Internal Audit Activity
Progress Report
2021/22

ARA
Audit Risk Assurance

STROUD DISTRICT COUNCIL

(1) Introduction

All Councils must make proper provision for Internal Audit in line with the 1972 Local Government Act (S151) and the Accounts and Audit Regulations 2015. This states Council's 'must undertake an effective Internal Audit to evaluate the effectiveness of its risk management, control and governance processes, taking into account public sector internal auditing standards or guidance'.

The Council's Internal Audit service is provided by Audit Risk Assurance (ARA) under a Shared Service agreement between Stroud District Council, Gloucester City Council and Gloucestershire County Council. ARA carries out the work required to satisfy this legislative requirement and reports its findings and conclusions to management and to this Committee.

The guidance accompanying the Regulations recognises the Public Sector Internal Audit Standards 2017 (PSIAS) as representing 'proper Internal Audit practices'. The standards define the way in which the Internal Audit service should be established and undertake its operations.

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

(2) Responsibilities

Management are responsible for establishing and maintaining appropriate risk management processes, control systems (financial and non-financial) and governance arrangements.

Internal Audit plays a key role in providing independent assurance and advising the Council that these arrangements are in place and operating effectively.

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

(3) Purpose of this Report

One of the key requirements of the PSIAS is that the Head of ARA should provide progress reports on Internal Audit activity to those charged with governance. This report summarises:

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

ii. The outcomes of the delivered Internal Audit Plan 2021/22 activity; and

iii. Special investigations/counter fraud activity.

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

The schedule provided at **Attachment 1** provides the summary of 2021/22 activities which have not previously been reported to the Audit and Standards Committee.

The schedule provided at **Attachment 2** contains a list of all 2021/22 Internal Audit Plan activity undertaken. This includes, where relevant, the assurance opinions on the effectiveness of risk management arrangements and control processes in place to manage those risks. **Attachment 2** also reflects where activity outcomes have been presented to the Audit and Standards Committee.

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

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

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

One assurance opinion only is provided per activity. Four opinion outcomes are possible: Substantial; Acceptable; Limited; and No Assurance.

The following criteria are used:

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

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

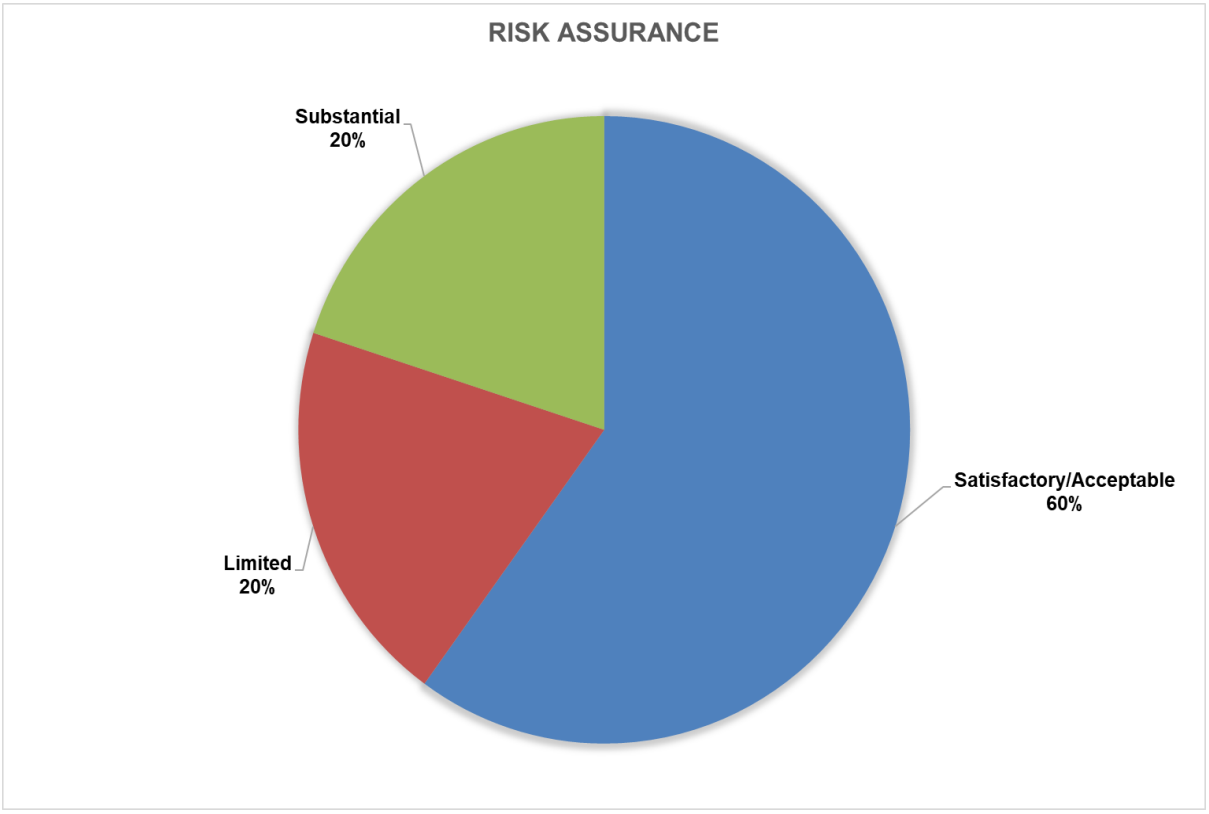
iii. Limited assurance – not all key controls are in place or are working effectively. The Council has a high to medium exposure to business risk; and

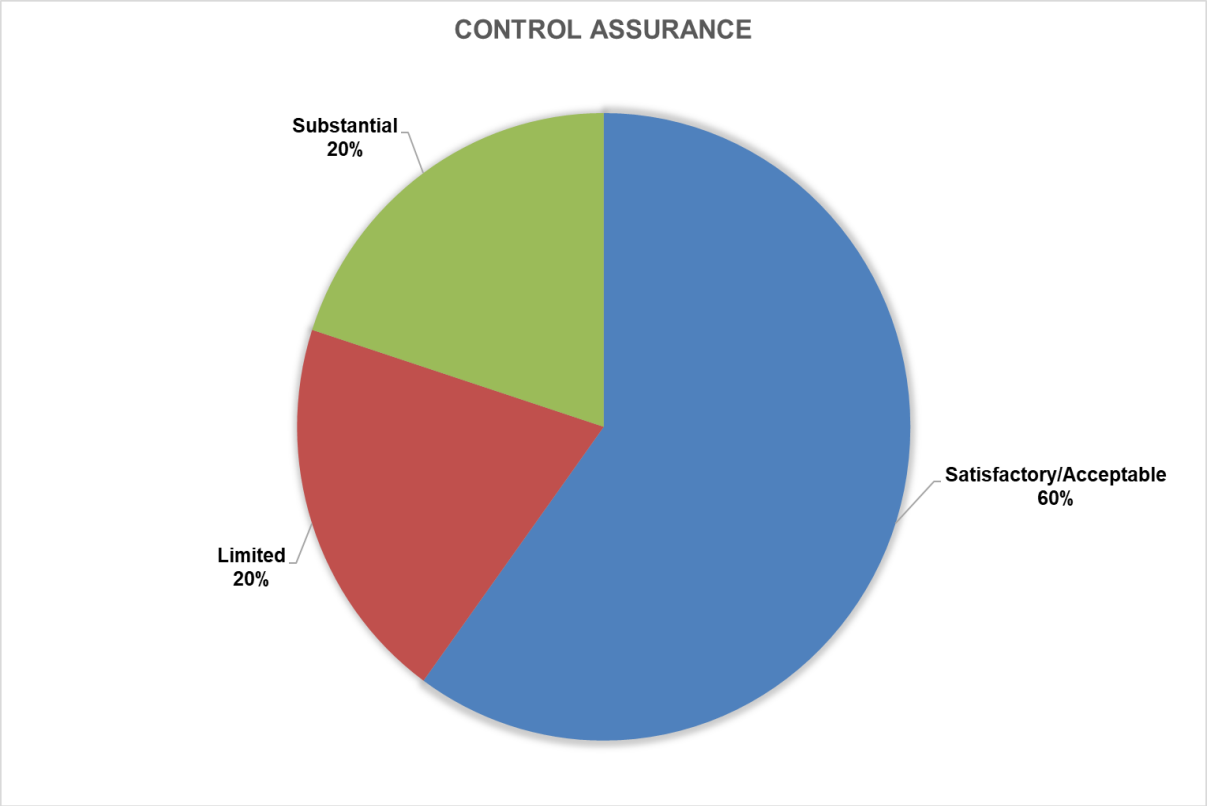
iv. No assurance – no key controls are in place or no key controls are working effectively. The Council has a high exposure to business risk.

Due to the timing of change, the ARA outcomes in **Attachment 2** will reflect both types of assurance approach within 2021/22.

(4a) Summary of Internal Audit Assurance Opinions on Risk and Control

The below pie charts show the summary of the risk and control assurance opinions provided in relation to the completed Internal Audit Plan 2021/22 activity.





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

(4b) Limited Control Assurance Opinions

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

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

No limited assurance opinions on control have been provided on concluded Internal Audit Plan 2021/22 activity during the period mid-March 2022 to June 2022.

(4d) Satisfactory (Acceptable) Control Assurance Opinions

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

(4e) Internal Audit Recommendations

Internal Audit made a total of **17** recommendations to improve the control environment, from the concluded Internal Audit Plan 2021/22 activity during the period mid-March 2022 to June 2022.

One of these was a high priority, **three** were medium priority and **13** were low priority recommendations. 100% of the recommendations have been accepted by management.

The Committee can take assurance that all high priority recommendations will remain under review by Internal Audit, by obtaining regular management updates, until the required action has been fully completed.

(4f) Risk Assurance Opinions

No limited assurance opinions on risk have been provided on concluded Internal Audit Plan 2021/22 activity during the period mid-March 2022 to June 2022.

(4g) Internal Audit Plan 2021/22 – Update

Members approved the Internal Audit Plan 2021/22 at the 27th April 2021 Audit and Standards Committee meeting.

The Internal Audit Plan 2021/22 delivers a range of ARA activity across the Council's Service areas. Activity types include:

i. Internal Audit;

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

iii. Consultancy review or advice;

iv. Grant certification or review; and

v. Resource support for priority areas.

All of these activity types generate an ARA outcome or conclusion, however only the Internal Audit activity stream will result in assurance opinions on risk and control.

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

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

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

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

The above weighting of ARA activity will impact upon the Internal Audit Progress Report **section 4** and **Attachment 2** content.

As detailed on **Attachment 2**, seven new activities have been added to the Internal Audit Plan 2021/22 based on risk position and need. These include:

i. The Strategic Leadership Team (SLT) and Member requested Planning Review (Enforcement), which was confirmed as a priority for ARA delivery;

ii. New mandatory grant certification and review work;

iii. New mandatory review work on the Brimscombe Port Annual Report, required by the Homes England funding agreement; and

iv. Management requested consultancy activity.

One new activity (Innovate to Renovate grant) was subsequently deferred to the Internal Audit Plan 2022/23, based on management request and in line with confirmed grant deadlines.

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

Summary of Substantial Assurance Opinions

Service Area: Resources

Audit Activity: Brimscombe Port

Background

The Council's re-generation project at Brimscombe Port is funded by a combination of its own financial resources plus funding from Homes England and The One Public Estate Scheme.

Scope

The objective of this audit was documented in the Homes England funding agreement: To provide an annual audited report for the project 2020/21 income receipts and expenditure statement. The project net expenditure for 2020/21 totalled £526k.

Assurance Opinion – Substantial

Key Findings

i. The methodology used for the income, expenditure and funding statements, was compliant with that published in the Homes England funding agreement.

ii. Disclosure checks were completed comparing the funding statement as at 31st March 2021 with the Council's 2020/21 accounts. Review confirmed that £2.776m of external funding, was consistently disclosed in both statements.

iii. The Council's financial systems correctly identify Brimscombe Port 2020/21 financial transactions. They are coded to ring fenced cost centres and subjective income and expenditure categories, which makes audit review effective.

iv. Re-performance checks reconciling the financial systems transactions to the 2020/21 income receipts and expenditure statement, showed they were accurately accounted for.

v. The Council receive income for tenant rent and service charges for occupation of business space at Brimscombe Port. An audit test was completed with the objective of checking that the income was correctly classified as belonging to the Brimscombe Port development. A sample of income totalling £17k had the correct transaction attributes.

vi. The Council incur a range of expenditure categories for the operational running costs and project refurbishment. A sample of expenditure totalling £105k, confirmed that they had been correctly accounted for.

vii. Review of the Council's Strategy and Resources Committee meeting discussions on 10th June 2021 was completed, with the objective of corroborating the financial figures in the Brimscombe Port 2020/21 statements.

viii. Evidence reviewed from the Strategy and Resources Committee meeting above, verified that the governance of external funding totalling £2.776m as at 31st March 2021 was consistent with the 2020/21 statements.

ix. The development project's combined Council and external funding available as at 31st March 2021 totals £4.7m.

Conclusion

Substantial assurance has been obtained that the Brimscombe Port 2020/21 Income and Expenditure Statement and Funding Position was accurately and appropriately compiled.

No recommendations were identified by ARA review.

Management Actions

The Head of Property Services will ensure that a copy of the audited statement of accounts and report is provided to Homes England to ensure conformance with the Funding Agreement.

Summary of Satisfactory (Acceptable) Assurance Opinions

Service Area: Communities

Audit Activity: Anti-Social Behaviour Management

Background

As part of the 2021/22 Internal Audit Plan, Internal Audit have undertaken a review of the Council's arrangements for anti-social behaviour (ASB) management, across its housing stock.

Section 218A of the Housing Act 1996 requires councils (with their own housing stock) to have a policy to deal with ASB occurrences.

The Neighbourhood and Community Standard, one of the Regulator of Social Housing's Consumer Standards, also shapes how councils should manage ASB (in neighbourhoods where they own homes).

Scope

To determine whether there are adequate and effective arrangements in place to ensure compliance with the Neighbourhood and Community Standard. The full period under review is 1st January 2021 to 31st December 2021.

Specific objectives include the following:

i. To assess the adequacy of the policies, procedures, and strategies in place to manage ASB (the focus here being those covering tenant issues and on the Council's obligations as a registered provider of social housing);

ii. To assess the effectiveness of the case management procedures in place to receive, record, and resolve ASB complaints in a timely manner (with due consideration to the range of legal powers at the Council's disposal); and

iii. To determine whether ASB complaints are handled in line with policies and procedures (to include consideration of case outcomes and performance reporting).

The arrangements for managing ASB incidents raised by non-tenants (wider residents within the Stroud District) are out of the scope, with the exception of any tenant-related ASB issues which would fall under the above Standard.

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

Key Findings

i. Audit review and testing completed has shown satisfactory consideration of welfare and safeguarding issues during the management of ASB complaints. The ASB and Enforcement Officer (ASBEO), will continue to further embed these processes within standard case management.

ii. A short peer review was completed, where the Council's approach to ASB management was contrasted with that of eight peers (who manage a similar size of housing stock). There were no deficiencies in the Council's approach highlighted during this exercise, and the ASB Tenant Services (TS) Policy was among the most comprehensive. The roll-out of the corporate ASB Policy and the continued success of the 'ASB App' place the Council in a good position relative to its peer group.

iii. The approach to file and case management requires further work to capture and reflect all key requirements of the ASB TS Policy. There is currently no organisation of ASB complaints using a 'Case File' approach, and the ASB Trackers in use require minor changes to improve their effectiveness and functionality.

iv. There are useful Key Performance Indicators which are not currently being monitored and reported-on. The ASB TS Policy sets out the requirements for performance monitoring, where further work is required from the service to ensure compliance.

v. There has not been any formal consideration of tenancy 'demotions' (from a Secure Tenancy to an Introductory Tenancy) as a tool in ASB management.

vi. Performance, ASB reduction and prevention initiatives, and positive outcomes have not been publicised to the expected extent.

Conclusion

Acceptable Assurance has been obtained that there is an adequate and effective control environment to ensure compliance with the Neighbourhood and Community Standard.

One Medium priority, and seven Low priority recommendations have been made to further strengthen the current arrangements. These relate to Key Findings points iii to vi.

Management Actions

Management have accepted all of the recommendations made.

Service Area: Resources

Audit Activity: Creditors follow-up

Background

An audit of Creditors was undertaken by Internal Audit during 2019/20. As part of the 2021/22 Internal Audit Plan, ARA have undertaken a follow-up audit to review the progress made with implementing the recommendations in the report, which were agreed by management.

The objective of the accounts payable function is to pay valid supplier invoices in respect of goods or services received within agreed payment terms. In 2021/22 the Creditors team were responsible for processing circa £54.5m payments (inclusive of VAT). It is therefore important to have robust and effective controls.

Scope

The purpose of this follow-up review is to provide an independent appraisal that the agreed actions to address the two high and 12 medium priority recommendations have been fully implemented.

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

Key Findings

This follow-up review was carried out during February and March 2022.

A total of 14 recommendations were made in the June 2020 final report, which were accepted by management. At the point of audit follow up, six recommendations have been fully implemented.

Eight have been partially implemented, categorised into the following five distinct areas that require further improvement:

i. Risk identification, monitoring and risk appetite or acceptance;

ii. Accounts payable procedures or guidance to be documented for the set-up of new suppliers in the Finance system (Business World) and amendments to supplier bank account, address and contact details;

iii. Control arrangements for the set-up of new suppliers and amendments to supplier bank account, address and contact details in Business World until implementation of the above planned system update;

iv. Monitoring of payment performance against target by management and introduction of corrective measures to achieve or exceed the target; and

v. Prompt investigation, recovery and clearance of outstanding credit notes highlighted as part of the creditor control reconciliation process.

Positive progress has been made in implementing the recommendations raised by Internal Audit in particular:

i. A clear distinction between Creditors and Finance roles and responsibilities in the accounts payable process has been established;

ii. Access privileges in Business World have been strengthened by restricting, reducing or removing officer access to high profile or sensitive levels, assignment of two access profiles and generic accounts;

iii. A mandatory requirement for the use of purchase orders by service areas in compliance with the Council's Financial Regulations and to support accurate budgetary management was introduced from 1st April 2022; and

iv. Stroud District Council's (the Council's) payment performance has been published on a monthly basis in accordance with the Public Contracts Regulations 2015 (regulation 113) requirements.

Four further recommendations have been raised as follows:

i. An update to Business World to strengthen the control environment for the management of supplier records is planned for September 2022. Internal Audit has raised a high priority recommendation for this update to maintain focus on its implementation as soon as possible;

ii. Explore with the software supplier amendments to the system to highlight to the payment authoriser of any new suppliers and recent amendments to existing supplier details - medium priority recommendation;

iii. Suspend permanent Finance user systems access set-up and amend supplier details - low priority recommendation; and

iv. Review all duplicate payment and invoice exception reporting criteria to rationalise their production and make the duplicate payment process more efficient and effective - low priority recommendation.

An update to Business World is scheduled for September 2022. This update will result in system enforcement of input, verification, and approval by different officers to set-up new suppliers and amend supplier bank account, address, and contact details. This should improve the control environment by securing supplier master data from unauthorised activity.

The above systems update does not apply to the back-office facility of Business World, which the Creditors team and a limited number of Finance officers have access to. This will dilute the above future control measure.

Internal Audit has raised an appropriate recommendation to remove this systems access or, to document risk acceptance in the Council's Risk and Performance Management system (Excelsis).

Conclusion

At the point of ARA follow up, positive progress has been made by management in implementing the recommendations from the 2019/20 audit review. In addition, management has confirmed, following the completion of this follow-up review, that the partially completed recommendations ii, iii, and iv (within the Key Findings first set of bullet points above) have now also been implemented.

Further work is therefore still required to fully implement the high priority recommendation relating to risk management and medium priority recommendation for the clearance of old supplier credit notes.

Management Actions

Management has responded positively to fully implementing all the recommendations from the original Creditors audit and to the new recommendations that have been raised.

Service Area: Resources

Audit Activity: ICT Change Management

Background

As part of the agreed 2021/22 Internal Audit Plan, Internal Audit have reviewed the recently introduced ICT Change Management procedures.

This is the first review of the ICT Change Management procedures at Stroud District Council. The Council have overhauled their change management approach, taking steps to improve the consistency and operation of the change management function.

Scope

To provide independent assurance on the operation of controls in place and make recommendations on any gaps discovered in the current arrangements.

Specific objectives of this review include:

i. Assess the arrangements in place against ITIL (formerly known as the Information Technology Infrastructure Library but now known as ITIL) best practice;

ii. Review the arrangements in place to assess and authorise changes to confirm that changes to production environments are proceduralised, and check listed;

iii. Review the arrangements in place to test changes, to confirm that rollback procedures are considered and to ensure that changes that impact services are agreed and scheduled at times to minimise impact; and

iv. Review the arrangements in place to fully document all changes and to ensure that communication with affected areas is effective.

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

Key Findings

i. All changes are recorded within the FreshService service desk solution using dedicated Change Request forms. Changes are identified from Service Desk tickets or directly from the IT team where a resolution requires a change. A flow process is in place for identifying which stages and authorisations are required for changes to be requested, signed off and performed. FreshService provides the requesting party with updates on the change automatically when the change record is approved, rejected, or completed.

ii. Documentation for change management and its controls is in development as the function matures. While an overarching process model exists, there are still documentation gaps in what is required for changes to take place, change criteria and rollback requirements.

iii. The Council has established a Change Advisory Board (CAB) which has clear responsibilities and reviews all changes before they are made. This follows ITIL good practice. The chair of the CAB ensures all changes are scheduled with stakeholders and communicated in a manner that minimises impact on Council services. The CAB notifies a change requester directly in the event of a rejected change with details on why this change was rejected. It was advised by a member of the CAB that changes can be rejected if not enough information is provided, or testing or rollback plans are not detailed or understood clearly. This is good practice as it ensures all changes approved are detailed and well-considered.

iv. The CAB is chaired by the ICT Service Delivery Manager to ensure that every change delivered into the production environment is signed off as being fit for purpose. To this end, each change is fully impact-assessed, tested and able to be rolled-back in the event of issues. Change requests are rejected where insufficient information has been provided to complete the assessment or where roll back plans do not provide sufficient assurance that changes can be reversed if necessary.

v. In the event of an emergency change, the ICT Service Delivery Manager advised that an Emergency CAB meeting is held, via Teams since the Covid-19 pandemic. This would enable the CAB to meet and approve emergency changes rather than grant retroactive approval after application of the change.

vi. Testing of changes is built into the current process, including it as a requirement for final sign-off approval and closure of the change by the CAB. Rollback planning is built into the FreshService change request form, with effective rollback arrangements required prior to review and approval by the CAB. Further to this, an impact assessment must also be completed to ascertain if the change will cause the Council delays or unavailability of its systems for an unacceptable period.

vii. The change management framework is detailed within the Service Management Operating Model (v0.3). This defines what "changes" are, the responsibilities of the requester and of the CAB and how Requests for Change are to be submitted. The change management process and the role of the CAB are compliant with ITIL best practice.

viii. The process and policy for emergency changes is currently ad-hoc and is not documented or formalised.

ix. Grading criteria for changes are not currently documented in the Service Management Operating Model.

x. Change entries in FreshService do not currently have input validation or rejection of blank text fields configured.

xi. Current policy and process controls are in development. Currently, they lack detail on specific change grading criteria, which assets and systems change requests are required for and the specific rollback requirements.

xii. The Council's change management technical approach is robust and mature. Changes are reviewed, considered by multiple senior level IT staff and subject to meeting specific requirements such as rollback plans, risks, and timescales, before being approved and actioned. These arrangements comply with ITIL best practices.

Conclusion

Acceptable Assurance has been obtained that there is an adequate control environment in place for ICT Change Management procedures.

One Medium, and three Low priority recommendations have been made to further strengthen the current arrangements. These relate to Key Findings points viii to xi.

Management Actions

Management have accepted all of the recommendations made, and are seeking to implement the actions by 31st August 2022.

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

Service Area: Place

Audit Activity: Grant Certification – Green Homes Grant Local Authority Delivery Scheme (GHG LADS) Phase 1b

Background

The Gloucestershire and South Gloucestershire Warm and Well Scheme has been instrumental in the delivery of the Fuel Poverty Strategy, targeting the vulnerable, integrating with the National Health Service (NHS), and improving Energy Performance Certificate (EPC) ratings. All works are delivered by Severn Wye Energy Agency (SWEA), the key delivery partner under the Warm and Well Scheme. Stroud District Council (SDC) is the lead partner in the Warm and Well Scheme.

SDC was successful in securing an initial £982,979 as part of GHG LADS Phase 1b. This funding was to provide 100 external wall insulation (EWI) retrofits to park home sites across Gloucestershire and South Gloucestershire. An additional £51,324 was secured in October 2021 to ensure that this target could be met, due to increases in the cost per install (Total Grant Amount = £1,034,303).

As of 31st March 2022, the end date for GHG LADS 1b, 102 EWIs have been installed. The total spend to deliver these was £1,029,539.36. The underspend of £4,763.64 will be returned to the Department for Business, Energy, and Industrial Strategy (BEIS).

Scope

Internal Audit sought to determine whether GHG LADS Phase 1b had been administered in line with the grant conditions. Internal Audit undertook a series of checks in order to support the grant declaration requirements set out within the Grant Determination Letter.

The objective of this review was to be able to provide the following declaration in support of the Council's grant expenditure(s) – "To the best of our knowledge and belief, and having carried out appropriate investigations and checks, in our opinion, in all significant respects, the conditions attached to GREEN HOMES GRANT: LOCAL AUTHORITY DELIVERY GRANT DETERMINATION (2021): No 31/5336 have been complied with."

Key Findings

i. A sample of 17 recipients of grant-funded works were reviewed in depth. For 14, SWEA were able to complete 'Verification Checks' (visits) at our request. The SWEA operative reviewed the documentation in support of the client's circumstances (as set out on their Application Form) and completed a Verification Report for our review. The public health implications of the 'Omicron' variant of Covid-19 prevented SWEA from completing Verification Checks within the available window.

ii. The results from the 14 successful visits provided reasonable assurance that the representations on Application Forms were a good measure of the circumstances of SWEA's clients. The absence of three checks has had no impact on Internal Audit's ability to progress to Grant Certification.

iii. For the sample reviewed, there were no instances of an ineligible individual receiving grant-funded works. All installations reviewed met the criteria set out in the GHG LADS 1b Memorandum of Understanding, including the requirement to be installed to the PAS2030:2019 standard.

iv. The delivery of the GHG LADS 1b was completed in accordance with the expectations of BEIS. SWEA worked closely with BEIS to address issues with project delivery as they emerged.

Conclusion

Internal Audit is not providing a formal assurance opinion as part of this activity. The work undertaken by Internal Audit was to enable the necessary sign-off for grant certification purposes.

Internal Audit is satisfied that the conditions attached to the grant have been complied with, as per the Grant Determination Letter and the Memorandum of Understanding. The Project Closure Letter has been completed and returned to the BEIS.

Management Actions

Management have confirmed that the project underspend had been returned to BEIS by the 31st May 2022 deadline.

Summary of Special Investigations/Counter Fraud Activities

2021/22 Final Position

The Counter Fraud Team (CFT) within Internal Audit received four new potential irregularity referrals in 2021/22. All four cases were linked to Covid-19 grant business grant applications.

A review by the CFT found there to be no issues with two of the applications and the grants were subsequently paid and the referrals closed. The CFT continues to work on the remaining two cases. The outcomes of these cases will be reported to the Audit and Standards Committee on their completion.

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

Since the start of the Covid-19 pandemic ARA has provided the Council with regular updates on local and national scams which seek to take advantage of the unprecedented circumstances. These include the following fraud risk areas: a rise in bank mandate frauds; inflated claims; duplicate payments; and the submission of fraudulent Covid-19 grant applications. This area of activity continues, with updates provided to the Council where relevant.

As in previous years, in 2021/22 Stroud District Council signed up to be a supporter of International Fraud Awareness Week. The aim of the week-long event is to encourage everyone to proactively take steps to minimise the impact of fraud by promoting anti-fraud awareness and education. By being a supporter of the event Stroud District Council is demonstrating its commitment to preventing and detecting fraud.

National Fraud Initiative (NFI)

The Council participates in the NFI which is a biennial data matching exercise administered by the Cabinet Office. The last data uploads occurred in October 2020 and the matches in respect of the main 2021/22 exercise were released in mid-January 2021.

Examples of data sets include housing, insurance, payroll, creditors, council tax, electoral register and licences for market trader/operator, taxi drivers and personal licences to supply alcohol. Not all matches are always investigated but where possible, all recommended matches are reviewed by either Internal Audit, the appropriate service area within the Council or by procuring the services of the Counter Fraud Unit (CFU).

The CFT provided assistance to the Council by reviewing around 400 of the NFI matches across a number of different reports. A small number of potential anomalies were identified and these were reported to the relevant teams for further investigation.

In addition, ARA has been advised that the services of the CFU have been employed to undertake some of the match reviews on behalf of the Council. The CFU findings will be separately reported to the Audit and Standards Committee.

2022/23 Current Status

For Committee awareness, to date in 2022/23 there have been no new irregularities referred to the ARA CFT. The CFT continues to work on two cases brought forward from previous years.

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

National Fraud Initiative (NFI)

The Council participates in the NFI biennial data matching exercise administered by the Cabinet Office. The current data match reports were released in mid-January 2021. The next data upload will be October 2022.