

- Define the nature of internal auditing within the UK public sector;
- Set basic principles for carrying out internal audit in the UK public sector;

- Establish a framework for providing internal audit services, which add value to the organisation, leading to improved organisational processes and operations; and

- Establish the basis for the evaluation of internal audit performance and to drive improvement planning.

The Internal Audit Charter, Code of Ethics and the Audit and Governance Committee's Terms of Reference reflect the requirements of the standards.

External Assessment of the effectiveness of Internal Audit

The last External Quality Assessment (an independent assessment of the effectiveness of an internal audit function which should take place at least every five years) was completed within 2015/16 of the Gloucestershire County Council internal audit service.

The review was undertaken during May 2015 by the Chartered Institute of Internal Auditors and included a review of the team's conformance to the International Professional Practice Framework (IPPF) as reflected in the PSIAS, benchmarking the function's activities against best practice and assessing the impact of internal audit on the organisation. There are 56 fundamental principles to achieve with more than 150 points of recommended practice in the IPPF. The independent assessment identified 100% conformance.

The Chartered Institute of Internal Auditors stated: *'It is our view that (the Council's) internal audit function conforms to all 56 principles. This is excellent performance given the breadth of the IPPF and the challenges facing the function'.*

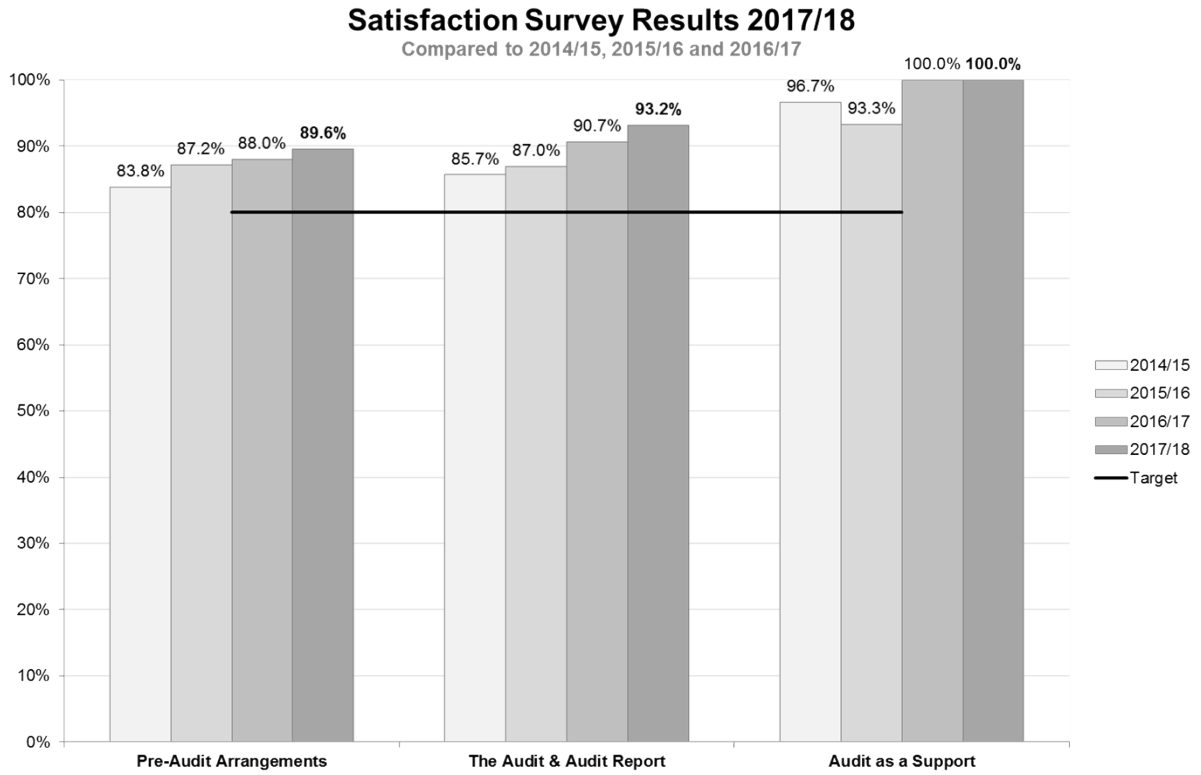
The internal audit shared service applies consistent systems and processes, which supports compliance across the Audit Risk Assurance Shared Service partners.

During 2016/17 the Chief Internal Auditor assessed Internal Audit's performance against the Internal Audit Quality Assurance and Improvement Programme (QAIP) as required by the PSIAS. The QAIP confirmed compliance against the PSIAS and highlighted opportunities for further service improvement.

Internal Assessment - Customer Satisfaction Survey results 2017/18

At the close of each audit review a customer satisfaction questionnaire is sent out to the Director, Service Manager or nominated officer. The aim of the questionnaire is to gauge satisfaction of the service provided such as timeliness, quality and professionalism. Customers are asked to rate the service between excellent, good, fair and poor.

A target of 80% was set where overall, audit was assessed as good or better. The latest results as summarised below, shows that the target has been exceeded, with the score of **100%** reflecting Internal Audit as being a positive support to their service.



In addition, the following positive comments have been received from our customers:

- *'It is good to have fresh eyes look at the way we do things. The auditor identified some areas where we could improve he did this in a professional and caring manner. Everyone in the team hears the word audit and it can make people nervous! My team were very positive about the interactions they had with the auditor and I feel his manner makes him a good auditor. All in all the process was positive for us.'*

- *'The auditor was very good at providing context for her recommendations and took a balanced view within the audit.'*

- *'The way the auditor approached it, she kept it straightforward and easy to understand.'*

- *I just wanted to say it has been a pleasure having the auditor conduct this audit with us. He is extremely professional in his approach and his detailed knowledge and expertise ensured it went really smoothly and was conducted with no negative impact on my staff's time/day job.'*

- *'Clarity of focus and positive approach as important partnership area.'*

- *'The ability to discuss the evidence before preliminary findings were circulated was appreciated'.'*

- *'Although the situation has not been without stress, I would like to thank you for the professional and courteous way in which you have handled matters and the open manner in which we have been able to hold discussions.'*

- *'The approach taken was focused on improvement and conducted in an open but robust way to get the best outcome.'*

- *'The auditor was very mindful to the time constraints that I was under due to my regular duties. Whenever we met, the meetings were short and concise which kept disruption to a minimum.'*

- *'The proportionate approach. The auditor's professionalism.'*

- *'Helpful to have the samples for testing in advance of the actual review.'*

- *'Providing an overview to those involved in the audit review about the role of audit and expectations of operators. Also explaining what those operators and managers can expect from the audit activity and when the activity will take place.'*

- *'Pre arranged meetings to avoid disruption to normal operations.'*

- *'The auditor ensured that he familiarised himself with the debt policy and maintained a focus on this throughout the audit.'*

- *'The auditor was also very knowledgeable on the subject matter of this audit which helped in our conversations and explanations.'*

- *'The fact that the auditor has done a lot of work to understand our service and role but especially how we perform our role.'*

- *'Really appreciated the opportunity to discuss the audit process and the scope at a very early stage and the follow up discussions to refine the process to ensure most benefit.'*

- *'It was good to have a health check and refocus us and our work on the key risk areas.'*

- *'Help from the auditor in setting up our monitoring reports.'*

Lessons Learned from customer feedback and actions taken by Internal Audit

The Chief Internal Auditor reviews all client feedback survey forms and where a less than good rating has been provided by the client, a discussion is held with both the relevant auditor and the manager to establish the rationale behind the rating and where appropriate actions are taken to address any issues highlighted.

The following specific feedback for improvement of audit approach has been received within 2017/18:

- *'The project was delayed a little bit by other priorities'.*

- *'It would be more helpful to have an electronic survey like ICT do rather than a clunky pdf.'*

- *'I think the issues that came up at the end could have been better dealt with had the auditor met with (XXXX)…… After the initial scoping meeting I had no contact with the auditor and hadn't realised the audit had been completed until being contacted with the draft report. The auditor failed to talk to all staff involved in the process for greater understanding of current practice.'*

The development comments will be taken on board for future internal audits within 2018/19 and beyond. For example, the audit management system version due for release in 2018/19 will enable audit customers to complete and submit an electronic customer satisfaction questionnaire directly through the system. Over the years, improvement areas have included, shorter, more focused internal audit reports, enhanced opening meetings i.e. to provide more information on the role of internal audit, the audit process and approach, ensure we fully consider the risk and the subsequent proportionality of the recommended controls to manage them, provide where possible more indication of when audit reviews will take place and a timelier turnaround of these reviews.

ARA Learning and Development

Development of leaders, managers and staff within internal audit is a key priority, to ensure that the service has the qualities, behaviours and skills to deliver efficient and effective services to our partners. The Chief Internal Auditor is a member of the Local Authorities Chief Auditor's Network, Midland Counties Chief Internal Auditor Network and the Midland District Chief Internal Auditors Group. ARA staff participate in CPD and / or are members of other relevant internal audit, counter fraud and risk related forums / groups, all of which provides the opportunities to discuss and understand the latest developments affecting the internal audit, counter fraud and risk management profession, contribute to strategy, exchange ideas and work collaboratively on problems and issues.

ARA is also committed to offering a structured trainee auditor programme, to attract people to the council and to the profession, currently supporting three trainee auditor posts.

ARA Partner Dividend

During 2017/18 ARA has been in a position to be able to provide a "dividend" to the Council in the sum of £28,331.55. This is due to efficiencies achieved.

Green Impact Award

Green Impact is a sustainability accreditation scheme with an awards element designed for departments and teams of staff across the Council. Green Impact supports the Council in meeting the reduction in energy and fuel use, cost and resulting C02 emissions as part of the 'carbon reduction and renewable energy project' under MtC2. Internal Audit achieved a bronze award demonstrating and evidencing change across the team and its activities making improvements in managing waste and recycling, reduction of energy use, reduction in water usage including preventing water wastage, reusing before procuring new, alternative travel use and improving overall team health and well-being. Internal Audit activity was also identified by the scheme as a front runner of the programme for its proactive approach in making positive changes to its processes to benefit the Council as a whole.

Appendix 1

Completed Internal Audit Activity during the period April – June 2018

Summary of Limited Assurance Opinions on Control

Service Area: Children and Families

Audit Activity: Schools

Background

The Council's Chief Financial Officer (S151 Officer) is required to submit an annual return to the Department for Education confirming that there have been no adverse comments in any reports issued by the Chief Internal Auditor relating to regularity, propriety and/or fraud with regard to Local Authority (LA) maintained schools expenditure.

Internal Audit provides independent assurance to the S151 Officer as to the effectiveness of the financial management arrangements within the schools audited.

Scope

Internal Audit's activity within schools is prioritised based on risk and as such, 7 Primary schools were visited during 2017/18. Individual reports were issued to each school for which satisfactory management responses were obtained.

Risk Assurance – 2 Satisfactory; 5 Limited

Control Assurance – 2 Satisfactory; 5 Limited

Key Findings

The overarching key findings that required improvement related to: Governance and Budgetary Control, School Fund, Procurement, Staffing and Payroll, Breakfast/After-School clubs, Petty Cash, Income and vehicles.

Conclusion

As the findings could apply to other schools, the information has also been shared with all LA maintained schools via Schoolsnet, Heads Up and What's Up Gov newsletters.

In addition, due to the increased level of limited assurance reviews, Internal Audit is currently liaising with management and is undertaking a risk assessment to determine future assurance requirements.

Summary of Satisfactory Assurance Opinions on Control

Service Area: Council Wide

Audit Activity: Compliance with Transparency Agenda

Background

As part of internal audit annual planning, the Director of Strategy and Challenge requested an audit review of the Council's compliance with the requirements of the Local Government Transparency Code 2015 (the Code).

The Director's Annual Assurance Statement 2016-17 identified that the Council was partially compliant with the Openness and Transparency Requirements. A development plan was put in place covering the requirements of the Code, aimed at delivering compliance within 12 months. This period has elapsed and there is now uncertainty if full compliance has been achieved.

As an aid to meeting the requirements of the Code the Local Government Association (LGA) issued a number of guides and data publication templates to clarify the data that 'must be published', data 'recommended for publication' and 'optional' data, the latter being aimed at aid understanding and use. Within the Code the government identified five stepped publication methods which would progressively enhance the end users ability to analyse, compare and contrast data sets across many Local Government entities. The LGA guidance has been used as the basis for the audit assessment of the Council's position and compliance with the requirements of the Code.

Scope

The objectives of this audit are to:

- Review the overarching arrangements to manage and monitor the Council's compliance with the Code;
- Review the progress made towards Council compliance with the 'must be published' requirement of the Code, assessing the action plans where there is non-compliance;
- Review the opportunity to deliver parts of the 'recommended for publication' section of the Code, having consideration for complexity and cost;
- Review the opportunity to deliver enhanced publication methods to increase the level of accessibility, having consideration for complexity and cost; and
- Sample test the controls applied to the data and information published on the website under the requirements of the Code, which ensures it is in accordance with the definitions, and is timely, complete, accurate, accessible and useable.

Risk Assurance – Satisfactory

Control Assurance – Satisfactory

Key Findings

Internal Audit has found the Council has a clear commitment to being transparent, evident within the Council Constitution and Code of Corporate Governance. The Corporate Management Team (CoMT) has specified and communicated the desired level of compliance with the Code, being to meet the mandatory requirements.

Internal Audit has reviewed the Council's approach to adopting and complying with the Code and found that, in most mandated areas, the Council publishes the data in accordance with the data definitions stated in the Code.

Opportunities to publish data that is 'recommended' within the Code has been considered but not pursued, apart from the Annual Fraud Report, as there has been no evidence of demand locally.

The Council publishes data in the recommended CSV format where it is best presented in a tabular format. Like many other Councils where data is best published within reports or directly to webpages, which places it in context, it does so. Again there has been no evidence of demand locally to move to a CSV format for all data sets.

There are areas where further steps are required to both enhance corporate ownership, and to move to full compliance with the mandated elements of the Code.

Recommendations have been raised for the Council to formalise the corporate ownership of the Code and to monitor and report on-going compliance.

Service leads are progressing actions to address Internal Audit identified areas of Code non-compliance, these being:

- Providing additional financial and parking space details in the Annual Parking Report;
- Providing additional detail on the budget responsibilities and number of staffed managed by those covered by the 'Senior Salaries' section of the Code; and
- Ensuring the timing of the publication of data is in accordance with the requirements of the Code.

A recommendation has been raised to monitor the delivery of the enhancements agreed during the audit to secure full compliance with the mandated elements and the publication of data in accordance with the timings specified in the Code.

Conclusion

With the completion of agreed actions to publish some data sets in more detail and swifter, the Council will comply with the mandated requirements of the Code. Clarifying the ownership of Code will aid monitoring and reporting of full compliance and the publishing of data sets in accordance with the timeframes specified in the Code. These enhancements will enable the Council to meet its desired approach of compliance with the mandatory areas of the Code.

Management Actions

Management have responded positively to the three medium recommendations made.

Service Area: Core Council - HR

Audit Activity: Recruitment and Promotion Limited Assurance Follow Up

Background

During 2016/17, Internal Audit undertook a review of the processes in place within Gloucestershire County Council (GCC) for recruitment and promotion of staff. The aim of the review was to seek assurance that appointments had been made in accordance with GCC's recruitment policies.

The findings emanating from the review resulted in a limited assurance opinion being given in respect of both risk identification and the control environment.

Scope

This follow-up audit reviewed whether the recommendations raised and subsequent agreed management actions from the original audit had been implemented and that new appointments/promotions are in line with GCC's revised Starting Salary Policy.

Risk Assurance – Satisfactory

Control Assurance – Satisfactory

Key Findings

Six recommendations were made as a result of the 2016/17 audit report, covering the following areas:

- The Starting Salary Policy only applied to existing employees who were promoted or changed position and did not cover new employees appointed to the Council;
- There was concern over the security of personnel documentation while it was waiting to be scanned and also that it was not being transmitted securely to the third party scanning company.

In addition, there was no confirmation that all files had been received by the scanning company and scanned accordingly; and

- Information needed to be provided to enable staff to search for particular documents held on the Council's electronic personnel documentation system.

Documentary evidence, where appropriate, in relation to the above was reviewed. Five recommendations were confirmed as implemented and one was confirmed as partially implemented.

The outstanding action for the partially implemented recommendation relates to ensuring that the system used for scanning documents complies with GCC's Scanning Policy. There is currently a project team reviewing the purchase of a new scanning system and implementation of the recommendation is planned to be considered and implemented as part of the project.

Audit testing on a sample on new starters and promotions highlighted that the revised Starting Salary Policy is not being applied consistently. For example, a case was identified where authorisation evidence to support a new starter being appointed at the top of a grade was not obtained by the recruiting manager and this decision was not challenged by the Business Service Centre.

Conclusion

The response to the original audit has been positive with internal controls being strengthened. A new recommendation has been made as a result of the follow-up audit, to ensure that the principles of the Starting Salary Policy are consistently applied and BSC staff challenge any salaries which are outside the policy guidelines.

Management Actions

Management responded positively to the recommendation made in respect of the issue identified in the follow-up audit report.

Service Area: Core Council - HR

Audit Activity: Flexible Retirement

Background

The Council has a Flexible Retirement Policy in place to allow employees who are members of the Local Government Pension Scheme and over 55 years old, to reduce their hours by at least 20% and/or their grade. In return, the individual will receive a pension based on their service to date, with discretion for the Council to agree to no abatement for early retirement in appropriate cases, as well as their new, reduced salary.

In the event there is a cost of allowing the pension to be paid early, it is borne by the Council, who are required to pay a lump sum into the pension fund.

The policy is discretionary and may be varied unilaterally by the Council. It does not form part of any employee's contract of employment and is entirely non-contractual. The decision on whether or not to approve an individual's application must be balanced with the changing needs of the service and the Council's commitment to providing high quality services. The policy can be utilised to support organisational change and in appropriate circumstances may be applied as an alternative to redundancy or business efficiency retirement.

Scope

The purpose of the audit was to determine whether the flexible retirement process and controls applied by the Council are in compliance with Council policy.

Risk Assurance – Satisfactory

Control Assurance – Satisfactory

Key Findings

A Flexible Retirement Policy and a Management Guidance Note (MGN) are available to all staff on Staffnet to provide guidance on the process involved in applying for flexible retirement. The documents have not been reviewed and updated since 2015 and 2016 respectively although Internal Audit was advised by HR that they are currently under review.

When a request for flexible retirement has been approved and the employee has been advised of the decision by their line manager, a Contract Change form has to be completed by the relevant budget holder. Where the reason for the change is flexible retirement, this has to be handwritten on the form. This places reliance on the form being correctly processed and the reason for change documented correctly.

There is no consistency in respect of who should retain the supporting documentation in relation to the flexible retirement request. Audit testing found that some documents were retained by the individual's manager whilst others were held by the Business Service Centre on their electronic filing system. However, the authorisation form, which has to be signed by both the Head of HR and Director: Strategic Finance, were all held on the electronic file.

A report was obtained from SAP (the Council's finance and personnel system) which highlighted that five individuals had taken flexible retirement between 1/4/17 and 31/12/17. There is no information available to show how many, if any, applied and had their request refused.

The report also included employees who had taken flexible retirement previous to 1/4/17 and a review of these highlighted two individuals whose circumstances did not appear to comply with the policy. These are being investigated by HR.

Of the five cases for 2017/18, four cases were confirmed as appropriately authorised. The remaining case had been authorised by the line manager and budget holder only, based on BSC and Pensions advice that due to the individual being above retirement age and their flexible retirement being of no cost to the service that Director approval was not required on the flexible retirement form.

Audit review of the five cases did identify opportunity for improvement in flexible retirement form completion and retention, to ensure that flexible retirement cases are actioned via the most up to date Council template forms and that the forms are fully complete for all data requirements.

Conclusion

Although there is inconsistency in where the documents are retained, the process documented in the MGN is followed in respect of obtaining pension costs and ensuring that the request is appropriately authorised. As the policy and MGN are currently being reviewed this is an ideal time to ensure that the whole process is clarified.

One of the recommendations made is to establish whether the authorisation process could be incorporated into an e-form. This would ensure that all the required information is completed before the form can be progressed for authorisation.

Management Actions

Management has responded positively to the recommendations made in respect of the issues identified.

Service Area: Core Council - ICT

Audit Activity: IT Disaster Recovery

Background

As part of the 2017/18 internal audit plan approved by the Gloucestershire County Council (GCC) Audit and Governance Committee, a review of IT Disaster Recovery arrangements was undertaken.

Disaster Recovery involves planning to protect an organisation from the effects of significant negative events. A disaster can be anything that puts normal IT operations at risk, from a cyberattack, hardware failures to natural disasters. Disaster Recovery plans and procedures should enable IT services to continue operating as close to normal as possible or recover to normal operations in a timely manner. The Disaster Recovery process includes planning and testing, and may involve a separate physical site for restoring operations.

Scope

The scope of this review was based on known good practice and encompassed:

- GCC information security policy guidelines on IT Disaster Recovery;
- Documented Disaster Recovery plans;
- Regular rehearsal and testing of Disaster Recovery arrangements;
- Technical recovery procedures for all key GCC systems;
- Physical security and environmental protection for all GCC server hardware;
- Data backup arrangements including off site data storage; and
- Commercial contracts including confidentiality agreements for key IT Disaster Recovery suppliers.

Risk Assurance – Satisfactory

Control Assurance – Satisfactory

Key Findings

Audit review identified a number of areas of good practice. Production servers are hosted at Corsham in a purpose built data centre. The Corsham site offers a high level of physical security including onsite security guards, CCTV and biometric access controls. Physical access controls are supplemented by environmental protection including Uninterruptible Power Supply, a bank of diesel generators and two power feeds to the National Grid.

The NetBackup utility has been deployed to manage daily (incremental) and weekly (full) data backup routines. Backup data is replicated across two file servers in Corsham and Gloucester. Authentication to NetBackup is managed by Active Directory and access restricted to valid and authorised members of the ICT team.

Sopra Steria are contracted to provide technical support for all live Council applications. As part of their technical support role, Sopra Steria negotiated the contract for hosting of all Council servers at the Corsham data centre.

The findings from this audit have identified some improvement actions to ensure that there is a reasonable chance of a timely recovery from an incident. The main areas that require attention are:

- The lack of a documented and authorised IT Disaster Recovery plan;
- No testing of ability to recover critical systems in the event of a disaster; and
- Absence of documented technical recovery procedures for critical GCC systems.

The above findings have resulted in three Medium Priority audit recommendations being raised within this report.

Conclusion

The lack of a documented and authorised IT Disaster Recovery plan, supported by prioritised critical system recovery procedures exposes the Council to the risk of inability to properly recover in a timely manner if a serious incident /disaster should befall the Council. At the point of audit report, ICT are proactively reviewing Disaster Recovery options to enable them to move towards a documented IT Disaster Recovery plan. Based on this documented positive direction of travel alongside the areas of good practice in place, a satisfactory assurance opinion has been applied to the IT Disaster Recovery risk identification maturity and control environment.

Management Actions

Management have responded positively to the three recommendations raised.

Service Area: Core Council - ICT

Audit Activity: Data Storage – Limited Assurance Follow Up

Background

The original Data Storage internal audit was completed in 2015/16 and the final report issued on 20th July 2016. The audit resulted in a limited assurance opinion for both risk identification and control environment. Seven audit recommendations were raised - three High (Fundamental) priority and four Medium (Significant) priority. Recommendation implementation dates ranged from September 2016 to December 2017.

This follow up review is to provide assurance that the agreed actions from the 2015/16 Data Storage internal audit have been appropriately implemented and that the original limited levels of assurance can be revised and reported to the Audit and Governance Committee.

Scope

The scope of this review was to extract the recommendations and agreed management actions from the 2015/16 Data Storage internal audit report and undertake appropriate audit testing to verify their implementation.

Risk Assurance – Satisfactory

Control Assurance – Satisfactory

Key Findings

The follow up review has identified significant progress against some of the original 2015/16 audit recommendations including:

- Detailed security policies have been published on the Gloucestershire County Council (GCC) website including guidelines on Data Protection, Freedom of Information, Information Security and Information Strategy;
- The number of Active Directory accounts assigned Domain Admin superuser rights have significantly reduced;
- Access rights and associated email accounts and P drive shared folder permissions are now promptly deleted for all GCC leavers;
- The e-storage Project has been commissioned to implement a strategic business change programme to address existing levels of e-storage and ensure that future demand for data storage is significantly reduced and managed instead of simply being met;
- The size of all mailboxes for new users has been limited to 200MB, limits to the size of existing mailboxes are being piloted and work to remove all dormant email accounts for users who have left GCC is underway;
- All live servers are hosted at the Corsham data centre with regular data backup routines run between replicated file servers in Corsham and GCC; and
- The NetBackup system actively monitors any corrupt disc space or incomplete backup cycles.

However, the review also identified a number of actions from the original 2015/16 report that are still to be implemented. The main areas that require attention are:

- Failure to review and disable all redundant service accounts that retain Domain Admin superuser rights;
- The existence of unstructured and obsolete data on Council file storage (S: drives); and
- The lack of adequate environmental protection for the GCC data backup File Server.

It is noted that at the point of audit, funding has been approved for Sopra Steria to design a technical solution to address the volume and ownership of all data stored on Council S Drives.

Conclusion

Extensive work has been undertaken to address the majority of findings from the original 2015/16 audit report and there continues to be a positive direction of travel, including the planned actions of the Council e-storage project. The follow up audit findings support a satisfactory assurance opinion for both risk identification and control environment on the Data Storage recommendation areas.

Management Actions

Management have responded positively to the three Medium Priority recommendations.

Service Area: Core Council - ICT

Audit Activity: Website Security (including Libraries Website Payments)

Background

As part of the 2017/18 internal audit plan approved by the Gloucestershire County Council (GCC) Audit & Governance Committee, a review of GCC Website Security has been undertaken.

Management of website content is administered by the Digital Communications team in GCC. The Public Consulting Group (PCG) was contracted to provide hosting and technical support for both the www.gloucestershire.gov.uk website and the GCC intranet. A wide range of GCC websites have been developed outside of the PCG contract and are hosted by separate suppliers.

Scope

The scope of this review encompassed:

- GCC security policy guidelines on digital content;
- Third party hosting of GCC websites;
- Secure configuration and external penetration testing;
- Review and management of GCC website content (including security where appropriate);
- Domain Name administration;
- Monitoring website performance and availability; and
- Failover protection for key GCC websites.

Risk Assurance – Satisfactory

Control Assurance – Satisfactory

Key Findings

The review identified a number of areas of good practice. The Digital Communications team provides technical support, training and guidance to users on all GCC digital content. The team also manages the contract with PCG for the hosting and technical support of the GCC website and staffnet intranet. PCG are contracted to provide a failover infrastructure to protect the live GCC website and complete monthly service reports outlining website performance and availability.

Hosting of the Gloucestershire County Libraries website has been outsourced to Capita. Similar to PCG, Capita offers a secure hosting environment and provide ongoing technical support and website administration.

All other gloucestershire.gov.uk websites are hosted by Sopra Steria at the Corsham data centre. Examples include

Website	Function
http://planning.gloucestershire.gov.uk/publicaccess/	Planning
https://myjobs.gloucestershire.gov.uk/Default.aspx	Recruitment
http://emsonline.gloucestershire.gov.uk/ems/ems_home.asp	Education Team
https://gloucestershire.apcoa.co.uk/pages/home.aspx	Parking Fines

GCC websites are subject to annual external penetration testing (with the caveat of the below audit finding).

The Digital Communications team provides both training and technical support for all GCC website and intranet Website Editors and Administrators. User access to the live website environment is via a secure and encrypted web portal. The Digital Communications team manages user set up and ensures access rights are restricted to valid and authorised personnel.

The findings from this audit have identified two control areas that require strengthening, including:

- The need to ensure the Libraries website is subject to annual external security testing; and
- Lack of adequate password security settings for Website Editors and Administrators on the GCC website and intranet.

Two audit recommendations have been raised as a result of the above findings.

Conclusion

The website security internal audit has resulted in satisfactory assurance for both risk identification maturity and control environment. Implementation of the two raised audit recommendations will further strengthen controls and the resulting assurance levels.

Management Actions

Management have responded positively to the two Medium Priority recommendations raised.

Service Area: Adults

Audit Activity: Annual Care Assessment Process (re-assessments reviews)

Background

The Care Act 2014 sets out in one place, local authorities' duties in relation to assessing people's needs and their eligibility for publicly funded care and support. Individuals who have been assessed as being eligible for social care support under the national eligibility criteria should also have their care plan periodically reviewed; the expectation is that this should be no later than 12 months to ensure that their assessed needs continue to be met.

The Council has a Section 75 agreement with the Gloucestershire Clinical Commissioning Group.

Under this agreement the Clinical Commissioning Group commissions the provision of Mental Health services which includes social care provision for this client category, which is currently delivered by 2gether NHS Foundation Trust (2g). Care reviews, for all other client categories are delivered through the Council's Integrated Adult Social Care teams.

Scope

This review will seek to determine whether there are effective governance arrangements in place to ensure that timely reviews of service users' needs are being undertaken in compliance with the requirements of the Care Act 2014.

Risk Assurance – Satisfactory

Control Assurance – Satisfactory

Key Findings

GCC - Personal budgets, planning and review policy

The Council has developed a 'Personal budgets, planning and review policy' This was ratified on 20th August 2015 by the Adult Social Care Management Team and subsequently issued on 1st September 2015. Internal Audit reviewed the content of the policy and found that section 20 detailed the requirements for reviewing the plan. These were found to be in compliance with the expectations of the Care Act 2014 and the Care and Support Statutory Guidance (February 2017).

The policy is subject to the requirement for an annual review. This was scheduled to be undertaken 31st July 2016 (as per the version control) but the review had not been undertaken as at the date of the audit.

2g NHS Foundation Trust

The Community Social Care Panel (CSCP) Terms of Reference and Operational Process was developed in June 2017 and was formally ratified by the Placement Project Board at their meeting held on 15th June 2017. These arrangements set out the requirements for the timeliness of reviews which were found to be in compliance with the Care Act 2014 and the Care and Support Statutory Guidance (February 2017).

Performance reporting

Internal Audit established that there is a hierarchical structure in place that enables oversight, management and monitoring of each of the respective client group's identified performance metrics/outcomes against target. Performance data is provided to the respective Committee, Boards, Groups and management meetings as scheduled (either on a weekly, monthly or quarterly basis).

Performance metrics

Performance metrics to measure the timeliness of reviews have been developed by the Council and 2g. Internal Audit established that the metrics are in compliance with the expectations of the Care Act 2014 and statutory guidance (February 2017).

The reported performance outcomes '% of ongoing service users who have had a full reassessment of their needs in the last 12 months', as stated within the Performance Scorecards for the period Q4 2015/16 - Q4 2016/17 where available, evidence that the average actual performance within this period across the client groups Learning Disabilities, Physical Disabilities and Older People range from 66%-76%, and is therefore significantly below the stated target of 90%. In contrast, the reported performance outcomes for the Mental Health client group for the same period, exceed the target and range from 93%-98%.

The Head of Service for Integrated Adult Social Care advised Internal Audit that one of the key factors that needs to be borne in mind when comparing the performance outcomes between Adult Social Care and Mental Health is the remit of each organisation.

The Council's wider statutory role i.e. safeguarding, does impact upon the timeliness of scheduled reviews due to the need to respond to urgent situations.

For a period of time between the end of 2016/17 to mid 2017/18, performance data had not been produced due to issues arising from the ContrOCC (the Council's finance module for Adult Social Care) migration. The recent Adult Social Care Performance Report that was presented to the Health and Care Overview and Scrutiny Committee on 9th January 2018 however also evidences that the trend analysis against target (albeit that the target has been reduced from 90% to 80%) is still reported to be below the stated target with the exception of September 2016. The latest period reported is for the quarter ending September 2017, the reported outcome is 57.2% against the target of 80%.

Allocation of reviews

Roles and responsibilities are clearly defined across all client groups for the allocation of reviews. Within the Council a workload management tool is available for use. This can help to inform workers' capacity and fair distribution of cases across teams. It is acknowledged by management that further work is needed to optimise its current usefulness. Work is currently being undertaken by the Principal Social Worker to further develop the caseload management tool to enhance its effectiveness.

Current actions and barriers

Past performance information has highlighted that there is a backlog of reviews for service users in Residential and Nursing placements. In acknowledgement of this and the financial pressures being placed on the Adult Social Care external care budgets together with the Council's Meeting the Challenge (MtC) agenda, resources are being directed to target overdue reviews of high cost placements and service users who are placed within a care home setting.

From discussions held with key officers during the undertaking of this review, Internal Audit has been advised that the completion of timely assessments across Learning Disabilities, Physical Disabilities and Older People may be impeded for the following variety of reasons:

- Currently reassessments are being undertaken using the full Functional Analysis of Care Assessments (FACE). Alternative models are currently being explored with the aim, going forward, to expedite the process. In addition, the Service will be reviewing the Panel process;
- High cost reassessments (excess of contract price) can be slow, are very time consuming, and need careful handling to ensure that the provider and client's expectations are effectively managed where resistance or legal challenge is encountered;
- A rise in complex transition cases/creation of services for placement;
- Data accuracy issues;
- Resourcing for targeted reviews;

- Delays during the review process Advocacy; appointments with families; engagement with other key professionals; changes in Education Plans; and

- Other work pressures including urgent prioritisation of cases, Provider performance improvement plans, Electronic Call Monitoring changes, Enablement, Safeguarding, Deprivation of Liberty Safeguards, Court of Protection and complaints.

Conclusion

From the findings emanating from the review, Internal Audit is able to conclude that there is a sufficient governance framework in place to enable oversight, management and monitoring of timely reviews for each respective client group.

It is evident however, from the available performance data that actual performance within the Learning Disabilities, Physical Disabilities and Older People categories is significantly below the stated target. In contrast, performance outcomes for the Mental Health client group exceed the current target.

Management are fully aware of the current barriers that are impeding the achievement of the timeliness of reviews within the Learning Disabilities, Physical Disabilities and Older People categories and are proactively seeking, where possible, to address these.

It is important, for those charged with governance, that they ensure that continued focus is given to improving the current performance position, in order to ensure that the associated inherent risks are appropriately mitigated, and that the Service can demonstrate that its operations meet the expectations of the Care and Support Statutory Guidance i.e. that it conducts a review of the plan no later than every 12 months.

Management Actions

Internal Audit has made one medium priority recommendation in respect of ensuring that the Council's Personal budgets, planning and review policy is reviewed and refreshed if appropriate. Management have responded positively.

Service Area: Adults

Audit Activity: FAB Limited Assurance Follow Up

Background

Gloucestershire County Council's (GCC) Adult Social Care relies on people who use services making a financial contribution to the cost of providing them, if they are able to afford to do so.

The Financial Assessments & Benefits (FAB) team ensure that any financial contributions required from service users for residential and non-residential Social Care services are calculated fairly and in accordance with GCC policies and Government guidelines.

The team also help to maximise income for individuals and maximise charging revenue for GCC by providing advice and practical assistance to all service users, their partners and carers to ensure that they are in receipt of their full welfare benefit entitlement.

In addition, the FAB team also assess Adoption Allowances, Fostering Allowances and Special Guardianship Allowances for Children's services and for Disabled Facility Grants for both Adults and Children.

In light of the above, it was agreed that a planned review of the FAB team would be undertaken as part of the 2014/15 Internal Audit plan. The findings emanating from the review resulted in a limited assurance opinion being given in respect of the level of assurance over the Service's Risk Identification Maturity and the Control Environment.

Internal Audit subsequently undertook a follow up review during 2015/16. The findings emanating from this review resulted in a satisfactory assurance opinion being given in respect of the level of assurance over the Service's Risk Identification Maturity, however once again only a limited assurance opinion could be provided over the Control Environment. It was therefore agreed that Internal Audit would undertake a further review of this area during 2017/18.

Scope

To review whether the four recommendations emanating from the 2015/16 Internal Audit have now been fully implemented.

Risk Assurance – Substantial

Control Assurance – Satisfactory

Key Findings

Since the review was undertaken in 2015/16 the Admin Hub and the FAB team no longer have a Service Level Agreement in place for the provision of the administrative functions of the FAB team. The administrative staff now fall within the service structure of the FAB team and are line managed by the FAB Team Manager.

As a consequence of this change, some of the 2015/16 recommendations, either wholly or in part are no longer relevant however, if appropriate, the recommendation has been followed through to the Service's current systems and processes.

Recommendation 1 Team Meetings

Team Meetings are being held periodically and minutes of the meetings are taken. A review of the minutes of the meetings held within the calendar year for 2017 evidence that attendance is inclusive to all staff within the FAB team.

Recommendation 2 Management/Monitoring System

Alternative systems for the management and monitoring of referrals has been considered, however the FAB team are currently still using the same spreadsheet that was in operation at the time of the last audit review to manage and monitor FAB referrals.

The FAB Team Manager advised Internal Audit that since the Admin staff transferred back to the FAB team there has not been the same error issues with the spreadsheet. Internal Audit was also able to verify from discussions held with the FAB Administrator that there have been no key issues with the functionality of the spreadsheet for the last 12 months.

Recommendation 3 Performance Metrics

Gloucestershire County Council uses an in-house bespoke computer system (ERIC) to support the management of its social care provision for adults across the county. During 2016/17 the Council implemented a new Finance solution (ContrOCC) that replaces ERIC's finance functionality whilst integrating with ERIC as the social care case management solution.

Due to the ongoing migration of the Service's systems and processes into ContrOCC, until all functions are successfully migrated, the measurement and monitoring of the Service's performance metrics have been put on hold based on management decision.

Recommendation 4 Risk Management

The Service has five risk entries recorded within In Phase, and it is evident, from a review of the entries that these have all been populated for the periods Quarter 1-Quarter 3 2017/18.

Conclusion

It is pleasing to report that the agreed management actions to address the recommendations emanating from the 2015/16 review have all been taken forward albeit that progress against some of the recommendations have been impeded, due to the migration of the Service's functions into ContrOCC. Once the migration is complete, focus will need to be given to prompt progression of the outstanding action in respect of the measurement, monitoring and reporting of the Service's performance metrics within In Phase.

Management Actions

There were no recommendations emanating from this review.

Service Area: Adults

Audit Activity: Client Contributions Limited Assurance Follow Up

Background

Gloucestershire County Council's Adult Social Care relies on people who use services making a financial contribution to the cost of providing them, (if they are able to afford to do so).

The Financial Assessments & Benefits (FAB) Team ensure that any financial contributions required from service users for residential and non-residential Social Care services are calculated fairly and in accordance with the Council's policy and Government guidelines. The Team also help to maximise income for individuals, and maximise charging revenue for the Council by providing advice and practical assistance to all service users, their partners and carers, to ensure that they are in receipt of their full welfare benefit entitlement.

In addition the FAB Team also assess Adoption Allowances, Fostering Allowances and Special Guardianship Allowances for Children's services and for Disabled Facility Grants for both Adults and Children.

In light of the above, it was agreed that a planned review of this area would be undertaken as part of the 2015/16 Internal Audit plan. The focus of the review was to determine whether financial assessments are accurately and promptly completed in order that any financial charges can, where appropriate, be applied.

The findings emanating from the review resulted in a satisfactory assurance opinion being given in respect of the level of assurance over the Service's Risk Identification Maturity, however only a limited assurance opinion could only be given in respect of the control environment. It was therefore agreed that Internal Audit would undertake a follow up review of this area.

Scope

To review whether the recommendations emanating from the 2015/16 Internal Audit have now been fully implemented.

Risk Assurance – Substantial

Control Assurance – Satisfactory

Key Findings

The findings emanating from the 2015/16 audit review resulted in 11 recommendations; these were aimed at strengthening the internal control environment of the area under review, which focused upon:

- Policy and procedural guidance;
- Capital assets (identification/recording of property details) that are considered as part of the financial assessment;
- Promotion of the availability of independent financial advice and optimum utilisation of the Direct Debit payment option;
- Periodic reassessment of Service Users who have had a previous financial assessment resulting in a nil or negative charge; and
- Improvements to the Quality Assurance process, including learning events in respect of identified errors within previous/current financial assessments, and a wider Safeguarding event.

It is pleasing to report that the agreed management actions to address these recommendations have all been taken forward, where possible, with some positive results emanating from the reassessment of Service Users who had previously been assessed as having a nil or negative charge. From the 105 cases that were reviewed, 58 (55%) of these resulted in an increase to the client's weekly contribution. The net result of these changes equate to an increased weekly Maximum Chargeable Income of £2,974.34, with a potential annual increase of circa £154k.

There are some ongoing actions in respect of the promotion of utilisation of the Direct Debit payment option, and reassessment of Service Users with a nil or negative charge. In addition, the Quality Assurance process should be further strengthened once a technological solution becomes available for use.

Conclusion

Internal Audit concludes that the internal control environment has been further strengthened following the implementation, where possible, of the proposed recommendations emanating from the 2015/16 review, resulting in a rise in the assurance level that can be provided over the Service's risk identification maturity and control environment.

Management Actions

There were no recommendations emanating from this review.

Service Area: Adults

Audit Activity: Direct Payments (Adults)

Background

Gloucestershire County Council (GCC) is committed to promoting individual wellbeing and to supporting independence through preventing, reducing or delaying the need for care and support. Direct payments are the Government's and GCC's preferred mechanism for personalised care and support as they promote Service User independence, choice and control over how their needs are met.

A Direct Payments team was set up in September 2015 to ensure compliance with the Care Act 2014 and embed direct payments as the preferred model of service delivery at GCC, where applicable. The Direct Payments team also provides a monitoring function to ensure Service Users in receipt of a direct payment use their accounts appropriately and meet their obligations where they are an employer. As at the date of the audit, there were 427 Service Users that the Direct Payment team are expected to monitor.

Scope

The objective of this review was to determine whether there are effective governance arrangements in place for the management and monitoring of adult direct payments by providing assurance that:

- The current framework for direct payment monitoring operates in accordance with statutory regulations and legislation and council policies and procedures; and
- Service User data is consistent across the Adult Social Care Case Management System (ERIC), the ContrOCC Financial System (ContrOCC) and the Microsoft Excel spreadsheet (the scheduling spreadsheet), for scheduling and managing reviews.

Risk Assurance – Satisfactory

Control Assurance – Satisfactory

Key Findings

Since the Direct Payments team was formed they have successfully recovered £1,039,948 of funding from Service Users through monitoring and reviewing of direct payment accounts.

The Direct Payments Policy reflects the review frequency specified in the Care and Support (Direct Payments) Regulations.

Due to resourcing issues and other team priorities, such as the introduction of the payment cards, the Direct Payments team have not been able to consistently review all direct payments annually. However all but three Service Users, who are not engaging with the review process, have been reviewed at least once since the team was set up.

From September 2017, a new type of account is being offered to Service Users who are eligible for support and are suitable to receive their personal budget in the form of a direct payment. The Direct Payments and Brokerage Lead anticipates that this will support more timely reviews and enable the Direct Payments team to identify issues with payments earlier than currently happens.

To further improve the number of direct payments being reviewed and minimise the risk to the Council, the Direct Payments team is also considering a proportionate auditing approach to reviews. This approach will assess and assign a 'Complexity Category' to each direct payment which will determine a grade/risk; then dependant on the grade/risk the review will take place between six and 12 months.

Internal Audit sampled 25 Service Users from the ContrOCC system, who had received a direct payment between June 2015 and November 2017, and compared with the ERIC system for evidence of reviews:

- 20 of the sampled 25 had received a review within the first six months or prior to de-allocation;
- 13 of the sampled 25 should have received an annual review and Internal Audit found evidence that 12 had received an annual review since the Direct Payment team was set up in September 2015; and
- Ten of the sampled 25 Service Users circumstances had changed since the direct payment was set up, and nine of these were found to have been reviewed. For the one which was not reviewed, correspondence indicates that the Direct Payment team were not informed of the change in client contribution by the Financial Assessment and Benefits (FAB) team.

Reviews are scheduled using the scheduling spreadsheet however it does not currently include previous review dates for all Service Users. This is being addressed by the Support Officer, but until this is fully populated the spreadsheet does not suffice as an effective scheduling tool.

At the start of this review it was found that Service User data was not always consistent across ERIC, ContrOCC and the scheduling spreadsheet, however during the review period the team have proactively implemented processes to ensure the consistency of data across all three recording systems.

Conclusion

Internal Audit concludes that it is evident that there is a framework in place for monitoring direct payments; however the timeliness of reviews is not currently compliant with statutory regulations. Management are proactively seeking to remedy this issue through the introduction of a new review process and roll out of a new type of account. Going forward, it is important for management to continue to monitor and review the effectiveness of these changes, and any further actions that may be needed to ensure compliance with external regulations and the Direct Payments Policy.

The current framework could be further strengthened and regulatory and policy compliance improved by:

- Formally documenting the inherent risk, mitigating controls and any further actions required to ensure compliance with the Care and Support (Direct Payments) Regulations 2014 in line with the Council's Risk Management Policy and Strategy 2017-18;
- Developing performance management information to help monitor the effectiveness of the current systems and processes for direct payment reviews;
- Formalising the proportionate auditing approach, and subsequently updating the respective guidance;
- Consideration, as part of the new case management system procurement, whether review dates for direct payments could be incorporated to enable a more robust scheduling process. In the interim the scheduling spreadsheet should be annotated with review dates to support the timely scheduling of future reviews;
- Giving consideration to strengthening the Direct Payment Agreement to stipulate actions with timeframes that GCC may take if Service Users do not engage with the review process; and
- Implementing a checklist to ensure consistency of reviews, prior to de-allocation, by the Direct Payment Specialists.

Internal Audit has made two medium priority recommendations which are aimed at further strengthening the control environment for the management and monitoring of direct payments.

Management Actions

Management have responded positively to the two medium recommendations made.

Service Area: Children and Families

Audit Activity: Alternative Provision School

Background

Alternative Provision Schools (APS) provide education for children who have been permanently excluded from school and they have the same delegated powers and duties as maintained schools. There are three such schools in Gloucestershire, covering the following areas:

- Cheltenham & Tewkesbury;
- Gloucester & Forest; and
- Stroud & Cotswold.

This audit was undertaken at one of the above.

Each APS has its own arrangements in place to provide support and advice for schools situated in their local area. Schools can contact the APS directly to discuss what may be available to support them with children at risk of exclusion. In addition, an APS can be commissioned by the Local Authority (LA) to provide a number of places for pupils who have been excluded from mainstream education and children who do not have a school place.

Scope

The objective of the audit was to review the management and governance processes in place to provide assurance that the funds are being spent appropriately on the pupils and for the purposes intended.

Risk Assurance – Satisfactory

Control Assurance – Satisfactory

Key Findings

The audit reviewed the following areas at the school: Governance and budgetary control, staffing and payroll, Income, Purchasing, Bank accounts and Vehicles.

The Management Committee members receive a budget update at each of the meetings to enable the deficit budget to be monitored. Monthly budget updates are also forwarded to the LA and Internal Audit was advised that there are regular meetings with the LA in this respect.

Seven recommendations were made, five of which related to purchasing procedures and processes, in particular compliance with the school's Finance Policy and reviewing expenditure on alternative provision. The remaining two recommendations were in respect of reviewing the responsibilities for processing transactions through the bank account to ensure separation of duties and maintaining a log of all journeys undertaken by the school's vehicles.

Conclusion

The school is in a deficit budget position and as such, the budget needs to be closely monitored. Controls surrounding purchasing need to be strengthened to ensure that both statutory and local regulations are adhered to.

Management Actions

Management has responded positively to the recommendations made in respect of the above issues identified.

Service Area: Children and Families

Audit Activity: Special Educational Needs (SEN) joint social care and education funded placements

Background

Special Educational Needs (SEN) joint social care and education funded placements is an area of significant spend for the Council. The 2017/18 budget for joint-funded placements was circa £6,500,000 with a projected overspend of circa £3,400,000.

Placements can be made across a variety of residential care providers and within Gloucestershire maintained schools, independent or non- maintained special schools, or out-of-county schools. Places are commissioned through the Special Educational Needs and Disabilities (SEND) and Commissioning teams, either as a block or individually (where there is an urgent requirement based on service user needs). The commissioning approach used should be in line with defined Council protocol and requirements to ensure that the needs of the service user are met whilst also achieving Value for Money (VfM) for the Council.

Scope

The objective of the audit was to review the systems and processes in place for the commissioning of SEN joint social care and education funded placements to ensure that:

- There is a defined commissioning approach and placements are commissioned in line with Council requirements and guidance;
- Placement decisions are formal, transparent and in line with the service user's needs and VfM is considered and achieved (where possible) within the placement approach; and
- An appropriate governance framework, including performance management and monitoring, is in place.

Risk Assurance – Satisfactory

Control Assurance – Satisfactory

Key Findings

Joint-funded SEN placements are currently tendered via an electronic dynamic purchasing system (DPS). Placements are tendered appropriately, contract documentation is in place and evidence of procurement activity and contract approval is retained, as per legislative requirements. A significant proportion of both the joint-funded and general SEN budget is spent with a small number of suppliers. The large amount of expenditure with a small number of providers may allow for negotiation of bulk discount, though it is currently unknown whether the DPS agreement permits this type of negotiation.

A reasonably appropriate governance framework is in place, with the Children and Young People Exceptional and Residential Needs (CYPERN) panel membership including representatives from each of the three service areas (health, social care and education). However, the Agency Decision Makers (ADMs) from the Health and Education services are not currently members of the panel, which can result in some delay regarding funding decisions. The ADMs who are not members of the panel receive performance updates from social workers via the meeting minutes as core members on the distribution list and they therefore have the opportunity to comment or liaise with the chair as appropriate and to assure themselves that placements are achieving agreed outcomes.

In the main, the Terms of Reference are appropriate for the purposes of the CYPERN panel, though they are perhaps ambitious in scope. It is unclear when the panel would be able to fulfil some of the higher level aspects.

In the cases tested, the needs of the service user were clearly defined and documented by social workers before the case was considered by the multi-agency CYPERN panel. However, it was observed at a panel meeting that there are quality and timeliness issues in preparing the necessary paperwork and effectively defining the user's needs, which was observed to delay the decision making process. The placement decision making process is robust, authorities are designated and decisions are formally recorded and retained. In addition, placements are funded according to the ratios agreed by ADMs and individual placement costs and the overall joint-funded budget are accurately monitored.

Current placements are reviewed on a regular basis by the CYPERN panel to ensure that they are still suitable to the user's needs and to consider the possibility of transition to mainstream services. In some cases, placements were not reviewed at the agreed intervals. Frequent delays were observed in the submission of paperwork by social workers to the CYPERN panel administrator. The root cause of this issue was not investigated during the course of the audit due to time limitations, however, subsequent discussions with the Interim Strategic Lead for Children in Care, Children and Families revealed that substantial resources were dedicated to chasing social workers for paperwork due to quality issues.

A number of internal and external metrics are used to assess the performance of both the provider itself and it's ability to meet the outcomes defined for the children in placement, including contract monitoring site visits undertaken by the commissioning team, annual reviews of placement suitability conducted by social care and quality assurance of education arrangements provided by the Virtual School (a Gloucestershire County Council (GCC)

quality assurance group who visit every Child in Care in a residential placement).

A variety of methods are used by the council to ensure value for money is achieved where possible, including benchmarking with statistical neighbours, placement performance monitoring and negotiation of additional costs. However, the lack of in-county provision and market competition presents a challenge for effective negotiation of placement core costs.

Conclusion

It was found that the arrangements for managing risk were satisfactory with some control weaknesses in key areas where improvements are required before an effective control environment will be in operation. The overall opinion of the controls within the system was that they provided satisfactory assurance.

Management Actions

Management has responded positively to the recommendations made.

Service Area: Communities and Infrastructure

Audit Activity: Highways Finance Team (follow-up to Administration Hub)

Background

The Highways Finance team is responsible for collecting and banking the income due to the Council in relation to a number of highways related activities, such as:

- Issuing licences for skips and scaffolding which are to be sited on the highway;
- Disabled space markings; and
- Developer contributions.

In 2015/16 the Administration Hub was responsible for this process and the procedures within the Hub were subject to a review. The review identified a significant breakdown in the process, which resulted in unnecessary delays in work being processed and income not being collected. Where income was collected it was not being banked in a timely manner. As a consequence, management introduced a number of improvement actions.

In 2017, the Administration Hub was disbanded and staff moved to service areas to provide administration support for each area. As part of this process the Highways Finance team was formed.

Scope

This audit reviewed the current processes within the Highways Finance team to establish whether the actions introduced by management following the 2015/16 internal review have been implemented.

Risk Assurance – Satisfactory

Control Assurance – Satisfactory

Key Findings

The financial processes have been revised and there are template request forms which should be completed by the person requesting the work, e.g. purchase orders, debtor invoices, credit notes.

There is a shared email inbox which is available to all members of the Highways Finance team where all requests should be sent. When the administrators in the team select an email to process they will put a particular category on it which indicates who is dealing with that request. It can also provide a quick guide to which requests are being processed and by whom.

This review highlighted that:

- The process around issuing credit notes needs to be strengthened;
- No record is maintained by staff at Highways depots of any income which is received and sent on to Shire Hall;
- Income, including cash, is not held securely by the Highway's contractor prior to it being taken to the Highways Finance team;
- Cash, although rarely received, is not included on the list of income given to Highways Finance administrators by the contractor;
- The tin where the cash and cheques are held prior to taking it to the cashiers for banking was not held securely; and
- Cash was not being logged on the income spreadsheet maintained by the Highways Finance administrators.

Conclusion

Overall, the principal concerns highlighted in 2015/16 have been appropriately addressed following positive action taken by management. The control environment would be further enhanced and strengthened by implementing the audit recommendations in respect of issuing credit notes and the collecting and banking income.

Management Actions

Management have responded positively to the recommendations made in respect of the above issues identified.

Service Area: Communities and Infrastructure

Audit Activity: Public Transport Contracts – Decision Making Limited Assurance follow up

Background

The Council awards a significant number of transport contracts and it is important that the rationale to support the decision making process is fully documented in case of challenge at a future date. The Internal Audit review completed in 2014/15 concluded that the documentation to support the decisions taken at that time fell below the new requirements of the Council's Scheme of Delegation. The audit further identified that too many extensions and variations to the existing contracts were being signed off retrospectively.

Scope

This follow-up audit reviewed the actions taken by the Integrated Transport Unit (ITU) to address the concerns identified in the earlier review in respect of the decision making and authorisation process for the tendering and award of Contracts.

Risk Assurance – Satisfactory

Control Assurance – Satisfactory

Key Findings

Staff from the ITU were able to demonstrate that since the 2014/15 review they have introduced a number of new systems and processes to strengthen the existing internal controls around the decision making process.

However, a number of areas highlighted in the original report have only been partially completed and remain a work in progress. Management should take steps to expedite the outstanding actions in the following areas as a minimum:

- New Contracts and Extensions/Variations
    - Update maintenance of the new/variation/extension contract spreadsheet;
    - Introduce a formalised process for ensuring the contract spreadsheet is regularly monitored and managed; and
    - Introduction of an escalation process to ensure contracts are returned in a timely manner.
- Retention of Decision Making Correspondence
    - Review the retention of decision making correspondence to ensure that key documents are retained for the appropriate length of time;

- Ensure that contract changes should be made on receipt of written and not verbal approval; and

- Introduce a consistent approach to the retention of those documents that are deemed to be key in order that they can be easily accessed by any team members needing to review them.

- Contract Expiry Dates

    - Undertake additional work on the contract spreadsheet to ensure that the information recorded is accurate and enables other aspects of the service to be reviewed and appropriate action undertaken in a timely manner. This should include trigger points to identify those contracts nearing expiry and enable contract changes or tendering action to be actioned prior to the start of a new/contract change (variation/extension).

Conclusion

There have been improvements to the systems and processes operated within the ITU since the previous audit in 2014/15, although the implementation of some of the agreed actions remains a work in progress.

Internal Audit will continue to monitor the progress of implementing the remaining agreed actions. In addition, a full audit will be considered under the 2019/20 Internal Audit work plan.

Management Actions

Management responded positively to the recommendation made in respect of the issue identified in the follow-up audit report.

However, it should be noted that based on the assurances provided by management that the agreed actions will be completed, Internal Audit concludes that a satisfactory assurance can be provided that those risks which are considered to be material to the achievement of the services objectives for this area are adequately managed and controlled.

Service Area: Communities and Infrastructure

Audit Activity: Gloucestershire Fire and Rescue Service – Health and Safety Management

Background

The Health and Safety at Work Act 1974 applies to all activities of the Gloucestershire Fire and Rescue Service (GFRS) in its role as an employer of fire and rescue service staff. The Act requires employers to ensure the health, safety and welfare at work of their employees and that their operations do not adversely affect the health and safety of other people.

The Health and Safety Executive (HSE) also provides guidance to assist Fire and Rescue Authorities in balancing risks, particularly in their wider role to protect the public and property, while meeting their health and safety at work duties to protect their staff and others.

Scope

The objective of the audit was to review the health and safety governance arrangements that are in place to mitigate the risk of injury to personnel and to consider the effectiveness of the systems that are in place for incident recording, investigation, reporting and monitoring.

Risk Assurance – Substantial

Control Assurance – Satisfactory

Key Findings

Governance arrangements

A policy and associated appendices has been developed for the management of health and safety within GFRS. Use is also made of relevant legislation and guidance issued by HSE. The policy was being reviewed at the time of the audit and it became apparent that a number of amendments will be required in order for the policy to reflect currently approved operational practice. A system is being put in place to ensure that the policy will always be updated in a timely manner going forward.

Roles and responsibilities in relation to health and safety have been allocated to operational staff, middle management and senior management. These roles also tie in with the governance structures that have been set up to ensure that health and safety matters are appropriately considered, recorded and reported. There is an appropriate escalation system in place should any matters need to be addressed at a higher level.

Two areas for improvement would be to ensure that any actions identified from meetings are followed up and that the Key Performance Indicators (KPIs) are relevant and accurately reported.

Sample testing of incident recording

GFRS uses a national incident recording system called RIVO to record all operational and non-operational incidents. All incidents are reported to Control Operations in the first instance and a check confirmed that all the incidents were subsequently recorded on RIVO.

A sample of incidents between April 2017 to December 2017 was selected for testing. The standard of recording was good but each incident is also meant to be investigated and the recording of the investigations on RIVO is not always happening as required (46% of the sample cases had no investigation reports on RIVO and this concurred with the monitoring systems of the Operational Assurance and Safety Coordinator).

The incidents in the sample had been recorded on RIVO in a timely manner and all of the assigned investigating officers were of the required seniority, not involved in the incidents themselves and were appropriately qualified to undertake the task.

Four of the incidents resulted in actions/recommendations being required but there is currently no formal recording system in place to confirm whether the actions had been implemented. Enquiries revealed that one action had been implemented but that the other three remained outstanding. A new electronic system is due to be implemented whereby specific actions can be 'attached' to individuals where they would be required to acknowledge receipt of the instruction.

Some incidents will result in safety notices being issued to ensure that similar incidents don't recur in the future. In one of the sample cases a safety notice had previously been issued in relation to a similar incident. If the safety notice had been observed, the incident would most likely not have occurred. A system will be put in place to ensure that safety notices are embedded into the organisation's operations to prevent similar incidents recurring.

Conclusion

Health and safety risks within GFRS are well understood and good systems of control are in place to mitigate those risks.

The following improvements have been identified:

- Health and safety policies should be updated in a timely manner;
- Actions identified from meetings and following incidents should be monitored for implementation and completion;
- KPI figures should be reviewed for relevance and be accurately reported;
- The investigation of all incidents should be recorded on RIVO; and
- Safety notices issued following incidents should be embedded into the organisation's operations to avoid similar incidents recurring.

Management Actions

Management has responded positively to the recommendations that were made.

Service Area: Communities and Infrastructure

Audit Activity: Section 38 and Section 278 Agreements

Background

Under section 38 and 278 of the Highways Act 1980 the Council levies fees on private developers with an income budget of circa £1.2m.

Scope

To provide assurance that key controls are operating effectively for Highways Development income. The audit approach considered the following areas:

- Evidence of relevant procedure notes to administer the initiation, raising and invoicing of fees payable;
- Sample testing the procedure to ensure that the billing process has raised the fees to developers, in compliance with the Council's schedule of fees and charges;
- Review of the procedures to ensure that fees are promptly paid or are subject to a suitable debt recovery process;
- The process and controls for accounting of commuted sum amounts in relation to future maintenance of section 38 and section 278 schemes; and
- Summary high level review of the Mastergov Road Adoption database, with the objective of identifying any improvements in project monitoring.

Risk Assurance – Satisfactory

Control Assurance – Satisfactory

Key Findings

- Highways Development fee income was correctly received in advance of completion of section 38 and section 278 agreements;
- MasterGov Road Adoption project records documents a full audit trail of the procedures that took place; and
- Commuted sum reserve balances to fund future maintenance of road schemes, are subject to an appropriate set of procedures led by Strategic Finance.

Conclusion

Internal Audit review confirmed that a systematic set of procedures and controls were in place and overall operating effectively. The control environment could be further enhanced by introducing

- An annual refresh of the "Manual for Gloucestershire Streets" fees and charges financial rates for technical and administration costs, and obtain governance approval to any changes;
- A single guidance document for "Commuted Sums for Highways Adoption", which will contain details of the categories, rationale and methodology to use in calculating them; and

- A schedule of fees brochure, which can add value to the marketing approach to private developers and property landlords.

Management Actions

Management has responded positively to the recommendations that were made.

Service Area: Pensions

Audit Activity: Pensions Cash Payment

Background

Gloucestershire County Council (GCC) is responsible for administering the Local Government Pension scheme (LGPS) on behalf of GCC and other employers, including district and parish councils, academies and various other admitted bodies.

Between April 2017 and January 2018 approximately £19 million has been paid out in lump sums from the pension scheme. Lump sums payments can be made for the following reasons:

- New pensioners (receiving standard or Additional Voluntary Contribution lump sums);
- Members leaving the scheme (refunds);
- Other pension providers (individuals transferring out); and
- Pensioner's relatives (death benefits).

Scope

This audit reviewed the effectiveness of the controls around the payment of lump sums to ensure they are made to the correct person/business, are accurate and monitored appropriately.

Risk Assurance – Substantial

Control Assurance – Satisfactory

Key Findings

Assurance for the accuracy of the payments of lump sums is taken from the checking process of the pink slip (manual payment document) calculations, with all pink slips required to be signed off by both the Pensions Officer, responsible for completing the calculations, and the Pensions Officer, responsible for checking the calculations before they are authorised for payment.

Internal Audit sample tested 30 out of 1442 pink slips used for lump sums, covering the period 1st April 2017 to 11th January 2018. In all cases the pinks slips had been correctly signed off by the officer responsible for completing the calculations, the officer who had checked the calculations and the manager authorised to approve the payment. In all cases the expected internal controls operated as intended and were effective.

Internal Audit identified that while the pension's database allows for the recording of payments and the identification of potential duplicate payments, there is a risk that a Pensions Officer could intentionally alter the information with the aim of causing a fraudulent payment after the checking process has been completed. Internal Audit has provided a recommendation to mitigate this risk by removing this opportunity from the control process.

Reconciliations are completed monthly for lump sums paid out of the pension fund. Internal Audit tested the reconciliation process on the same 30 pink slips and found that the reconciliation was effective in identifying discrepancies and took place as intended, with queries raised to the Pensions Administration Manager for resolution where appropriate.

Queries identified during the reconciliation by the Pensions Investment Team are reviewed and rectified by the Pension's Administration Manager. The Clerical Officer (Pensions) maintains and monitors a spreadsheet of all queries identified and the date on which they are subsequently resolved. Internal Audit sample testing confirmed the effective application of, and compliance with, the controls examined.

Conclusion

Whilst the current systems/internal controls mitigate risk of unintended errors and sample testing did not identify any issues, to improve the control environment Internal Audit have provided one high priority recommendation. This concerns strengthening the control activities in place that provide management assurance that lump sum payments are being completed accurately and as intended, removing an opportunity for fraudulent payments to occur.

Management Actions

Management have responded positively to the audit recommendation raised as part of the review.

Summary of Substantial Assurance Opinions on Control

Service Area: Core Council - ICT

Audit Activity: Sopra Steria Improvement Plan – process review

Background

As part of the 2017/18 internal audit plan approved by the Gloucestershire County Council Audit and Governance Committee, a review of ICT was undertaken with specific emphasis on the Sopra Steria managed service contract.

A mid-contract review has been undertaken internally which resulted in the development of a service improvement plan. The mid-contract review was conducted to ascertain whether or not to consider an alternative provider at the end of the current fixed five year term or to extend Sopra Steria for the two years extension written into the contract. The Sopra Steria response to the service improvement plan and their proposal to the Council will determine whether or not to extend the contract.

The Head of ICT and ICT Operations Manager requested that an audit was undertaken to review the process followed to date and obtain independent assurance.

Scope

This audit assessed and evaluated the management processes undertaken; the options considered for the contract going forward; the governance arrangements; the required approvals; the information provided leading to the decision making; and the next steps with timescales in order to ensure that the future contract change arrangements are properly set up and based on rigorous and evidence based information.

The objective of the audit was to give an opinion on the extent to which the key risks (is the decision to extend the contract or not based on sound business information) are being addressed and mitigated. This was completed through a desk-top review of available documentation which supported the overall decision making process.

The review is advisory is nature however an opinion based on the review outcomes is provided.

Risk Assurance – Substantial

Control Assurance – Substantial

Key Findings

The audit review of the key documentation noted that the Head of ICT had appropriately articulated the review rationale, key observations, issues and risks to senior management i.e. that a mid-term review had revealed some performance issues and also that the transformation programme and the council's emerging digital strategy had changed the

landscape. This commenced with the presentation of the findings of the mid-term review as early as May 2017. Then followed a detailed presentation of the issues and finally, an options appraisal in September 2017.

The process has ensured that senior management have been properly updated and informed of key data (as outlined above and including the background information, risks, option costs and timings). This has included the briefing of the Chief Fire Officer and Operations Director (responsible for the corporate ICT service) and also the Cabinet Member and Portfolio Holder; and then informing the ICT Governance Board and the Corporate Management Team (CoMT).

The three options put forward by the Head of ICT on 21st September 2017 to CoMT appeared sensible and realistic. It is noted that the 21st September 2017 paper to CoMT excluded the Council's potential options to bring the service back in house, or to split the contract and let the component parts to specialists. Further analysis of the documents provided showed that this had been captured and discussed within the preceding management presentations and had then been discarded based on appropriate officer decision.

The option for ratification by CoMT (i.e. to offer Sopra Steria a contract extension with an improvement plan, based on the information seen (see Appendix A)) is deemed to be the most appropriate for the Council at this time as it maintains a level of stability whilst managing an improvement work programme for selected services in a controlled manner and engaging a separate specialist partner to work with the Council on the digital strategy.

It is the opinion of audit, at the time of doing this review, that there would be a significant risk to the Council of opting to re-procure the service. This would be time consuming and to start at this stage could deflect ICT management and resources from other important work (including but not exclusive to the digital strategy). It would also likely result in a change of provider which would need to be managed. The 'do nothing' option has indexation costs associated with it, which would increase the annual cost of the contract without any improvement in service.

Based on the documentation reviewed and the discussions held, it is considered that the actions taken were reasonable and appropriate, and as a result no recommendations were raised by Internal Audit.

Conclusion

It is considered that the ICT mid contract review strategic options, and also the key risks associated with those options, have been properly and adequately documented and considered by the Council.

Based on available audit trail, this review also concludes that:

- The process completed appeared robust and inclusive;

- The option recommended was well supported by the information contained in the documentation provided; and
- On balance the rationale for rejecting the two options (re-procure or 'do nothing'), as put forward by the Head of ICT, looked appropriate and reasonable.

Management Actions

Not applicable. No recommendations were raised by Internal Audit.

Service Area: Adults

Audit Activity: GIS Healthcare procurement

Background

GIS Healthcare (GIS) is a Gloucestershire County Council service organisation, operating as the in-house provider of medical equipment, aids and adaptations that enable service users in Gloucestershire to live at home, return home from hospital or to facilitate intermediary accommodation.

During 2014/15 the Council's Commercial Services Team undertook a Category Review of GIS to ensure that the Council has in place effective, legally compliant, value for money processes for the procurement of medical equipment and aids, whilst ensuring that prescribing professionals have confidence in the products and services being delivered. The findings emanating from the review resulted in a series of recommendations and it was agreed that an implementation plan would be developed to support the introduction of the agreed actions.

The 2017/18 GIS forecast outturn for procurement of equipment, aids and adaptations totals £4.4m. An additional £0.7m of equipment servicing and maintenance expenditure is forecast for 2017/18.

GIS planned to use a new procurement framework provided by NRS Healthcare, to be operational from 1st April 2018.

Scope

The agreed audit scope was to provide the Council with assurance on whether there are now effective arrangements in place for the procurement of medical equipment and aids.

The audit approach considered the following areas:

- GIS medical equipment/aids expenditure to date within 2017/18 to determine the split between framework and non-framework expenditure;

- Examination of the current medical equipment/aids supplier/product framework and other contracts (if applicable) in place, including scope and term;

- Audit review and sample testing of both framework and non-framework expenditure, to ensure compliance with the Council's Contract Standing Orders/Contract Management Framework and to seek to see evidence that procurement takes advantage of value for money;

- The current GIS position against the Commercial Services Team category review action plan;

- The monitoring process and financial reporting procedure for GIS medical equipment and aids expenditure and procurement routes;

- The current position and agreed actions from the GIS project to join a new framework agreement (NRS) with the goal to cover all medical equipment and ensure Contract Standing Order compliance; and

- Use of exception reports from the purchase and stock system to replenish levels to meet client demand.

Risk Assurance – Substantial

Control Assurance – Substantial

Key Findings

The audit scope control objectives were assessed and tested by Internal Audit. The key areas tested were; i) the monitoring and reporting procedures for procurement; ii) the existing procurement arrangements for equipment; and iii) the project to move to the framework contract with NRS. Internal Audit review results (both walkthrough and sample testing), confirmed that:

- The monthly monitoring and reporting of equipment purchased is a timely procedure completed after month end;

- Equipment purchased was complaint with the Council's Contract Standing Orders; and

- Good use was made of the equipment stock issue and inventory reports, as a tool to assess the procurement quantities required to satisfy future demand.

In addition, audit testing of a sample of equipment purchased (page 5 of the report) confirmed that the supplier purchase prices resulted in the goods being cheaper than the open market had to offer at the point of purchase.

The procurement project to implement a new framework contract (from 2018/19 onwards) was due to be finished in March 2018. The project team (including staff members from GIS, NRS and Commercial Services) had clearly roles, responsibilities and actions.

The previous framework contract for medical equipment and aids was with YPO and expired in January 2017. 2017/18 equipment purchased has been made on the basis of supplier honoured prices from the YPO arrangement. For future equipment purchases, the objective is to take advantage of price savings under the NRS framework contract.

Conclusion

Audit review of the GIS procurement control environment as at February 2018, found appropriate and effective controls to be in place at the point of audit which were consistent with the Council's Contract Standing Orders and notable procurement practice.

No improvement areas were identified by the internal audit, supporting the audit outcome of substantial assurance for both risk identification maturity and control environment.

Management Actions

Not applicable. No audit recommendations were raised by the report.

Service Area: Children and Families

Audit Activity: Liquidlogic (ICT) – Limited Assurance Follow Up

Background

The original Liquidlogic Application Security internal audit was completed in 2015/16 and the final report issued on 28th January 2016. The audit resulted in a limited assurance opinion for control environment and satisfactory assurance opinion for risk identification maturity. Eleven audit recommendations were raised – five High (Fundamental) priority and six Medium (Significant) priority. Management responses confirm the ICT Operations Manager as the action owner for all eleven recommendations.

Scope

The scope of this review was to extract the recommendations and agreed management actions from the 2015/16 Liquidlogic Application Security internal audit report and undertake appropriate audit testing to verify their implementation.

Where the recommendations are found to be not/partially implemented, Internal Audit evaluates the residual risk and make such recommendations as will mitigate that risk.

Risk Assurance – Substantial

Control Assurance – Substantial

Key Findings

The follow up review confirmed significant progress has been made against the original 2015/16 audit recommendations.

The Liquidlogic application comprises two modules: Liquidlogic Children's System and the Early Help Module. Day to day system administration is managed by the Project and Systems Team Leader. Access rights are restricted to valid and uniquely identifiable user accounts. A monthly task has been created to review all accounts that have been inactive for 60 days.

The Council SAP payroll and HR system generates regular reports of all Gloucestershire County Council (GCC) leavers. Once identified, leaver's access rights are promptly disabled. In addition, the Project and Systems Team Leader proactively reviews any unused or unnecessary third party Liquidlogic accounts.

The ADMIN role has been created for any superuser accounts. A review of access to the ADMIN role confirmed that all were assigned to valid and named users.

Examination of the Liquidlogic password policy confirmed that password complexity, minimum length, history and ageing settings were invoked. In addition, the system was securely configured to prevent any brute force access attempts.

The original audit review highlighted potential vulnerabilities surrounding remote user access. These have been addressed through the deployment of the remote access utility. This provides secure and encrypted remote access to the GCC network domain and access to Liquidlogic for all valid and authorised users.

To provide greater resilience, the live application resides on a pair of application and database servers. Live servers are configured to provide failover protection. Separate server environments have been created to support the test and training databases.

All Liquidlogic servers are hosted at the Council off site data centre. Liquidlogic has been designated as one of the top five most critical Council systems. It's subject to daily backup routines, with data held both on and off site. UK Cloud have been contracted to provide Disaster Recovery protection in the event of a major outage.

At the time of our review, the ICT Operations Manager was reviewing other potential recovery options including cloud hosting via the Liquidlogic software vendor.

The findings from this audit identified only one outstanding recommendation (Medium priority) regards the prompt disabling of all inactive and unused accounts. The audit identified a number of historic inactive accounts, where the last login was completed between March and May 2016. Internal Audit has reported the cases to the ICT Operations Manager for prompt resolution.

Conclusion

Extensive work has been undertaken to address the findings from the original 2015/16 audit report. The follow up audit findings support a substantial assurance opinion for both risk identification and control environment on the Liquidlogic Application Security original recommendation areas.

Management Actions

Management have responded positively to the one remaining Medium Priority recommendation and have confirmed immediate action.

Service Area: Pensions

Audit Activity: BSC Pensions

Background

The Business Service Centre (BSC) run payroll for a number of different employers including Gloucestershire County Council (GCC). Employees whose payroll is administered by the BSC are eligible to be members of various pension schemes, the main one being the Local Government Pension Scheme (LGPS).

This audit reviewed the correspondence relating to a sample of new employees and the setting up of these employees in the various pension schemes, the procedures agreed between the BSC and the various pension schemes for provision of information, and the accuracy of the information supplied by the payroll section.

Scope

The objectives of this audit were to:

- For GCC new starters: review the systems, processes and controls in respect of pension related information received from service managers, sent to and from new starters, and the control of information provided to pension providers.
- For other organisations for whom the BSC act as payroll administrator: review the processes and controls in respect of pension related information received from the organisations, sent to and from new starters, and the control of information provided to pension providers.
- Review the processes and controls for specific elements of the process, to include auto-enrolment, opting out and those electing for 50/50 contributions, teachers data collection and TUPE transfers - for GCC and other organisations new starters only.

Risk Assurance – Substantial

Control Assurance – Substantial

Key Findings

In line with the Pensions Act 2008 all eligible employees are now auto-enrolled into pension schemes. As a result, the risk of administrative enrolment error is reduced, e.g. for both the LGPS and Teachers Pension enrolment is an automated process when new starters are set-up on the personnel and payroll system (SAP) by the BSC.

Actions are required by both the employee and the BSC to process an 'opt out' or any other variation from the standard pension enrolment. In each case, an audit trail is maintained of the request from the employee and of the amendment processed on SAP.

For GCC employees who are entitled to be enrolled into the LGPS, whilst GCC retains the responsibility, the BSC has an informal processing agreement with the LGPS Pension Administration Team. It is noted that the informal processing agreement is considered outside of the agreed audit scope and therefore has not been reviewed as part of this internal audit.

The Pension Administration Team obtains the required information needed to enrol an employee into the LGPS from the SAP system direct. This arrangement streamlines the process for both the BSC and LGPS Pension Administration Team, ensures access to all of the required information, and eliminates risk of paper record reliance and transfers.

Where the BSC administer payroll for external organisations in most instances the responsibility to process pension enrolment rests with the employing organisation. Where the BSC undertook this task as part of the contracted arrangements, appropriate controls were found to be present.

No issues were identified through Internal Audit review of controls or testing of this area.

Conclusions

Internal Audit has found that GCC (through the BSC) fulfils its requirements of providing information to the pension providers and has effective controls in place to ensure the information is complete, accurate and on time.

Management Actions

Not applicable. No recommendations were raised within the issued Internal Audit report.

Summary of Consulting Activity and/or support provided where no opinions are provided

Service Area: Adults

Audit Activity: Standards of Proficiency for Social Workers

Background

The Standards of Proficiency for social workers set out what a social worker in England should know, understand and be able to do when they complete their social work training so they can register with the Health and Care Professional Council. The standards set out clear expectations of social workers knowledge and abilities when they start practicing; and social workers must continue to meet the standards.

Scope

Internal Audit has provided professional risk and control advice to the client lead to support the development of a control framework to manage and monitor compliance against the practice standards.

Service Area: Grant Certification

Audit Activity: Troubled Families Grant Claim 2

Background

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

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

Scope

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

Key Findings

As at 26th March 2018 there were 130 PBR claims prepared for submission. The claims reviewed related to the period November 2017 to March 2018.

Internal Audit testing was completed on 10 claims (7.69% of the population) to ensure appropriate coverage of the eligibility criteria and the six localities. Internal Audit testing confirmed:

- The PBR claims in the sample met the criteria outlined by the Troubled Families Grant; and
- There were effective systems and processes for how families and their eligibility markers i.e. education/crime/anti-social behaviour; progress to work; and continuous employment (and off out-of-work benefits) were being collated and verified. This statement duplicates the paragraph below.

Conclusion

The Internal Audit identified that effective systems and processes are in place for how families, their eligibility markers and related outcomes are being collated and verified. Audit testing confirmed the validity of the claims for the sampled cases.

Management Actions

No recommendations were raised.