Internal Audit & Counter Fraud Shared Service
Medway Council & Gravesham Borough Council

Internal Audit & Counter Fraud Annual Report 2021-22

Medway Council

1. Introduction

The Internal Audit & Counter Fraud Shared Service was established on 1 March 2016 to provide internal audit assurance and consultancy, proactive counter fraud and reactive investigation services to Medway Council & Gravesham Borough Council.

The Institute of Internal Auditors (IIA) defines internal auditing as: an independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control, and governance processes. The Internal Audit & Counter Fraud Shared Service combines this role with working alongside the councils to manage their fraud risk, including work to prevent, detect and investigate fraudulent activity committed against the councils. The team also acts as the Single Point of Contact between both authorities and the Department for Work & Pensions Fraud & Error Service for their investigation of housing benefit fraud.

In accordance with the Public Sector Internal Audit Standards (the Standards), the Head of Internal Audit & Counter Fraud provides Members with Update reports detailing the work and findings of the team. The Standards also require that the Chief Audit Executive must deliver an annual internal audit opinion and report that can be used by the organisation to inform its governance statement. The annual internal audit opinion must conclude on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

2. Independence

The Audit & Counter Fraud Charter was approved by Medway's Audit Committee in March 2021 and sets out the purpose, authority, and responsibility of the team. The Charter sets out the arrangements to ensure the team's independence and objectivity through direct reporting lines to senior management and Members, and through safeguards to ensure officers remain free from operational responsibility and do not engage in any other activity that may impair their judgement.

The work of the team during the period covered by this report has been completed with full independence as set out in the Charter and Standard 1100. The work completed has also been free from any inappropriate restriction or influence from senior officers and/or Members.

Given its responsibilities for counter fraud activities, the Internal Audit & Counter Fraud Shared Service cannot provide independent assurance over the counter-fraud activities of either council. Instead, independent assurance over the effectiveness of these arrangements will be sought from an external supplier of audit services on a periodic basis. The most recent of these reviews was undertaken by Tonbridge & Malling Borough Council in 2018-19.

3. Resources

The Internal Audit & Counter Fraud Shared Service reports to the Section 151 Officers of Medway Council and Gravesham Borough Council. At the start of the year, the team had an establishment of 14 officers (13.64FTE), made up of the Head of Internal Audit & Counter Fraud, two Internal Audit Team Leaders, six Internal Auditors (5.78FTE), one Counter Fraud Team Leader, two Counter Fraud Officers (1.86FTE), one Audit & Counter Fraud Intelligence Analyst and one Audit & Counter Fraud Assistant.

The Shared Service Agreement sets out the basis for splitting the available resources between the two councils, approximately 64% for Medway with the remaining 36% for Gravesham. At the time the Internal Audit & Counter Fraud Plans for 2021-22 were prepared, this establishment was forecasted to provide a total of 1,815 days available for internal audit and counter fraud work (net of allowances for leave, training, management, administration etc.). The Internal Audit & Counter Fraud Plan for Medway was prepared with a resource budget of 1,162 days.

Following the retirement of the Audit & Counter Fraud Assistant and resignation of one Internal Audit Team Leader, the service was restructured to reflect the move back to designated roles and redistribute some of the responsibilities. The establishment of 14 officers remains, made up of the Head of Internal Audit & Counter Fraud, one Internal Audit Manager, one Senior Internal auditor, six Internal Auditors (5.78FTE), one Counter Fraud Manager, two Counter Fraud Officers, and two Counter Fraud Intelligence Analysts (1.86FTE). Some existing Officers were successful in changing roles within the service and as a consequence there were several periods of vacancy while staff were recruited.

As of 31 March 2022, the net staff days available for Medway for 2021-22 amounted to 1,182 days and 1,005 days (85%) were spent on chargeable internal audit and counter fraud work. Of this chargeable time, 622 days (62%) was spent on audit assurance and consultancy work, while 383 days (38%) was spent on pro-active counter fraud and investigations work. The current status and results of all work carried out are detailed at section five of this report.

Learning and development needs and objectives were agreed through the Performance Development Review (appraisal) process, and delivered through a mixture of formal qualification training, formal skills training, job-shadowing/mentoring and 'on the job' training. Team meetings have taken place throughout the year, both virtually and in person, and all team members have had regular one to one meetings with their line manager to monitor progress with work-plans.

4. Opinion of the Chief Audit Executive

The Accounts & Audit Regulations 2015 require local authorities to ensure that they have: *a sound system of internal control which— (a) facilitates the effective exercise of its functions and the achievement of its aims and objectives; (b) ensures that the financial and operational management of the authority is effective; and (c) includes effective arrangements for the management of risk.*

In my capacity as Chief Audit Executive, with responsibility for the provision of internal audit services to the council, I am required to provide the organisation, and the Chief Executive, with a statement as to my opinion of the adequacy and effectiveness of the organisation's risk management, internal control, and governance processes. This opinion is intended to support the council's annual governance statement.

The overall scope of Internal Audit work is defined in the Audit & Counter Fraud Charter and the specific scope of work for the year 2021-22 was detailed in the Internal Audit & Counter Fraud Plan, both of which were approved by the Audit Committee. The Plan cannot address all risks across the council, but available resources are focused on the highest areas of risk to the authority and those linked to its corporate objectives. There are no specific limits of our scope to report to the Committee.

The Internal Audit Team operates in accordance with the working practices set out in the Internal Audit Manual and work is subject to supervision and quality review. This means we can be satisfied that the team has carried out all internal audit work in line with the Public Sector Internal Audit Standards and in accordance with our Quality Assurance & Improvement Programme.

In forming my opinion, I have considered the outcomes of work completed during the year, which is based on the plan agreed by Members on 18 March 2021 and the subsequent amendments to that plan that were agreed on 4 January 2022 to address changes in resource and risk priorities. While placing no specific reliance on sources of external assurance, these have been considered alongside the work completed by the Internal Audit Team.

The council has a duty to manage its resources in a proper, economic, efficient, and effective manner to achieve its objectives. It applies internal controls to manage risks to an acceptable level as it is not possible to remove risks to achieving these objectives completely. Internal Audit can only provide reasonable and not complete assurance of effectiveness. The work completed as part of the Internal Audit & Counter Fraud Plan for 2021-22 is summarised in this report, assessing the effectiveness of managing the risks identified by the council, and forms the basis of evidence for my overall opinion.

In addition to planned assurance reviews, the monitoring of progress to implement agreed actions identified in earlier reviews have also been considered. While not all risks have been examined within our work programme, I am satisfied that those not directly examined have a sufficient assurance approach in place to provide reasonable assurance of effective management.

While it has been identified that the authority has mainly established adequate internal controls within the areas subject to review since my last opinion was issued in June 2021, there are areas where compliance with existing controls should be enhanced or strengthened or where additional controls should be introduced to reduce the council's exposure to risk. Where such findings have been identified, actions have been agreed by management to improve the controls within the systems and processes they operate. Management have accepted responsibility for the implementation of these actions and follow up arrangements are in place to ensure that appropriate action is taken

I am therefore satisfied that there is sufficient evidence to draw a reasonable conclusion as to the adequacy and effectiveness of the organisation's risk management, system of internal control and governance processes.

Annual Opinion 2021-22

It is my opinion that during the year ended 31 March 2022, Medway Council's risk management, system of internal control, and framework of governance, were sufficient and effective, and contributed to the proper, economic, efficient, and effective use of resources in achieving the council's objectives.

James Larkin

Head of Internal Audit & Counter Fraud Shared Service

5. Results of planned Audit & Counter Fraud work

The Internal Audit & Counter Fraud Plan 2021-22 for Medway was approved by the Audit Committee in March 2021. The Plan was intended to provide a clear picture of how the council would use Internal Audit & Counter Fraud resources, reflecting all work planned for the team for Medway during the financial year, including the assurance over the council's core finance and governance arrangements, operational assurance work, proactive counter fraud work, responsive investigations, and consultancy services.

Arrangements to monitor the delivery of planned work are built into the team's processes with individual officer time recording data feeding into an automated performance monitoring workbook; this tracks the performance of the team against the shared service work-plan as a whole and enables the supervisory staff to plan and support officers to deliver their individual work plans.

During the course of the year the plan was amended to take into account changes in resource levels created by sickness and staff vacancies. Members agreed revisions to the original plan for 2021-22 to remove planned reviews of:

- Ethics
- Bad Debt Provision
- Income Collection
- Will Adams Centre
- Corporate Debt Recovery

The tables below provide details of the work from 2020-21 that was finalised in 2021-22, the progress of work undertaken as part of the 2021-22 annual plan and the results of investigative work completed.

2020-21 Internal Audit Assurance work finalised in 2021-22 (items in italics have been detailed in previous update reports)

Ref	Activity	Number of Days allocated	Number of Days Used	Current status	Opinion, summary of findings & actions agreed
19	*Section 17 - no recourse to public funds*	*15*	*17.8*	*Final report issued*	*The review considered the following Risk Management Objective:* ***RMO1 - Effective processes are in place to manage the Section 17 Payments in relation to children from No Recourse to Public Funds families.*** *The review found that a new overarching policy, 'Financial Assistance Section 17 (s17) Children Act 1989', was agreed in August 2020; however, the officers who deal with s17 No Recourse to Public Funds (NRPF) cases were not aware of the new policy at the time of audit. The majority of NRPF family's approach via Housing Options and it was found that there are clearly defined roles and responsibilities around s17 NRPF cases, with Housing Options gathering the necessary evidence and once it has been determined that no housing duty is owed, the Early Help Key Worker (EHKW) responsible for NRFP cases assessing the best way to support the family and regularise their immigration status. Prior to the Covid-19 pandemic, joint interviews took place with both the EHKW and one of the Housing Options Officers attending to carry out the necessary assessments. Due to the Covid-19 restrictions however, the EHKW now calls the applicant and interviews them over the phone instead. A slight delay in receiving documents from the initial assessment on some occasions was identified and the Head of Strategic Housing advised that it may be possible for the EHKW to be given access to Locata, the Housing Options system, which would allow them to access the documents collected at the initial interview by the Housing Options Officer and not delay any action needed. Although the majority of NRPF family's approach via Housing Options, there are also families who present at Front Door; we were advised that this sometimes resulted in cases being assigned to a different EHKW. However, the service underwent a restructure during the audit. This resulted in the EHKW responsible for NRPF cases being placed in Front Door, which will enable all NRPF cases to be captured and passed to that officer for actioning.* *Audit testing on a random sample of five NRPF cases in 2020 showed that families had a financial assessment where appropriate.* *A procedure is in place for authorising s17 NRPF payments, however this authorisation is not recorded on the Mosaic system, where the rest of the paperwork is held. It would provide greater transparency and a clear audit trail if these authorisations were uploaded onto Mosaic by the officer authorising the payment. A Finance Panel is in place and is held every two weeks, to ensure lessons learnt and best practices are shared and that the support ends as soon as*

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					reasonably practicable. The Finance Panel minutes provided showed that where a case is subject to s17 payments because the family has NRPF, the case is discussed on a regular basis to ensure all efforts are being made to regularise the immigration status of the family and ensure payments are kept to a minimum. It was noted that the 'Financial Assistance Section 17 (s17) Children Act 1989' Policy does not currently reflect the fact the Finance Panel is used to monitor NRPF cases. It was found that three different cost codes were used for the recording of s17 NRPF payments in 2020-21, two of which did not have a budget attached and one of which was overspent. ***Opinion: Amber.*** ***Overall Opinion: Amber. Agreed Actions: One high and three medium priority. Actions relate to the new policy, 'Financial Assistance Section 17 (s17) Children Act 1989', being disseminated to all relevant staff as soon as possible to ensure they are aware of it; the agreement to make s17 NRPF payments being entered onto Mosaic by a senior officer to ensure that an audit trail is maintained; the Financial Assistance Section 17 (s17) Children Act 1989 Policy being updated to include that the Finance Panel is used to monitor the S17 spend and to promote best practices; and, the service working with Finance to review GL coding / budget monitoring arrangements in respect of s17 NRPF payments.***
21	*Children's independent safeguarding & review service*	*15*	*16.8*	*Final report issued*	*The review considered the following Risk Management Objectives:* ***RMO1 - A robust quality assurance function is in place.*** *The review found that following the Ofsted Inspection of Local Authority Children's Services (ILACS) in July 2019, the Quality Assurance (QA) Framework was reviewed and revised, and the audit tool was redesigned with a stronger focus on learning and reflection. The QA Framework is updated in line with the Children's Services Improvement Plan, the most recent of which was finalised in June 2021.* *Regular auditing is an agreed activity outlined in the QA Framework and internal audit were informed that there is an expectation that Team Managers and above undertake audit activity on some level. Moderators are selected from Group Managers and above, including the Safeguarding and Quality Assurance Service's wider staff, QA auditor and also external moderators.* *Records of audits undertaken are maintained and the QA team produce quarterly sheets that contain comprehensive details of audits, which can be analysed under a number of headings including assessment, overall grade, and moderation; that includes areas of good practice that can be shared across the service and actions*

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					that should be taken within given timescales with audits signed-off by Group Managers and Head of Service. *Audit logs are reviewed and any patterns of inconsistencies between auditor and moderator scores used to run individual coaching sessions with anyone that is struggling.* *A Reflection and Learning Tool, and associated guidance, was introduced in November 2019, setting out the areas to be covered in audits and the key factors to consider when auditing in respect of the child's journey. Training in the use of the tool has been provided and a log is retained of who has attended training.* *The service advised that the storage of data has been discussed with the council's Information Governance Team and the service holds the same expectations as the wider Children's Services. It was noted that external moderators can sometimes be used during QA audits, and it is understood that this process should be covered by a Data Protection Impact Assessment (DPIA), although the service believes this is covered by the wider Privacy Notice for all of Children's Services which negates the need for a DPIA. On seeking advice from the Information Governance (IG) Manager and Data Protection Officer it was confirmed that DPIAs and Record of Processing Activity (RoPA) documents etc. are required before privacy notices can be developed.* ***Opinion: Amber.*** ***RMO2 - Effective arrangements have been put in place to undertake the actions arising from the Medway Children's Services Improvement Plan in relation to quality assurance.*** *The review found an Improvement Board was set up in October 2019, comprising the Leader of the Council and the Lead Member for Children's Services, local authority officers including the Chief Executive, and key partner agency representatives. The board was independently chaired and was attended by Eleanor Brazil, the Children's Commissioner. The purpose of the board was to oversee progress on the Improvement Plan and provide challenge and support.* *The Secretary of State withdrew Commissioner Eleanor Brazil from Medway Council with effect from 1 January 2021, based on improvement evidenced in a series of progress reports from the commissioner, Ofsted, and Chair of the Improvement Board. To support Medway with its ongoing improvement journey, the Secretary of State has appointed Gladys Rhodes White as Medway Council's improvement adviser.*

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					The Improvement Plan was refreshed in June 2020 and signed off by the Improvement Board in July 2020 and Cabinet in August 2020. At the time of finalising this review, we were advised that the plan had been revised in April 2021 and signed off in May 2021 and will continue to be monitored on a quarterly basis. The QAPIB chaired by the Director, was set up to meet six-weekly, to oversee and challenge all aspects of the Improvement Plan. *A progress update report on the Children's Improvement Plan was presented to QAPIB in February 2021, which stated that a comprehensive audit programme is in place with all managers now taking part. The Ofsted inspectors for the August 2020 monitoring visit agreed with the moderated audit grades for all six cases they tracked. The report highlighted areas for development/improvement and a RAG rated progress report. We understand that since completing this review and during the Ofsted Covid assurance visit in May 2021 another six cases were reviewed with the audit grades found to be appropriate.* *Work with Essex County Council as a Partner in Practice to improve the QA framework and strengthen the audit process was undertaken and is now complete.* ***Opinion: Green.*** ***Overall Opinion: Amber. Agreed Actions: One medium priority.*** ***Action relates to ensuring that data processing documents are in place relating to GDPR. Note: Action implemented before report finalised.***
22	*Child exploitation (previously Child sexual exploitation)*	*15*	*11.0*	*Final report issued*	*The review considered the following Risk Management Objectives:* ***RMO1: Appropriate arrangements are in place to support the tackling of Child Exploitation in Medway**.* *The review found that the Medway Safeguarding Children Partnership (MSCP) was set up on 2 September 2019. Medway Council is a statutory member of the partnership, alongside Kent Police and the Kent and Medway Clinical Commissioning Group. The MSCP comprises of an Executive and a number of subgroups. The Executive meets every two months and is led by the three safeguarding partners. One of the subgroups of the MSCP is the Joint Exploitation Group, which is attended by council representatives, as is the Missing and Exploitation Panel which feeds into this group. The work of the MSCP is directed by the MSCP Strategic Plan 2020-22, which sets out five priorities for the period: effective partnerships, contextual safeguarding and trauma informed practice, domestic abuse, neglect, and effective early help.*

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					The council also has a 'Contextual Safeguarding and Child Exploitation' Strategy in development, which will be passed for agreement with MSCP's Executive Board. The Strategy embraces the Contextual Safeguarding approach, recognising that children who are at risk of exploitation are often at risk from more than one kind of exploitation, and contains five workstreams: Prevent, Protect, Pursue, Provide and Participation. *Training is provided not only to staff within Children Services, but to all officers of the council to raise awareness of safeguarding and the overall responsibility of each officer to report any concerns. There is not a specific budget for child exploitation, however the council makes a financial contribution to the MSCP as a safeguarding partner.* ***Opinion: Green.*** ***RMO2: Appropriate management of referrals is conducted.*** *The review found that the council has a comprehensive area of its website dedicated to Safeguarding and how to report concerns. It was noted that the page for reporting concerns was not particularly prominent on the website, however this has since been rectified with a link titled 'Report a safeguarding concern' now provided directly with the in the Children and Families area of the website. The service makes use of social media to raise awareness of the work it is doing and provide information regarding child exploitation.* *The referral mechanism for child exploitation concerns is via an MSCP toolkit to the MSCP Missing and Exploitation Panel. Cases, when agreed for the Panel, automatically enter a multi-agency arena. The Panel reports back to the MSCP Joint Exploitation Group to ensure trends and knowledge is shared with the wider partners.* *Referrals to the Missing and Exploitation Panel are managed internally through a 'Risk Panel Tracker,' with minutes of meetings loaded onto Mosaic. Testing identified some delays with minutes being uploaded, however we were advised that a new member of staff has been recruited who will take over responsibility for the minuting of Panels and the uploading of minutes, and it is anticipated that a delay of less than 48 hours will be the norm going forward.* *Currently no analysis of council referrals is undertaken, however this is an area the service is keen to develop, to ensure emerging risks and trends are identified. Again, an additional staff member has recently been recruited and it is intended that this will not only add resilience to the team but will also allow the senior officer to undertake the above analysis.*

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					The MSCP produces an annual report detailing the work of the partnership in the previous year. The 2019-20 report went before the Children & Young People Overview & Scrutiny Committee on 1 December 2020 and Health & Wellbeing Board on 16 February 2021. ***Opinion: Green.*** ***Overall Opinion: Green. Agreed Actions: None.***
24	*Commercial property management - Pentagon Centre*	*15*	*11.9*	*Final report issued*	*The review considered the following Risk Management Objective:* ***RMO1 – There are arrangements in place to manage the Pentagon Centre.*** *The review found that on 12 February 2019, a report was presented to Cabinet providing the business case for acquiring the head leases of the Pentagon Centre and other freehold property. The report set out the advice of external specialists used to analyse the opportunity and the reasons for acquisition; after consideration of the report, Cabinet approved the acquisition. On 21 February 2019, Full Council agreed for the funding of the purchase and investment in the Pentagon Centre to be added to the Capital Programme; officers completed the purchase of the Pentagon Centre head leases, together with some freehold properties, in April 2019 for £34.875 million.* *The council have appointed Ellandi LLP as the Asset Manager for the Pentagon Centre and alongside Ellandi there is a property management company, Workman LLP, who manage the day to day running of the Pentagon Centre; this includes rent collection and collection of service charges. The contract with Workman has now expired, however it was advised that a tendering process is underway and should be completed within the current financial year. There are clear roles and responsibilities for the management of the Pentagon Centre, with agreements in place with Ellandi and Workman for this purpose.* *Recommendations to let and cease lettings are provided by Ellandi to the Head of Valuation and Asset Management and the Chief Legal Officer; delegated authority was given to the Chief Legal Officer to make such arrangements at the Cabinet meeting on 9 July 2019. During the audit, the Valuation and Asset Management Team were moved to the Regeneration Division and these delegations were transferred to the Director of Place and Deputy Chief Executive and then sub-delegated to the Head of Valuation and Asset Management.* *A sample of three recommendations from December 2020 was provided and all showed the recommendation and approval from the Chief Legal Officer; for two of the three recommendations there had also been consultation with the Leader and Portfolio Holder for Resources.*

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					There are arrangements are in place for very regular liaison with Ellandi and Workman to monitor the delivery of services in line with legal agreements; this includes monthly progress meetings, regular presentations at the Strategic Property Board and quarterly reports which are in line with the Ellandi contract. There is comprehensive reporting and monitoring of finances, including income collection, and there are arrangements in place to monitor and report on the overall financial performance of the Pentagon Centre, including cash flow forecasting. *In light of the COVID-19 pandemic, on 4 May 2020, a report was presented to Cabinet including a proposal to provide financial assistance in the form of rent deferrals to tenants of the Pentagon Centre and other commercial properties within the council's property portfolio. The Leader, using urgency powers, agreed to delegate authority to the Chief Legal Officer, in consultation with the Leader and the Portfolio Holder for Resources, to agree the delaying of current rent of Pentagon Centre tenants as and when requested on a case-by-case basis. Ellandi put forward proposals to the Head of Valuation and Asset Management and if these were deemed reasonable, they were put forward to the Chief Legal Officer for consideration; the most appropriate course of action would then be discussed with the Leader and the Portfolio Holder. Evidence was seen of this process being followed in practice. Rent collection is managed by Ellandi and Workman and it was explained that the Government moratorium on landlords taking action against tenants for non-payment of rent has made collection of rent in some instances difficult. It was explained that there were very few tenants that chose to defer rent and most used the opportunity to regear leases, which has meant tenants can be supported during this period and units within the Pentagon Centre remain occupied. Any deferred rental payments are to be repaid within 12 months of the agreement and monitoring is via the monthly progress meetings. It was advised that the urgency powers were revisited in November 2020, and it was agreed that the powers will not be extended further, and deferrals would not continue past the first two quarters of the 2021 calendar year.* ***Opinion: Green.*** ***Overall Opinion: Green. Agreed Actions: None.***
27	*Medway Norse - waste & recycling contract*	*15*	*16.7*	*Final Report Issued*	*The review considered the following Risk Management Objective:* ***RMO1 - There are arrangements in place to monitor the Medway Norse Waste and Recycling Contract.***

Ref	Activity	Number of Days allocated	Number of Days Used	Current status	Opinion, summary of findings & actions agreed
					The review found Cabinet agreed on 6 March 2018 to transfer the Waste Collection and Cleansing Contract to Medway Norse from October 2019, subject to completion of a contract in terms to be agreed by the Chief Legal Officer in consultation with the Leader and the Portfolio Holder for Resources. There is a draft Waste Management Contract in place which defines roles and responsibilities and sets out the outputs/service standards required, however the contract between the council and Medway Norse is yet to be signed and this something that is currently being worked on by Legal Services. It was advised that from an operational point of view the contract is up and running. The General Requirements Specification within the Waste Management Contract includes a contents, which refers to a Service Delivery Plan, however this is not included in the document. We were advised that a Service Delivery Plan has not yet been shared but should include details of the Medway Norse key contacts for the contract. Medway Norse's Board of Directors includes two representatives from the council. There is also an Operational Liaison Board, with representatives from both Medway Norse and the council. An Authorised Officer for the Waste Management Contract has been set, as has corporate client responsibility for the contract. There is a team in place responsible for contract monitoring. *The General Requirements Specification discussed above, details the expectations and requirements for meetings between the council and Medway Norse. It was explained that any urgent issues are raised immediately, however monthly contract meetings also take place with Medway Norse, which is in line with the requirements set out in the contract. We were advised that these meetings are used to discuss "hot topics," usually areas that are highlighted as a concern or anything that is a priority. Review of the meeting minutes found they broadly cover the points mentioned in the contract.* *Quarterly Medway Norse reports are presented to Cabinet which include a review of the performance of the joint venture from the perspective of the council client and an update on the joint venture's achievements and financial performance. There is evidence of these reports regularly being presented to Cabinet. An Annual Review of Waste Contracts report is also presented to the Regeneration, Culture and Environment Overview and Scrutiny Committee. An Environment Service Plan 2020-21 is available on Pentana and is updated quarterly. The draft Waste Management Contract includes a Performance Mechanism document, which includes a number of Key Performance Indicators (KPIs) and Performance*

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					Measures (PMs). For each of the 16 Performance Measures listed, a timeframe is provided for reporting the information to the council, however it was advised that this specific information not currently something that is provided or reported. There are arrangements in place for complaints to be investigated and monitored by the team responsible for monitoring the Waste Management Contract. There are arrangements in place to set the budgets for the Waste Management Contract and for budget monitoring to take place. The draft Waste Management Contract includes a Payment Mechanism document which details the requirements of the council and Medway Norse. Monthly finance information is now received with monthly finance meetings between the council and Medway Norse planned. ***Opinion: Amber.*** ***Overall Opinion: Amber. Agreed Actions: One high, two medium and one low priority.*** ***Actions relate to arrangements being made for the Medway Norse Waste Management Contract to be finalised and signed as soon as possible; arrangements being made to ensure that the council receives the Medway Norse Service Delivery Plan as detailed in the contract; arrangements being made to develop a template for monthly contract meetings to ensure all of the points in the contract are discussed; and review of the arrangements for the regular monitoring and reporting against KPIs and PMs to measure service delivery.***

2021-22 Internal Audit Assurance work (items in italics have been detailed in previous update reports)

Ref	Activity	Number of Days Allocated	Number of Days Used	Current status	Opinion, summary of findings & actions agreed
Core governance and financial systems assurance work					
1	Constitution maintenance	15	14.6	Final Report Issued	The review considered the following Risk Management Objective: **RMO1 - Effective arrangements are in place to maintain Medway Council's Constitution.** The review found that the Council has an appropriate Constitution in place which was updated and agreed at Full Council on 28 April 2016. The council's Constitution meets the requirements detailed in Section 9P Local Government Act 2000. The council has appointed a Monitoring Officer in line with the Local Government and Housing Act 1989. Article 14 of the Constitution sets out the

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					arrangements for the review and revision of the Constitution and states that the Monitoring Officer will monitor and review the operation of the Constitution to ensure that the aims and principles of the Constitution are given full effect. Operationally, the Head of Democratic Services supports the maintenance of the Constitution. The Monitoring Officer has delegated authority to make minor changes to the Constitution, with a copy of such changes being supplied to all Group Leaders and Whips within 14 days. All other changes to the Constitution will only be approved by Full Council after consideration of the proposal by the Monitoring Officer. Audit testing found in all instances, the changes and updates to the Constitution had received appropriate approval and in line with the Constitution, the Monitoring Officer provided a copy of changes to all Group Leaders and Whips. An appropriate audit trail is held for all changes made to the council's Constitution by Democratic Services. **Opinion: Green.** **Overall Opinion: Green. Actions: None.**
2	Performance management framework & reporting	15	22	Final report issued	The review considered the following Risk Management Objective: **RMO1 – Arrangements are in place to monitor & report on the council's corporate performance.** The review found that the council has a performance management framework in place, with the council's vision, priorities, ways of working and the outcomes it expects to achieve set out in the Council Strategy, and the Council Plan setting out how the council will achieve these outcomes and the measures that will be used to track performance. Arrangements exist for the Council Plan measures to be reviewed annually and for changes to be discussed and agreed via the appropriate governance processes; audit testing confirmed that these processes were followed for the 2021-22 Council Plan. A corporate system is in place for tracking progress against the Council Plan measures, though two Directorates also use their own dashboards and databases. Arrangements exist for Council Plan measures to be set up on the system and audit testing confirmed this to be case for a random sample of 20 measures reviewed. Outturns against each of the Council Plan measures must be entered into Pentana on a quarterly basis, along with any appropriate supporting notes or commentary, and emails are sent to the relevant officers to remind them of this. Audit testing confirmed that data is appropriately entered on a quarterly basis,

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					however inconsistencies were identified in how data is input and activated across the different Directorates. Quarterly performance reports are presented to the Corporate Management Team, each of the Overview and Scrutiny Committees and Cabinet, which summarise how the council has performed in each quarter against the Council Plan measures and the actions the council is taking to improve performance where necessary. Audit testing confirmed that the quarterly reports for Q1-4 of 2020-21 were presented as expected. There are procedures within individual Directorates for performance to be monitored, though it may be beneficial for these to be reviewed with a view to adopting a consistent approach across Directorates. **Opinion: Green.** **Overall Opinion: Green. Agreed Actions: One medium priority.** **Action relates to the process for inputting and activating performance data being reviewed to ensure a consistent approach is used throughout the council.**
3	*Ethics*	*15*	*N/A*	*Removed from plan*	*Removal from Plan agreed at the January 2022 Meeting.*
4	*Bad debt provision*	*15*	*N/A*	*Removed from plan*	*Removal from Plan agreed at the January 2022 Meeting.*
5	*Income collection*	*20*	*N/A*	*Removed from plan*	*Removal from Plan agreed at the January 2022 Meeting.*
6	Housing Benefit & Council Tax Reduction appeals	15	11.8	Final Report Issued	The review considered the following Risk Management Objective: **RMO1 - Arrangements are in place to appropriately process HB and CTR appeals.** The review found that appeal rights are included on the decision letters issued each time a claim is assessed. Information is provided regarding appeals on the public facing website but could have clearer information about the stages in the appeal process to prevent confusion on the part of the appellant. Cases are initially reconsidered by an independent officer, which audit testing confirmed is happening in appropriate instances in practice. The service issues individually tailored letters to explain any reconsideration decision, ensuring this serves as a learning experience for the potential appellant and with the hope this knowledge will be shared with friends and family, reducing the appeals received. If a case is not resolved on reconsideration, ultimately, it is for the Tribunal Services for the respective schemes to consider if an appeal is valid, but the team are diligent in contacting appellants where an issue needs to be resolved to

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					progress the matter. The service has no control over how long the Tribunal take to hear a case but can request an early hearing for urgent cases. Performance is monitored via local targets and objectives within staff Performance Development Reviews. **Opinion: Green.** **Overall Opinion: Green. Actions: One low priority.** **Action relates to more transparency on the public website regarding the stages of any appeal.**
7	NNDR reliefs	20		*Fieldwork complete, In quality control*	The review considered the following Risk Management Objective: **RMO1 - Arrangements are in place for the application of discretionary and mandatory NNDR relief as appropriate.**
8	Payroll	15	29.8	Final Report Issued	The review considered the following Risk Management Objective: **RMO1 – Arrangements are in place to calculate and pay staff salaries effectively, including allowances and overtime.** The review found appropriate arrangements are in place for new starters to be added to the payroll, including allocation of a unique payroll reference number. Appropriate forms are also in place for managers to notify the Payroll Team of changes and leavers via a self-service portal, though there is currently an element of double handling in the process, including the storing of forms in multiple locations. Audit testing confirmed starters, leavers and changes are actioned accurately on the payroll system, with appropriate control checks in place. Weaknesses were however identified in relation to the processes in place to ensure all forms are submitted by officers with appropriate authority to do so. Arrangements are in place for salary payments to be calculated based on the information input to the payroll system, and for income tax and national insurance contributions to be deducted; audit testing confirmed these arrangements to be working effectively in practice. Likewise, there are arrangements for adding allowances and making deductions on receipt of appropriate instruction. Procedures exist for a variety of exception reports to be produced and checked both prior to and following the final pay run in each pay period, though testing identified minor omissions in the administration of checklists used to confirm all checks have been undertaken. Reports are also run identifying changes to bank details, though there was a backlog of checks on such reports at the time of audit. Arrangements are in place for BACS files to be produced and transmitted, with appropriate checks of the submission undertaken. Arrangements are also in place transactions to be uploaded to the General Ledger to ensure that all payroll

Ref	Activity	Number of Days Allocated	Number of Days Used	Current status	Opinion, summary of findings & actions agreed
					payments are appropriately accounted for. Access to the payroll system is restricted via user profiles and audit testing confirmed user profiles are appropriate. It should be noted that the payroll function moved back to HR from Finance in 2021-22 and the team has been affected by significant staff vacancies. A large-scale transformation programme is currently underway to assist with the automation and streamlining of services and this work will assist with addressing the actions identified in this audit. **Opinion: Red.** **Overall Opinion: Red. Actions: Three high, two medium and one low priority. Actions relate to amendments to mandatory fields in the staff leaver form, reviewing arrangements for the storage and retention of payroll forms, reviewing the authorised signatory process, ensuring pay run checklists are completed in full, and, supervisor checks being undertaken in a timely manner.**
9	Insurances	12	24.6	Final Report Issued	The review considered the following Risk Management Objective: **RMO1 - Arrangements are in place to maintain appropriate insurance cover and process insurance claims.** The review found that the council maintains inventories for all assets held, however, the inventory for Lease and Fleet Vehicles was not an up-to-date reflection of the vehicles held by the council. We were able to give assurance that the council's insurance premiums are correctly calculated, promptly paid and recorded on the General Ledger. Audit testing in respect of premiums for three of the main insurance suppliers confirmed that the amounts quoted on the broker schedules had been agreed and were correctly recorded on the spreadsheet, and the Non-Purchase Order Slips (NPOS) to pay the brokers had been completed, authorised correctly, recorded on the General Ledger, and had been paid within 32-37 days of receipt. Arrangements are in place for all insurance claims to be appropriately processed. Records are currently held on two systems, with the new system expected to be fully implemented in January 2022. Procedure notes were provided for some areas of the service, and it was recognised that process notes will be required for the new system. Arrangements are in place to ensure that claims are legitimate with experienced and adequately trained officers requesting and analysing information relating to the claim. There is also a process in place to ensure that prompt action is taken to rectify problems to prevent re-occurring incidents further claims.

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					The council self-insures, and therefore there are very few payments coming from insurance companies. All payments made and received in respect of claims were recorded on the relevant spreadsheets and more recently on the new system. We were able to see that settlement decisions are authorised by the Head of Service prior to payment ensuring segregation of duty. It was found that although the insurance function of the council works, there is no strategy in place to show the roles and responsibilities of the officers. It was noted that the section is currently managed and staffed by officers who have a wealth of experience, however, going forward due to expected staff changes, the delivery of the council's insurance function could be compromised if the roles and responsibilities are not established and documented. **Opinion: Amber.** **Overall Opinion: Amber. Actions: Two medium Priority.** **Actions relate to asset inventories being regularly updated and reconciled to ensure they are a true reflection of the assets held and** **There being no strategy or insurance policy in place for the insurance service to document the administration arrangements for insurance claims.**
10	Budget monitoring (Capital)	15	21.4	Final Report Issued	The review considered the following Risk Management Objective: **RMO1 – Budgets within the council's capital programme are appropriately monitored.** The review found the council's Constitution clearly sets out roles and responsibilities, with Full Council responsible for setting the capital budget and Cabinet responsible for managing spend within that budget. As well as the roles stated within the Constitution, Directors, Assistant Directors, and Service Managers have overarching responsibility for managing their budgets. There are four rounds of budget monitoring per year, which are managed through Integra, with forecasts and explanations for any variances provided by budget / project managers and checked / challenged by accountants. Variances that cannot be resolved by other means can be rectified by virement or additions to the capital programme; the council's Constitution sets out approval arrangements for virements and additions, including financial limits. Audit testing confirmed virements and additions are carried out in accordance with the Constitution. In practice, the same rules are applied to removals from the programme, however removals are not explicitly covered in the Constitution and therefore it may be useful for this to be added on next review. Regular capital budget monitoring reports are produced and

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					presented to Directorate Management Teams, the Corporate Management Team, Cabinet and Business Support Overview & Scrutiny Committee in line with the council's Constitution. Audit testing confirmed that reporting is undertaken as expected. At the time of audit, a review was being undertaken of the way capital budget monitoring is reported, with the new format expected to be introduced in 2022-23. **Opinion: Green.** **Overall Opinion: Green. Actions: None.**
11	Schools				Three schools were selected as part of a risk assessment looking at budgets and the date of the last internal audit review. The objective of each review is to provide assurance that the school has appropriate mechanisms in place to ensure it is in a sound financial position and that there are no material probity issues. Key areas for review include: • Governance • Payroll • Purchasing and payments • Income & Cash Handling • Asset Management
	Horsted School	20		*Fieldwork complete, In quality control*	
	Luton Primary School	20		Draft report with client for consideration	
	Will Adams Centre	*20*	*N/A*	*Removed from plan*	*Removal from Plan agreed at the January 2022 Meeting.*
Corporate risks assurance work					
12	Adult social care - assessments & reviews of financial support	20		*Fieldwork complete, In quality control*	The review considered the following Risk Management Objective: **RMO1 – Effective arrangements are in place to carry out adult social care financial assessments and reviews.**
13	Market income collection	15		*Fieldwork complete, In quality control*	The review considered the following Risk Management Objective: **RMO1 – Arrangements are in place for the collection and banking of market income.**
14	*Parking enforcement*	*15*	*16.3*	*Final report issued*	*The review considered the following Risk Management Objectives:*

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					RMO1 - All Penalty Charge Notices (PCNs) are issued correctly, and income is appropriately monitored and collected where possible. *The review found there is a Parking Enforcement Policy in place; the policy was last updated in April 2021 and is reviewed on an annual basis. Civil Enforcement Officers (CEO) are responsible for identifying contraventions and issuing PCNs and have been appropriately trained for this, though some newer members of the team are awaiting more formal training that has been delayed due to the Covid-19 pandemic.* *Arrangements exist for PCNs to be issued where necessary and for recipients to be made aware that the PCN has been issued, either by attaching the PCN directly to the vehicle or by sending it to the registered keeper in the post. Details of all PCNs are uploaded from the CEO handheld devices into the parking system, Taranto; all PCNs are allocated a unique reference number. The system is covered by a contract, which requires the supplier to ensure software is kept up to date with legislation. Parameters within the system apply the correct charge to each PCN based on the contravention selected by the CEO, including applying the full charge if the PCN is not paid within statutory timescales for the reduced rate. Audit testing confirmed that the correct charges are applied in practice. Arrangements exist for payments received in respect of PCNs to be allocated correctly on the Taranto system each weekday; procedures are also in place for income to be recorded on the General Ledger. If payments or representations are not received within statutory timescales set within the Taranto system parameters, arrangements exist for PCNs to automatically move to the next enforcement stage, with officers notified of action which needs to be taken via daily reports. This includes issue of appropriate Notices / Certificates and ultimately court action and referral to enforcement agents if required. Appropriate monitoring of PCNs allocated to enforcement agents is undertaken.* *A monthly audit of all cancelled PCNs is carried out, checking a sample to ensure the correct process has been followed and that there is the evidence to support the cancellation.* *The Local Government Transparency Code requires the council to publish data relating to its parking account within one month of the end of the financial year, however the most recent data published at the time of audit related to 2018-19.* ***Opinion: Amber.***

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					RMO2 - Appeals against PCNs are administered correctly in accordance with required legislation. *The review found an appeals process has been established, which allows for informal and formal representations, prior to an appeal to the Traffic Penalty Tribunal (TPT). Information regarding the process is available to the public within the Parking Enforcement Policy, on the council's website and on the PCN itself. Arrangements exist for all representations to be dealt with in line with council policy and current legislation. Audit testing on a sample of successful representations confirmed that representations are supported by appropriate evidence and responded to within a timely manner. If a representation is unsuccessful, owners can choose to proceed to an independent appeal to the TPT; audit testing confirmed that in such cases, information is provided to the TPT within the 14-day required timescale.* ***Opinion: Green.*** ***Overall Opinion: Green. Actions: One high priority.*** ***Action relates to publishing annual parking reports in line with the Local Government Transparency Code.***
15	*Information requests*	*15*	*15.9*	*Final report issued*	*The review considered the following Risk Management Objective:* ***RMO1 - Arrangements are in place for the council to assess and respond to information requests in accordance with legislation.*** *The review found that appropriate information is made available to the public via the council's website regarding Freedom of Information (FOI) requests and Subject Access Requests (SAR), though there is currently no information provided regarding Environmental Information Regulation (EIR) requests.* *Employees throughout the council who are responsible for responding to FOI/EIR requests are known as FOI Handlers; in 2018, training was provided to all FOI Handlers, however audit testing found that only approximately 40% of employees currently named as having a role in responding to FOI/EIR requests completed the training. Testing also indicated that there may be a need for further guidance on the refusal of requests. Some employees have indicated that they have received training from previous employers or have learnt from colleagues. SARs are responded to by different handlers; with the exception of GDPR training in 2018, it is understood that no other corporate training has been provided for the handling of SARs.*

Ref	Activity	Number of Days Allocated	Number of Days Used	Current status	Opinion, summary of findings & actions agreed
					A suite of procedure notes and flowcharts exist but these are currently in draft form, pending discussions regarding transformation of the process for recording information requests. *Arrangements exist for information requests to be received into dedicated email inboxes, checked for validity, acknowledged, logged, and passed to the relevant request handler(s). Request handlers are required to coordinate assessment of and responses to information requests within the timescales set out by legislation. Regular information is provided to FOI Handlers on the position of all current FOI/EIR requests and Assistant Directors are provided with a weekly summary of outstanding requests within their areas. Monthly SAR reports are also created and shared with the Children's Social Care SARs team in a monthly meeting. Audit testing on a random sample of FOI/EIR requests and SARs confirmed that responses are largely provided within the appropriate timescales, though there were some omissions relating to use of standard templates and manager approval of FOI/EIR responses.* *The council's performance in responding to information requests is monitored and reported via quarterly reports to the council's Corporate Management Team (CMT), though it was noted that additional information could be supplied to aid monitoring; there was evidence of action being taken to improve performance. Audit testing confirmed the accuracy of data included in these reports.* ***Opinion: Amber.*** ***Overall Opinion: Amber. Actions: One high, two medium and two low priority. Actions relate to reviewing information available relating to information requests on the council's website; training / refresher training being provided to request handlers; request handlers being reminded of elements of the agreed process; and more detailed reporting on outstanding responses to information requests.***
16	Tenancy Enforcement	15		*Fieldwork complete, In quality control*	The review considered the following Risk Management Objective: **RMO1 – There are arrangements in place for tenancy enforcement.**
17	*Accessibility Regulations*	*15*	*13.5*	*Final report issued*	*The review considered the following Risk Management Objective:* ***There are arrangements in place to ensure compliance with the Public Sector Bodies Accessibility Regulations 2018.*** *The review found that arrangements are in place to provide guidance on the Accessibility Regulations by way of dedicated pages on the staff intranet, Teams*

Ref	Activity	Number of Days Allocated	Number of Days Used	Current status	Opinion, summary of findings & actions agreed
					channels and communications. There is also training currently being finalised which is due to take place in the early part of 2022. A list of over 40 websites and mobile applications was provided for the audit. There is not currently a formal approval process in place to ensure that when a website or mobile application is created and/or developed, the service is signposted to the Digital Team, where advice can be provided regarding the Accessibility Regulations. There are appropriate arrangements in place to check and fix accessibility problems on the main website, medway.gov.uk; an appropriate accessibility statement has also been published. However, audit testing found that only 20 out of 23 websites and mobile applications in the sample selected have an accessibility statement. A review of the statements found that 17 use appropriate methods to check the website for accessibility issues, but three statements did not provide this information. Further review of the 20 accessibility statements in the sample found that whilst the majority use the sample statement made available in the Government guidance, some legally required wording and sections have been omitted. In addition, 11 out of the 20 accessibility statements available have not been reviewed within the last year as is required by the Accessibility Regulations. There is also evidence that some statements have not been updated to reflect fixes that have been made. There is not currently a compliance process in place to ensure websites and mobile applications are compliant with the Accessibility Regulations, with reliance placed on website owners. *There are arrangements in place to ensure that new content added to the council's main website meets the Accessibility Regulations however this approach is not consistent across all websites, and it is understood that the training discussed above will assist with these processes.* ***Opinion: Amber.*** ***Overall Opinion: Amber. Actions: Two High Priority.*** ***Actions relate to reviewing processes in place to request an online presence and introducing a compliance process.***
18	Adult social care - self-directed support (direct payments)	15	18.6	Final Report Issued	The review considered the following Risk Management Objective: **RMO1 – Effective arrangements are in place to manage Self-Directed Support (Direct Payments).** The review found that the current procedure note with regard to Direct Payments is out of date; a new procedure is currently being written. Arrangements are in place for referrals to be made to the Direct Payments Team, with initial visits, or since the pandemic, appropriate contact to be made by coordinators who explain

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					the Direct Payment and make arrangements for the relevant documents to be completed. An issue with document storage was identified, making it difficult to evidence authorisation processes, though this is being addressed by management and all staff will be reminded of the need to comply with GDPR requirements. Steps to streamline the authorisation process have taken place, while ensuring no payment is made without proper authorisation is a priority. The team are proactive in offering support and advice to their clients, with new and innovative ways to meet the clients' Plans being adopted in during the pandemic. Signposting to training opportunities are made to ensure the client and their carers are confident to use the Direct Payment effectively. Early intervention, linked to close monitoring of the accounts, as well as continuing contact with the client and their carers has been shown to prevent misuse of the cards and allow flexibility to realise objectives. **Opinion: Amber.** **Overall Opinion: Amber. Actions: Two High Priority.** **Actions relate to writing and circulating updated procedure notes, the Carers Plan authorisation being brought in line with that used on the My Plan, and ensuring that all documents are stored correctly.**
19	Business parking permits	15	16.2	Final report issued	The review considered the following Risk Management Objective: **RMO1 – Business parking permits are issued and managed effectively.** The review found that any business located in a Medway Controlled Parking Zone (CPZ) can buy annual business permits for staff or company vehicles; similar permits are available to schools within CPZs, and permits are also available for traders who need to park in any of Medway's CPZs to carry out their day-to-day business. Information regarding the issue and use of these permits is accessible via the council's website, where online applications can also be made for business and trader permits. Paper application forms can also be requested. Charges for business and trader permits are approved by Full Council as part of the annual budget setting process; however, discounts available for school business and trader permits, and the administration fees for lost, stolen and cancelled permits, are not approved in the same way. Documents required to support applications are set out on the application forms for all three types of permit, which also require customers to confirm they will adhere to a set of terms & conditions; however, it was noted that there are some inconsistences between the paper and online application forms. Arrangements exist for permits to be issued via the parking system, Taranto, once a completed application has been received,

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					together with the associated fee and the supporting evidence, which is verified; all permits are allocated a unique reference number. Application forms and supporting documents are stored in compliance with GDPR, however there is not a written process for regularly reviewing and destroying documentation that is no longer required. Audit testing on a random sample of 10 permits also identified issues with the storage of documentation for paper applications. Business and trader permits can be renewed online via the council's website, which includes completion of an associated form, however no such form is required for 'paper' renewals. There is appropriate monitoring of application processing, including a monthly audit to ensure applications are processed correctly. There are also arrangements to deal with requests to change, cancel and re-issue permits, including processing any additional fees or refunds, though audit testing identified a lack of segregation of duties specifically around the processing of card refunds. A review of the council's financial system Integra identified that permit charges and administration fees are not always being coded accurately. In addition, although budget monitoring is undertaken, there is no specific monitoring of permits issued against income received or checking that all payments have been receipted. **Opinion Amber.** **Overall Opinion Amber. Agreed Actions: One high, five medium and one low priority.** **Actions relate to all parking permit charges being reviewed and approved annually; ensuring consistency between online and paper application; all application forms and supporting evidence being retained and filed accurately; a process for ensuring all documents that include personal data are stored for the appropriate retention periods; refunds for card payments being independently checked before being processed; checks being carried out that all payments are processed and receipted; and, regular checks being carried out to ensure all permit payments and refunds are accurately coded on the general ledger.**
20	HRA building compliance	15		*Fieldwork complete, In quality control*	The review considered the following Risk Management Objectives: **RMO1 – The council has arrangements in place to ensure the required safety checks are carried out on HRA properties so that the council meets its duties as a landlord.** **RMO2 - The council has arrangements in place to respond to new legislation or changes to current legislation.**

Ref	Activity	Number of Days Allocated	Number of Days Used	Current status	Opinion, summary of findings & actions agreed
21	Advocacy	15	21.8	Final report issued	The review considered the following Risk Management Objective: **RMO1 – Arrangements are in place to provide and monitor Advocacy Services to adults under the Care Act 2014** The review found that the council entered a contract with POhWER for them to deliver statutory advocacy services in 2017. The council's website contains information about advocacy services but there is no information relating to POhWER and reference to a previous provider was found. There are no strategies or policies in place relating to advocacy, however, audit was advised that the Care Act 2014 stipulates when advocacy services should be used. There are no procedures within the social care teams that specify how to appoint an advocate. However, audit was advised that as social care staff are highly trained, or supervised if new to the role, the use of advocates would be familiar to them. It was however acknowledged by management that written advocacy procedures could be created and made accessible to all staff. There is no requirement for a referral to the advocacy service to be authorised as one must be appointed if the need is identified. However, social workers have regular supervision with their team managers where such issues would be discussed. POhWER provide the Commissioning Team with a number of reports and information about performance of the advocates. Monthly invoices are received from POhWER for all advocacy services provided, broken down charges under various sections of the Care Act. However, it was noted during testing that the invoices also include charges for other activities that are not specified in the invoice detail. It is suggested that more transparency in invoicing should be sought. During testing it was noted that the council may have been invoiced for duplicate hours during the same timeframe for one client who had two open cases. This was discussed with the provider and an administrative error was identified and rectified. **Opinion: Green.** **Overall Opinion: Green. Agreed Actions: One low priority.** **Agreed Action relates to random spot checks of invoices to ensure accuracy of charges.**
22	*Child protection – virtual conferences (previously Virtual*	*15*	*17.2*	*Final report issued*	*The review considered the following Risk Management Objective:* ***RMO1 - Arrangements are in place to manage child protection virtual conference meetings.***

Ref	Activity	Number of Days Allocated	Number of Days Used	Current status	Opinion, summary of findings & actions agreed
	conferences - children's social care)				*The review found that virtual child protection conferencing relating to both Child Protection Conferences (ICPCs) and Review Child Protection Conferences (RCPCs) at the council commenced in April 2020.* *There has been no specific legislation/regulation relevant to running Child Protection Conferences (CPCs) virtually due to the Covid-19 pandemic. An internal document entitled Operating Procedures for Children's Social Care during Covid-19 was put in place at the start of the lockdown period. This included a section on CPCs and outlines the use of virtual conferencing, as a multi-way phone call/video-call or if technology does not allow, a series of phone calls/video-calls, led by the Child Protection Chair and details the process to be undertaken. Evidence was seen to confirm that CPCs are happening within the required timeframes set in the original legislation.* *The service advised that a Data Protection Impact Assessment (DPIA) is not in place for the processing of data in relation to CPCs.* *Although there has not been a formal review of virtual CPCs, Child Protection Chairs working with social workers have provided feedback from conferences to enable changes/improvements to be made where relevant and to inform the Covid-19 recovery plan. A move to hybrid CPCs, which allow for more flexibility and interaction is planned for early 2022.* ***Opinion: Green.*** ***Overall Opinion: Green. Actions: One medium priority.*** ***Action relates to ensuring that data processing documents are in place relating to GDPR.***
23	HR - sickness absence reporting & monitoring	15	19.1	Final report issued	The review considered the following Risk Management Objective: **RMO1 – Arrangements exist for staff sickness absence to be reported and accurately recorded.** The review found there is a 'Managing Sickness Absence' policy in place, which includes the roles and responsibilities of employees, line managers and HR, though there is more than one version of the policy available. New employees receive information about the policy and other general policies through their contract of employment and the staff induction process. A sickness absence reporting and recording process is in place which is detailed within the policy and staff contracts. Employees are required to contact their line manager in the first instance, with a form completed on their return, signed by their line manager, and then forwarded to Payroll for recording on ResourceLink, the HR/payroll system. In cases of long-term absence, forms are submitted by line

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					managers in the interim. Changes made during the Covid-19 pandemic, including introduction of an online reporting form specifically for Covid-19 absences has led to line managers submitting information through various channels, which means the Payroll team are having to spend a great deal of time managing the redistribution of information to relevant pay clerks. Sickness absence recording is carried out based on the monthly pay run cycle; this means notifications received before the pay run cut-off deadline are processed, and those received after that will not be processed until the following month. Therefore, sickness reported may not appear on ResourceLink system for 4-5 weeks, this being a lesser priority than payroll processing which impacts employee pay. A review of sickness absence data recorded on ResourceLink in 2020-21 showed that 66% of sickness absences were recorded within 30 days and a further 24% were recorded within 60 days. Audit testing on a random sample of 25 sickness absence records confirmed, in 18 instances, the records had been accurately recorded and the was supporting evidence available, however discrepancies were identified in the remaining seven instances, including missing PCM004 forms, missing fit notes and on one occasion the date of the fit note was recorded incorrectly. **Opinion: Amber.** **Overall Opinion: Amber. Agreed Actions: Two medium priority.** **Actions relate to publishing consistent versions of the Managing Sickness Absence policy and streamlining the process of sickness absence reporting.**
24	*Corporate debt recovery*	*15*	*N/A*	*Removed from Plan*	*Removal from Plan agreed at the January 2022 Meeting.*
25	Care leavers - supported housing	15		*Fieldwork complete, In quality control*	The review considered the following Risk Management Objective: **RMO1 – Arrangements are in place to manage the transition of young people leaving care placements into supported accommodation in accordance with the Children Act 1989.**
26	*Looked after children - bank account provision*	*15*	*14.8*	*Final Report Issued*	*The review considered the following Risk Management Objectives:* ***RMO1 - Medway Council provide Looked After Children with regular savings which are made available to them when they leave care.*** *The review identified that the council's payments to foster carers include funds to be to be used as savings for the looked after child, with the foster carer expected to allocate a set amount of money to each child for savings. Details of the amounts expected to be allocated to savings are set out in the Pocket Money & Savings Policy included in the in-house foster carers handbook. However, we cannot give assurance that looked after children placed with Independent Fostering Agencies*

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					(IFA) or looked after children in residential care have the same allocation of savings as these are less clear. We were advised that these are stipulated in individual contracts, which are currently being reviewed as part of a new procurement for April 2022. The Pocket Money & Savings Policy is focused on foster carers and sets out their responsibility for dealing with the looked after child's savings. It also sets out that monitoring of an individual child's savings and ensuring that it stays with the child throughout their time in care, is the responsibility of the supervising social worker for the foster carer and independent reviewing officers. Testing indicated that for a large number of children recorded as being looked after, there was no record of any savings. In addition, information received from the Commissioning Team and from interviews with staff, showed little to provide assurance that recording, and monitoring of savings was taking place to ensure that savings stayed with the children and was available to them when they left care. Due to the lack of monitoring and reporting, if a claim of missing money were to be reported, it would be difficult to confirm the accuracy of savings held and could lead to the council having to make up any perceived shortfall. ***Opinion: Red.*** ***RMO2 - Children who are in care for more than 12 months have a Junior ISA or Child Trust Fund opened for them.*** *The review found that the council has arrangements in place to ensure all looked after children that have been in care for more than 366 days have a Junior ISA opened for them. This process is administrated by The Share Foundation (TSF) who, on receipt of information from the council, arrange for accounts to be opened and record any changes in the children's circumstances.* *The Corporate Parenting Service's Business Support Team are responsible for sending reports to TSF and monitoring their returns and responses, with updated balances added to the looked after child's Mosaic record and in some cases copies of correspondence.* *Testing identified a number of children who meet the criteria for a Child Trust Fund (CTF) account to have been opened but the account could not be located. There were also small number of children eligible for a Junior ISA but there were no records of one with TSF. However, it was noted that TSF had recently advised of an issue with opening accounts and that they expected this to be rectified within a few months. Monies in Child Trust Funds and Junior ISA accounts cannot be taken out until the account holder is 18. These accounts can remain open, and*

Ref	Activity	Number of Days Allocated	Number of Days Used	Current status	Opinion, summary of findings & actions agreed
					responsibility is passed to the account holder to choose what happens to the monies. For children who move out of care and whose accounts are held by TSF, the person who assumes parental responsibility is advised of the details of the account. ***Opinion: Amber.*** ***Overall Opinion: Red. Actions: Four high, one medium and one low priority. Actions relate to reviewing and updating procedure notes, regular monitoring of records to ensure all eligible LAC have Child Trust Fund or Junior ISA and keeping a record of correspondence between LAC and The Share Foundation on Mosaic records.***
27	Kyndi (formerly Medway Commercial Group) - governance & accounting	15		Draft report with client for consideration	The review considered the following Risk Management Objective: **RMO1 – Governance arrangements in place are effective to ensure the delivery of quality services and value for money through Kyndi Ltd.**
28	IT asset management	10	18.1	Final report issued	The review considered the following Risk Management Objective: **RMO1 – Arrangements are in place to monitor distribution and relocation of IT equipment.** The review found that that a covid loan shop was available on the service portal, where arrangements were in place for covid loan equipment to be requested via TopDesk. Staff had to include a cost code, reason, and line manager details for approval. Procedures were in place for the circumstances of each request to be assessed by ICT to ensure it related to Covid loan purposes and, if approved, the device would then be built. Some omissions with the approval of requests and declarations were identified during testing, which are going to be taken forward for future schemes. Since the audit was carried out the covid loan scheme has finished. A spreadsheet was created to record all covid loan equipment and a master asset spreadsheet was also used to log all equipment purchased. Two asset management tools are also used to monitor and track devices, however, cannot be used for monitors etc. Prior to the ICT Asset Manager starting no records were held. However, a project is currently underway for all asset information to be entered within TopDesk and a dynamic link being set up within the two asset management tools to update TopDesk automatically.

Ref	Activity	Number of Days Allocated	Number of Days Used	Current status	Opinion, summary of findings & actions agreed
					Reviews and reconciliations are not currently carried out between the information held within the two asset management tools to the information recorded on the master asset spreadsheet. This is due to the resources available within ICT. **Opinion: Amber.** **Overall Opinion: Amber. Agreed Actions: One high priority.** **Action relates to the recording and reconciling of non-trackable assets.**
29	*Client financial affairs*	*15*	*19.1*	*Final report issued*	*The review considered the following Risk Management Objective:* ***RMO1 - Arrangements are in place to manage client financial affairs (CFA) appropriately.*** *The review found that the council has a Corporate Appointee/Deputy in place, along with a CFA Team responsible for managing the financial affairs of clients who are unable to do so themselves; however, there is not currently an up-to-date record of responsibilities that have been delegated by the Corporate Appointee/Deputy. The Office of the Public Guardian (OPG) has a number of professional deputy standards that should be adhered to, including training of staff, however it was not possible to confirm the training that staff have undertaken. In addition, there are CFA policies and procedures in place, however not all have been reviewed recently and duplicate versions exist.* *There are arrangements for social workers to make referrals for support under CFA, including completion of relevant documents, and for applications for appointeeship / deputyship to be made where appropriate. Due to resourcing issues, there have been difficulties with completion of COP3 forms required for existing clients to move from appointeeship to deputyship to enable the investment of their capital in accordance with OPG requirements, although this risk has been recognised and there are now plans in place to rectify this.* *Appropriate arrangements exist for the handling of cash and the setting up of payments to / from client accounts, with appropriate approval levels and segregation of duties in place. Use of cash is minimal, with Allpay cards used instead. An issue was identified with the location of cash held by the team not being in accordance with the council's insurance policy, but this has since been rectified.* *The CFA Team carry out financial reviews on receipt of uprated benefit letters and visit clients when able, though this has not been possible more recently due to Covid-19. Visits were however restarted in April 2021, although are currently being prioritised. Appropriate procedures are in place for the investigation of complaints.*

Ref	Activity	Number of Days Allocated	Number of Days Used	Current status	Opinion, summary of findings & actions agreed
					There are various systems used to record client details and audit testing confirmed there are appropriate arrangements for: • *Clients being assigned to an CFA Officer in accordance with an alphabetical split.* • *Clients having a National Westminster current bank account set up in the name of client and the council.* • *Clients having a summary of income/expenditure recorded on the Client Monies Case Management System.* • *Client bank accounts being regularly reconciled.* • *Management of debts.* • *Property held by the team on behalf of clients being appropriately logged and securely stored.* • *Annual reports being produced in line with OPG timescales.* *Although some evidence was seen of investments being placed and reviewed, a number of clients in the sample exceeded the maximum level of funds that CFA investment policies say should be kept in their current account (linked to the COP3 issue discussed above), including an instance where there was a need for a benefit review.* ***Opinion: Amber.*** ***Overall Opinion: Amber. Actions: Two high, two medium and one low priority. Actions relate to completion of an OPG document stating the duties that have been delegated by the current Corporate Appointee/Deputy; CFA policies and procedures being reviewed and updated; review and recording of mandatory training for CFA staff; review of clients with funds exceeding thresholds for claiming benefits; and, the securities list being dated to reflect the last time it was amended.***
30	Safeguarding adults	15	8.4	Final Report Issued	The review considered the following Risk Management Objective: **RMO1 – Effective arrangements are in place within the Adult Social Care team for the safeguarding of adults in need of care and support in Medway.** The review found the annual 'self-assessment of organisational arrangements to safeguard and promote the wellbeing of adults at risk' for 2020-21 was completed and submitted to the Kent & Medway Safeguarding Adults Board (KMSAB) by the required date, as was the annual Agency Safeguarding Report. Audit testing confirmed there is evidence available to support the requirements of the self-assessment. There are arrangements in place to address areas where compliance with requirements did not fully meet the KMSAB's expectations. Following review

Ref	Activity	Number of Days Allocated	Number of Days Used	Current status	Opinion, summary of findings & actions agreed
					of the 2020-21 self-assessment, seven areas were given an amber RAG rating; at the time of audit, work had been completed or was in the process of being completed for four of the seven; the remaining three were still under review by the team. Arrangements exist for ongoing progress of the work towards improving the ratings to be monitored. **Opinion: Green.** **Overall Opinion: Green. Actions: None.**
31	District enforcement	15		Fieldwork complete, In quality control	The review considered the following Risk Management Objective: **RMO1 – There are arrangements in place for District Enforcement to supply enforcement services.** **RMO2 - There are arrangements in place to monitor the contract with District Enforcement and operation of services provided.**
32	Student services - Medway test	15	12.8	Final Report Issued	The review considered the following Risk Management Objective: **RMO1 – Arrangements are in place to appropriately administer, assess and report the results of the Medway Test.** The review found there is information available to appropriate parties regarding the Medway Test on the council's website and further information is shared with schools. In line with relevant legislation and guidance, the council has published their secondary School Admissions Scheme. There are appropriate arrangements in place to administer the Medway Test, including preparation and delivery of test papers, invigilation and collection of completed papers. There are also arrangements in place to assess the Medway Test; the Verbal Reasoning and Mathematics tests are marked by the test provider and the Extended Writing test is marked by markers recruited by the council. Each paper is marked to provide 'raw' scores. The raw scores are then standardised to reflect the child's age at the time they sit the test and a formula applied to calculate an overall score. The minimum score for the Medway Test is set at the 23rd percentile of the Medway cohort. Audit testing on the data for the 2021 test to replicate the process described above, identified the same results. There are appropriate arrangements in place to report the results of the Medway Test accurately and in a timely manner; results are either sent by email or by letter. Quality checks are carried out on the Medway Test scores as well as the results, however these checks are not currently documented. If a child who sat the Medway Test is assessed as non-grammar, parents/carers can request an academic review; the review found there are appropriate arrangements in place to carry out academic reviews. **Opinion: Green.**

Ref	Activity	Number of Days Allocated	Number of Days Used	Current status	Opinion, summary of findings & actions agreed
					Overall Opinion: Green. Actions: Three low priority. **Actions relate to reviewing the log for test packing, the log for receipt and delivery of the tests and recording of quality checks carried out.**
33	North Kent Marshes Internal Drainage Board	20	9.1	Complete	The Internal Audit Team conducted a review of the accounts for the North Kent Marshes Internal Drainage Board for the period 1 April 2020 to 31 March 2021 and were satisfied as to their completeness and accuracy with one non-material exception. Issues relating to regular reviews of the risk register, billing calculations being checked by an independent officer and ensuring documents are published by required deadlines, were also identified during the review, and were included as action points to be addressed in the final summary report.
34	Troubled Families assessment validation	25	22.1	Complete	
35	Grant validations	15	8.5	Complete	Independent validation has been conducted in respect of a number of grants received from Central Government Departments to confirm that the grant funding had been spent in accordance with set conditions to enable to the Chief Executive and Head of Internal Audit & Counter Fraud to sign a statement confirming that grant funding had been appropriately spent.
36	*Finalisation of 2020-21 planned work*	*20*	*36.9*	*Complete*	*Please see table staring on page 5.*
37	*Responsive assurance work*	*20*	*6.9*	*Complete*	*Please see table below*

Responsive Assurance Activity

Activity	Opinion, summary of findings & actions made
Covid 19 Additional Restrictions Grants	*Two officers supported newly appointed temporary staff with the assessment and validation of alternative restrictions grant applications.*
Building Compliance Inspections	*Officers carried out assurance checks on buildings moving into the final stages of re-opening as the last of the national restrictions were eased.*

Other consultancy services including advice & information

Client service area	Services provided
Strategic Risk Management Group	Internal Audit have a representative on this corporate working group, which supports the council in its efforts to co-ordinate Strategic Risk Management.
Security and Information Governance Group	Internal Audit have a representative on this corporate working group to offer advice on relevant risk management, control, and governance issues.

Counter Fraud Activity

Ref	Activity	Number of Days Allocated	Number of Days Used	Current status	Opinion, summary of findings & actions agreed
43	Counter fraud proactive work (inc external data matching such as NFI & KIN)	75	121.5	Active	A significant amount of resource has been dedicated to the review of data matches received from both the 2019-20 and 2020-21 NFI exercises, many of which led to investigations, the results of which are detailed in the table for 'Reactive Investigations work: external investigations'. Full details relating specifically to the results of the NFI Exercise will be included in the NFI annual report. Potential discrepancies highlighted by the activity of the Kent Intelligence Network (KIN) have also resulted in investigations that have identified commercial premises not included in the ratings list, which have resulted in new business rate liabilities.
44	Fraud awareness	5	0	N/A	Due to staff shortages, there has been no fraud awareness training during the year.

Reactive Investigations work: external investigations

Area	Number of referrals rejected	Number of investigations concluded	Summary of results	Cashable Savings	Non-cashable Savings	Prevented Losses
Blue Badge	1	2	Two cases closed with no evidence of fraud/misuse.	N/A	N/A	N/A
Business Rates (NNDR)	2	14	Seven cases were concluded with the removal discount/exemption or had a new liability created. Seven cases were concluded no evidence of fraud.	£245,842.16 (New Liabilities)	N/A	N/A

Area	Number of referrals rejected	Number of investigations concluded	Summary of results	Cashable Savings	Non-cashable Savings	Prevented Losses
Business Support Grants	15	25	Seven cases concluded with local authority errors identified. 18 cases concluded with no evidence of fraud.	£50,000	N/A	N/A
Concessionary Pass Fraud	0	6	Six cases concluded with no evidence of fraud.	N/A	N/A	N/A
Council Tax	67	531	218 cases were concluded with the removal of the council tax discount/exemption/CTR award, seven of which also resulted in overpayments of housing benefit and one case was also concluded with the recovery of a council property. 308 cases were concluded with no evidence of fraud and five were passed to the DWP for investigation of potential benefit offences.	£178,686.51 (Historic Liability) £110,041.15 (Additional liability for future years) £24,919.44 Housing Benefit overpayments	£93,000	N/A
Homelessness	0	1	One case was concluded with no evidence of fraud.	N/A	N/A	N/A
Housing Allocations	1	4	Two cases concluded with removal from the housing register. Two cases concluded with no evidence of fraud.	N/A	£8,000	N/A
Parking Permits	0	1	Once case concluded with warning letter issued.	N/A	N/A	N/A
Procurement	2	6	Six cases closed with no evidence of fraud.	N/A	N/A	N/A
School Admissions	0	5	Three offers for school places withdrawn as a result of investigations and identified false information. Two cases were concluded with no evidence of fraud.	N/A	N/A	N/A
Tenancy	9	10	Two cases concluded with recovery of the council property. Eight cases concluded with no evidence of fraud.	N/A	£186,000	N/A

Reactive Investigations work: internal investigations (items in italics detailed in previous update reports)

Allegation	Investigation activity

6. Quality Assurance & Improvement Programme

The Standards require that: *The chief audit executive must develop and maintain a quality assurance and improvement programme that covers all aspects of the internal audit activity*. A Quality Assurance & Improvement Programme (QAIP) has been prepared to meet this requirement. The Audit & Counter Fraud Shared Service QAIP for 2021-22 was agreed by Medway's Audit Committee in March 2021.

The arrangements set out in the QAIP have been implemented with the collection and monitoring of performance data largely automated through the team's time recording and quality management processes. It should be noted that the results recorded below have not been subjected to independent data quality verification.

In line with the QAIP, the team monitor performance against a suite of 24 performance indicators. Performance targets have been set for 12 of the 24 indicators and outturns presented are those as of 31 March 2022.

Ref	Indicator	Target	Outturn for report period
Non-LA Specific Performance Measurements			
A&CF1	Cost of the Audit & Counter Fraud Service Total Cost LA Share	N/A	 £546,759 (Budgeted cost £600,574) £348,361 (Budgeted cost £390,907)
A&CF2	Cost per A&CF day	£400	£326
A&CF3	Proportion of staff with relevant professional qualification: Relevant audit qualification Relevant counter fraud qualification	75%	 21% 36%
A&CF4	Proportion of non-qualified staff undertaking professional qualification training	25%	28%
A&CF5	Time spent on CPD/non-professional qualification training, learning & development	70 days	83 days
A&CF6	Compliance with PSIAS	100%	Our January 2019 self- assessment showed full compliance with 94% of the standards, partial compliance with a further 4% and work required to address the remaining 2%. Work to address the areas that require improvement has been delayed due to reallocation of resources during the covid pandemic and a number of periods of staff vacancy.
A&CF7	Staff turnover	N/A	21%
LA Specific Performance Measurements			
A&CF8	Average cost per assurance review	£5,000	£5,040
A&CF9	Proportion of available resources spent on chargeable work	85%	85%
A&CF10	Proportion of chargeable time spent on: assurance work consultancy work	N/A	 62% 0%
A&CF11	Proportion of chargeable time spent on:	N/A	

Ref	Indicator	Target	Outturn for report period
	proactive counter fraud work reactive counter fraud work		12% 26%
A&CF12	Proportion of productive time spent on SPOC associated duties	N/A	55 days
A&CF13	Proportion of agreed assurance assignments: Delivered Underway	95%	 90% 10%
A&CF14	Proportion of completed reviews subject to a second stage (senior management) quality control check in addition to the primary quality control review	10%	13%
A&CF15	Proportion of actions agreed by client management	90%	100%
A&CF16	Number of actions agreed that are: Not yet due Implemented Outstanding	N/A	 13 62 24
A&CF17	Proportion of agreed actions implemented by agreed date	N/A	72%
A&CF18	Number of referrals received	N/A	747
A&CF19	Number of investigations closed	N/A	605
A&CF20	Value of fraud losses identified, by fraud type: Cashable (losses that can be recovered) Non-cashable (notional savings based on national estimates) Prevented losses (savings associated with blocked applications)	N/A	 £611,489 £287,000 £0
A&CF21	Customer satisfaction with individual review/assignment	95%	100% Two responses received in relation to separate reviews, scoring nine out of ten and ten out of ten.
A&CF22	Customer satisfaction with overall service	95%	100% The annual survey asked those who had received services form internal audit in the last two years to rate their satisfaction on a scale of one to ten. Scores of eight or higher are considered to be positive satisfaction. Eight people responded to the annual survey, four of which had received services from internal audit in the last two years, and all four scored nine or higher.
A&CF23	Member satisfaction with assurance provided (based on Chair of Audit Committee contribution to Appraisal of the Head of Audit & Counter Fraud role	Positive	
A&CF24	Statement of external audit	Positive	External Audit report by exception and have raised no issues with the Head of

Ref	Indicator	Target	Outturn for report period
			Internal Audit & Counter Fraud.

7. Follow up of agreed actions

Where the work of the Internal Audit team finds opportunities to strengthen the council's risk management, governance and/or control arrangements, the team make and agree actions for improvement with service managers. The Standards require that a follow-up process is established: *to monitor and ensure that management actions have been effectively implemented or that senior management has accepted the risk of not taking action*. As with all audit work, resources should be prioritised based on risk.

Service managers are asked to provide an update on steps taken towards implementing all agreed actions due on a monthly basis and are also asked to supply evidence to confirm that High priority actions have been implemented, which is verified by the Internal Audit Team.

The first of the two tables below set out the position of all agreed actions which have formed part of the follow-up process during the 2021-22 financial year and provide an update on the progress as of 31 March 2022.

The second table details agreed actions that were more than six months over their planned implementation date as of 31 March 2022 (this includes any that have not been implemented by their revised implementation dates); along with an update from the relevant Service Manager/Assistant Director/Director.

The majority of those outstanding as of 31 March have now been completed and one has been superseded by an action identified in a more recent review. However, there are four requests for revised implementation dates in relation to actions that remain outstanding.

Status of Agreed Actions

Audit & Counter Fraud Review title	Overall opinion and number of actions of each priority agreed with management	Proportion of actions due for implementation where a positive management response has been received
HR Self-Serve	**Opinion: Needs Strengthening** Three actions agreed: one **high**, one **medium** and one **low** priority. Actions relate to electronic approval processes, staff delegations and subsequent notifications of roles and responsibilities.	Three actions due, two implemented. One **high** priority outstanding relating to electronic approval processes.
Fairview Community Primary School	**Opinion: Red** Three **high** priority actions agreed. Actions relate to the nomination of an LA representative for the Governing Body, the Governing Body updating declarations of interest, and the Governing Body working with the council to their leadership structure is in line with governance requirements.	Three actions due, three implemented.
Whistleblowing	**Opinion: Amber** Seven actions agreed: two **high** and five **medium** priority. Actions relate to reviewing the whistleblowing policy, raising awareness of the whistleblowing policy, training of whistleblowing officers, managers, and staff, investigating the introduction of an online reporting form and ensuring there are systems in place for recording and reporting all concerns.	Seven actions due, six implemented. One **medium** priority outstanding relating to ensuring there are systems in place for recording and reporting all concerns.
Write-offs	**Opinion: Amber** Eight actions agreed: Six **high** and two **medium** priority. Actions relate to reviewing and circulating the Corporate Debt Strategy and Policy, putting in place procedure and process documents for all areas to ensure a consistent and timely approach to writing-off debt from the Council financial systems, ensuring records kept of any sub-delegated authority to write off debt, ensuring that exhaustive checks are made in a timely manner before writing-off debts, ensuring there is a segregation of duties and that write-offs are actioned on Integra, and ensuring that Management Teams and Cabinet receive reports on debt recovery performance and debt write-off.	Eight actions due, three implemented. Three **high** and two **medium** priority outstanding relating to reviewing and circulating the Corporate Debt Strategy and Policy, putting in place procedure and process documents for all areas to ensure a consistent and timely approach to writing-off debt from the Council financial systems, ensuring records kept of any sub-delegated authority to write off debt, ensuring that exhaustive checks are made in a timely manner before writing-off debts, ensuring there is a segregation of duties.
Staff Performance Management Framework	**Opinion: Amber** Four actions agreed: Three **high** and one **medium** priority. Actions relate to updating training requirements in the Corporate Induction Programme; ensuring all staff undertake training in relation to the MedPay framework, investigating the PDR recording process available through SelfServe4You and updating PDR guidance to state how PDR documents should be retained for GDPR compliance.	Four actions due, three implemented. One **medium** priority action outstanding relating to investigating the PDR recording process available through SelfServe4You.

Audit & Counter Fraud Review title	Overall opinion and number of actions of each priority agreed with management	Proportion of actions due for implementation where a positive management response has been received
Children in Need - Section 17 Financial Assistance	**Opinion: Red** Two **high** priority actions agreed. Actions relate to the distribution of new policies and procedures and identifying secure payment methods as an alternative to cash.	Two actions due, one implemented. One **high** priority outstanding relating to identifying secure payment methods as an alternative to cash.
Adoption & Fostering Allowances & expenses	**Opinion: Red** Nine actions agreed: Six **high**, two **medium** and one **low** priority. Actions relate to procedure notes being created and issued to all staff with records maintained to confirm staff have received them, records being maintained of all policies issued to staff along with acknowledgement that they have been read and understood, declaration of interest forms being completed by all staff, expense claim forms being reviewed to include signatures and declarations in prominent positions, all claims being accompanied by evidence of expenditure, which is then retained, an episode being created on Frameworki for the authorising officer to confirm any decisions made and approval for all expenses, including verification of receipts, the policy/accepted practice relating to respite care being reviewed to close the loophole identified or claim forms updated to require exact hours of respite to be declared, a requirement for all mileage to be detailed on claim forms, and the Foster Carer agreement being updated to include overpayment recovery details.	Nine actions due, six implemented. Three **high** priority outstanding relating to procedure notes being created and issued to all staff with records maintained to confirm staff have received them, records being maintained of all policies issued to staff along with acknowledgement that they have been read and understood, and an episode being created on Frameworki for the authorising officer to confirm any decisions made and approval for all expenses.
Innovation Centre Medway	**Opinion: Amber** Five actions agreed: One **high** and four **medium** priority. Actions relate to a review of the Innovation Strategy, formalising the application process for tenants ensuring consistency for all applications, the maintenance of records, and the process for debt recovery.	Five actions due, five implemented.
Capital Accounting – HRA	**Opinion: Green** One **low** priority action agreed. Action relates to the inclusion of a link to the latest capital programme schemes monitoring information in the Capital and Revenue Budgets report that is presented to Council for decision making.	One action due, one implemented.
Purchase Ledger	**Opinion: Green** Three actions agreed: One **medium** and two **low** priority. Actions relate to updating links to guidance documents within e-forms; deactivation of suppliers not used for more than 18 months and review of the authorised signatories list to remove past employees and update users with name changes.	Three actions due, three implemented.
Highways - winter service	**Opinion: Green** Three actions agreed: Two **medium** and one **low** priority.	Three actions due, three implemented.

Audit & Counter Fraud Review title	Overall opinion and number of actions of each priority agreed with management	Proportion of actions due for implementation where a positive management response has been received
	Actions relate to ensuring amendments to the plan are recorded, the checking of data provided by the contractor to ensure accuracy and investigating means of ensuring there is financial resilience to deliver statutory duties in the case of severe inclement winter weather.	
Fostering – Virtual Panels	**Opinion: Green** One **medium** priority action agreed. Action relates to approval of the Data Protection Impact Assessment for paperless panel meetings.	One action due, none implemented. One **medium** priority outstanding relating to approval of the Data Protection Impact Assessment for paperless panel meetings.
New Road Primary School	**Opinion: Amber** Ten actions agreed: One **high**, seven **medium** and two **low** priority. Actions relate to declarations of interest for staff, purchase orders being raised for all non-emergency spend, all spending above the Head Teacher's limit being supported by appropriate quotes, approved by the governing body and recorded in the relevant meeting minutes, the School Business Manager being replaced as an authorised signatory, members of staff not authorising their own reimbursements and the governing body having regular oversight of any reimbursements to the Head Teacher, credit card processes being reviewed, regular reporting on the financial outcome of all trips, clear procedures being set up for the charging, collection, and reconciliation of snack money contributions, all assets being recorded on the asset register, including the production of accurate reports, and the annual check of the asset register being carried out by an independent member of staff.	Ten actions due, ten implemented.
Caldicott Guardian	**Opinion: Red** Twelve actions agreed: Ten **high** and two **medium** priority. Actions relate to creating a profile page for the Caldicott Guardian that is available to all, ensuring all council officers are aware of the Caldicott Guardian's roles & responsibilities, appointing a deputy, maintaining records of Caldicott Guardian activities and decisions, ensuring all data sharing agreements & protocols are recorded and their use monitored, being responsible for the DSP toolkit sign off, Completing bespoke training, creating a strategy or action plan, ensuring officers responding to ROI are appropriately trained for the role, ensuring all officers are aware of the Caldicott Principles by having training, signing the required data access agreement, all those accessing personal data having managerial approval, and all officers completing Data Protection Impact Assessments having awareness of the Caldicott Principles.	Twelve actions due, twelve implemented.
Free school transport	**Opinion: Amber** Three actions agreed: Two **medium** and one **low** priority.	Three actions due, three implemented.

Audit & Counter Fraud Review title	Overall opinion and number of actions of each priority agreed with management	Proportion of actions due for implementation where a positive management response has been received
	Actions relate to maintaining accurate records so that duplicate passes are not still active and incurring additional costs and ensuring that passes are cancelled when continued eligibility is not confirmed and updating internal procedure notes.	
Tree Service	**Opinion: Red** Eight actions agreed: Seven **high** and one **medium** priority. Actions relate to updating the Tree Policy, making the Tree Preservation Order Register available on line and giving Medway Norse Tree Officers further access, exploring the reasons for the high level of tree works applications and putting remedies in place, ensuring Medway Norse conform to the s211 notice requirements and that these notices were actioned in the six week time period, ensure Tree Preservation Orders have adequate sign off, that the Senior Tree Officer carries out enforcement action where appropriate, and a review of the trees covered by Tree Preservation Orders.	Eight actions due, six implemented. Two **high** priority outstanding relating to updating the Tree Policy, and a review of the trees covered by Tree Preservation Orders.
Fraud Focused Review of Special Guardianship Orders	**Opinion: Red** Six actions agreed: Four **high**, one **medium** and one **low** priority. Actions relate to a review of the financial assessment form and calculator (including the declaration), supporting evidence for assessments being retained and stored in one place, assessments being authorised by senior officers prior to payment, annual declarations of interest being completed by staff, SGO's being paid two weeks in arrears in line with foster care payments, and procedures being put in place to support recovery of overpaid awards.	Six actions due, two implemented. Three **high** and one **medium** priority outstanding relating to a review of the financial assessment form and calculator (including the declaration), supporting evidence for assessments being retained and stored in one place, SGO's being paid two weeks in arrears in line with foster care payments, and procedures being put in place to support recovery of overpaid awards.
Cyber Security	**Opinion: Green** Two **medium** priority actions agreed. Actions relate to review of the arrangements that are in place to allow staff to confirm that ICT Security policies have been read and to confirm that mandatory ICT Cyber Security training has been completed by staff.	Two actions due, one implemented. One **medium** priority outstanding relating to review of the arrangements that are in place to allow staff to confirm that ICT Security policies have been read.
Disabled Facilities Grants	**Opinion: Amber** Two actions agreed: One **high** and one **low** priority. Actions relate to regular reconciliation checks to ensure that data held in the Uniform System matches the records held on spreadsheets for monitoring purposes, and the draft DFG policy being finalised and going through correct governance processes to be formally adopted and made available for public inspection.	Two actions due, one implemented. One **high** priority outstanding relating to the draft DFG policy being finalised and going through correct governance processes to be formally adopted and made available for public inspection.
Visitor Parking Vouchers	**Opinion: Amber** Three **medium** priority actions agreed.	Three actions due, three implemented.

Audit & Counter Fraud Review title	Overall opinion and number of actions of each priority agreed with management	Proportion of actions due for implementation where a positive management response has been received
	Actions relate to stock control and reconciliation of the vouchers sold and income received.	
Section 17 - No Recourse to Public Funds	**Opinion:** Amber Four actions agreed: One high and three medium priority. Actions relate to the new policy, 'Financial Assistance Section 17 (s17) Children Act 1989', being disseminated to all relevant staff as soon as possible to ensure they are aware of it; the agreement to make s17 NRPF payments being entered onto Mosaic by a senior officer to ensure that an audit trail is maintained; the Financial Assistance Section 17 (s17) Children Act 1989 Policy being updated to include that the Finance Panel is used to monitor the S17 spend and to promote best practices; and, the service working with Finance to review GL coding / budget monitoring arrangements in respect of s17 NRPF payments.	Four actions due, three implemented. One medium priority outstanding relating to the new policy, 'Financial Assistance Section 17 (s17) Children Act 1989', being disseminated to all relevant staff as soon as possible to ensure they are aware of it.
Childrens independent safeguarding & review service	**Opinion:** Amber One medium priority action agreed. Action relates to ensuring that data processing documents are in place relating to GDPR. Note: Action implemented before report finalised.	One action due, one implemented.
Medway Norse – waste & recycling contract	**Opinion:** Amber Four actions agreed: One high, two medium and one low priority. Actions relate to arrangements being made for the Medway Norse Waste Management Contract to be finalised and signed as soon as possible; arrangements being made to ensure that the council receives the Medway Norse Service Delivery Plan as detailed in the contract; arrangements being made to develop a template for monthly contract meetings to ensure all of the points in the contract are discussed; and review of the arrangements for the regular monitoring and reporting against KPIs and PMs to measure service delivery.	Four actions due, three implemented. One high priority outstanding relating to arrangements being made for the Medway Norse Waste Management Contract to be finalised and signed as soon as possible.
Parking enforcement	**Opinion:** Green One high priority action agreed. Action relates to publishing annual parking reports in line with the Local Government Transparency Code.	One action due, one implemented.
Information requests	**Opinion:** Amber Five actions agreed: One high, two medium and two low priority. Actions relate to reviewing information available relating to information requests on the council's website; training / refresher training being provided to request handlers; request handlers being reminded of elements of the agreed process; and more detailed reporting on outstanding responses to information requests.	Five actions due, four implemented. One high priority outstanding relating to training / refresher training being provided to request handlers.
Client financial affairs	**Opinion:** Amber	Five actions due, five implemented.

Audit & Counter Fraud Review title	Overall opinion and number of actions of each priority agreed with management	Proportion of actions due for implementation where a positive management response has been received
	Five actions agreed: Two **high**, two **medium** and one **low** priority. Actions relate to completion of an OPG document stating the duties that have been delegated by the current Corporate Appointee/Deputy; CFA policies and procedures being reviewed and updated; review and recording of mandatory training for CFA staff; review of clients with funds exceeding thresholds for claiming benefits; and, the securities list being dated to reflect the last time it was amended.	
Business Parking Permits	**Opinion Amber** Seven actions agreed: one **high**, five **medium** and one **low** priority. Actions relate to all parking permit charges being reviewed and approved annually; ensuring consistency between online and paper application; all application forms and supporting evidence being retained and filed accurately; a process for ensuring all documents that include personal data are stored for the appropriate retention periods; refunds for card payments being independently checked before being processed; checks being carried out that all payments are processed and receipted; and, regular checks being carried out to ensure all permit payments and refunds are accurately coded on the general ledger.	Four actions due, four implemented.
Looked After Children – Bank Account Provision	**Opinion: Red** Six actions agreed: four **high**, one **medium** and two **low** priority. Actions relate to reviewing and updating procedure notes, regular monitoring of records to ensure all eligible LAC have Child Trust Fund or Junior ISA and keeping a record of correspondence between LAC and The Share Foundation on Mosaic records.	No actions due before 31 March 2022.
Child Protection – Virtual Conferences	**Opinion: Green** One **medium** priority action agreed. Action relates to ensuring that data processing documents are in place relating to GDPR.	No actions due before 31 March 2022.
Accessibility Regulations	**Opinion: Amber** Two **high** priority actions agreed. Actions relate to reviewing processes in place to request an online presence and introducing a compliance process.	No actions due before 31 March 2022.

Actions outstanding more than six months after scheduled implementation date (as of 31 March 2022)

Directorate	Audit & Counter Fraud Review title	Action	Priority	Planned Implementation Date	Management Update
BSD	HR Self Service	Only Director or Assistant Director can approve posts to electronically authorise payment of expenses and irregular claims through self-serve. Providing they have approved a post to authorise payments the current practice requiring an authorised signatory form when new staff move into post is unnecessary. Removing this process will save time spent processing and saving unnecessary paperwork. To ensure the list of approved posts is correct HR should send Directors and Assistant Directors a list of approved posts to review on an annual or bi-annual basis.	High	~~31 August 2017~~ ~~Revised~~ ~~30 June 2020~~ Revised 31 March 2022	This action is superseded by actions identified in a recent review of payroll and will therefore be removed. James Larkin Head of Internal Audit & Counter Fraud
BSD	Whistleblowing	A whistleblowing concern and monitoring form, or similar, should be made available to ensure that all relevant details and timescales are recorded.	Medium	31 January 2021	Although outstanding as of 31 March, this action has now been completed.
BSD	Write Offs	The Corporate Debt Strategy and Policy should be reviewed, circulated, and posted on the council's Intranet site.	Medium	~~30 October 2020~~ Revised 28 February 2022	Although outstanding as of 31 March, this action has now been completed.
BSD	Write Offs	All service areas handling write-offs should have their own procedure documents in place outlining the process followed including timescales.	Medium	~~31 March 2021~~ Revised 28 February 2022	Although outstanding as of 31 March, this action has now been completed.
BSD	Write Offs	Should authorisation limits differ from the Constitution, this should be formally recorded and reviewed when there is a change of staff / role.	High	~~31 March 2021~~ Revised 28 February 2022	Although outstanding as of 31 March, this action has now been completed.
BSD	Write Offs	All areas writing-off debt should run regular reports identifying outstanding debt and should be able to demonstrate that exhaustive checks have been undertaken in a timely manner before writing-off the debt.	High	~~31 March 2021~~ Revised 28 February 2022	Although outstanding as of 31 March, this action has now been completed.
BSD	Write Offs	There should be evidence of a segregation of duties on all write-offs.	High	~~31 March 2021~~ Revised 28 February 2022	Although outstanding as of 31 March, this action has now been completed.

BSD	Staff Performance Management Framework	The PDR recording process available on SelfServe4You should be investigated and line managers should be encouraged to use it so that reports can be run showing that PDRs, 1-to-1s etc. are taking place.	Medium	~~31 July 2020~~ Revised 31 March 2022	Although outstanding as of 31 March, this action has now been completed.
C&A	Children in Need - Section 17 Financial Assistance	Alternative secure methods of payment should be identified with an implementation plan to minimise the need for cash payments.	Medium	~~31 December 2020~~ Revised 31 March 2022	This action is currently ongoing and sits within the Business Change Team. Children's services have been asked to provide specific information to create a template which has been completed. Business Change team are working with the Payment Card provider on the template, the process, the volume of cards required and negotiating a cost for the service. Analysis work shows at least 145 payment cards have been identified as being required for S17 payments. The scale of this work is expected to take a further 3-6 months in order to fully implement the new processes and so an extension to this action is requested until 31 January 2023.
C&A	Adoption & Fostering Allowances & Expenses	Procedure notes relating to adoption and fostering allowances and expenses should be created and issued to all staff and a record maintained to confirm who has received them.	High	~~31 May 2021~~ Revised 31 March 2022	Given the work that was being done on a new fee structure we were too ambitious in the original dates proposed. When the audit was done, the proposed implementation for the new fees was July 2021 but was subsequently delayed to September 2021, hence our timetable was also put back. There were also more changes to Mosaic than originally anticipated which has used more time. As a result of the changes, we have been working on new forms and procedures to match the new fee structure, plus additional changes to make the process more streamlined as payments to carers are often delayed by a cumbersome system. Staff changes have also had an impact. A revised implementation date of

					30 September 2022 is therefore requested.
C&A	Adoption & Fostering Allowances & Expenses	Records should be maintained of all policies issued to staff along with acknowledgement that they have been read and understood.	High	~~31 May 2021~~ Revised 31 March 2022	Given the work that was being done on a new fee structure we were too ambitious in the original dates proposed. When the audit was done, the proposed implementation for the new fees was July 2021 but was subsequently delayed to September 2021, hence our timetable was also put back. There were also more changes to Mosaic than originally anticipated which has used more time. As a result of the changes, we have been working on new forms and procedures to match the new fee structure, plus additional changes to make the process more streamlined as payments to carers are often delayed by a cumbersome system. Staff changes have also had an impact. A revised implementation date of 30 September 2022 is therefore requested.
C&A	Adoption & Fostering Allowances & Expenses	An episode should be created on Framework for the authorising officer to confirm any decisions made and approval for all expenses, including verification of receipts	High	~~31 March 2021~~ Revised 31 March 2022	Given the work that was being done on a new fee structure we were too ambitious in the original dates proposed. When the audit was done, the proposed implementation for the new fees was July 2021 but was subsequently delayed to September 2021, hence our timetable was also put back. There were also more changes to Mosaic than originally anticipated which has used more time. As a result of the changes, we have been working on new forms and procedures to match the new fee structure, plus additional changes to make the process more streamlined as payments to carers are often delayed by a cumbersome system. Staff changes have also had an impact. A revised implementation date of

					30 September 2022 is therefore requested.
C&A	Fostering - Virtual Panels	Prior to using an electronic platform for panel documentation, arrangements should be made for the DPIA to be processed by the Information Governance Team.	Medium	~~28 February 2021~~ Revised 30 November 2021	Work has been completed in full from a CSC point of view. The DPIA is with ICT and despite multiple chasers, no response has been received. The IG team has also stopped reviewing these for the time being due to staff shortages. We continue to chase ICT for the return of this document.
C&A	Fraud Focused Review of Special Guardianship Orders	The financial assessment application form and calculator should be reviewed to ensure they are fit for purpose and meet latest guidance. This review should also include updating the declaration to ensure it includes a warning about the risk of prosecution if incorrect or incomplete information is provided or there is failure to report changes in circumstances.	High	30 September 2021	Although outstanding as of 31 March, this action has now been completed.
C&A	Fraud Focused Review of Special Guardianship Orders	All supporting evidence should be retained and stored in one place to avoid errors in the financial assessment and streamline the process for quality checking.	High	30 September 2021	Although outstanding as of 31 March, this action has now been completed.

8. Update on 2022-23 Planned Internal Audit Work

Ref	Activity	Day budget	Days Used	Current status	Opinion, summary of findings & actions agreed
1	HIF Project Management		N/A	Terms of Reference being prepared	
4	Childrens Commissioning		N/A	Terms of Reference being prepared	
6	Financial Planning & Budget Setting (HRA)	15	N/A	Fieldwork Underway	The review will consider the following Risk Management Objective: **RMO1 - There are arrangements for HRA financial planning & budget setting.**
7	Emergency Planning		N/A	Terms of Reference being prepared	
9	Childrens Services Improvement Plan		N/A	Terms of Reference being prepared	
10	Risk Management Framework	15	N/A	Fieldwork Underway	The review will consider the following Risk Management Objective: **RMO1 - Effective arrangements are in place for risk to be managed in accordance with the council's Risk Strategy.**
11	Housing Allocations	15	N/A	Fieldwork complete, In quality control	The review considered the following Risk Management Objective: **RMO1 - Arrangements are in place to manage housing allocations for social housing.**
12	Service Charges for HRA and Leasehold Properties		N/A	Terms of Reference being prepared	
14	Medway Integrated Community Health Equipment Service (MICES)		N/A	Terms of Reference being prepared	
15	Deprivation of Liberty		N/A	Terms of Reference being prepared	

Ref	Activity	Day budget	Days Used	Current status	Opinion, summary of findings & actions agreed
17	Medway Register Office		N/A	Terms of Reference being prepared	
18	Environmental Enforcement		N/A	Terms of Reference being prepared	
19	Staff Travel & Subsistence		N/A	Terms of Reference being prepared	
20	Planning Enforcement	15	N/A	Fieldwork Underway	The review will consider the following Risk Management Objective: **RMO1 - Measures are in place to ensure Planning Enforcement is carried out appropriately.**
21	VAT		N/A	Terms of Reference being prepared	

Definitions of audit opinions & Action Priorities

Green – Risk management operates effectively, and objectives are being met	Expected controls are in place and effective to ensure risks are well managed and the service objectives are being met. Any errors found are minor or the occurrence of errors is considered to be isolated. Actions agreed are considered to be opportunities to enhance existing arrangements.
Amber – Key risks are being managed to enable the key objectives to be met	Expected key or compensating controls are in place and generally complied with ensuring significant risks are adequately managed and the service area meets its key objectives. Instances of failure to comply with controls or errors / omissions have been identified. Improvements to the control process or compliance with controls have been identified and actions have been agreed to improve this.
Red – Risk management arrangements require improvement to ensure objectives can be met	The overall control process is weak with one or more expected key control(s) or compensating control(s) absent or there is evidence of significant non-compliance. Risk management is not considered to be effective and the service risks failing to meet its objectives, significant loss/error, fraud/impropriety, or damage to reputation. Actions have been agreed to introduce new controls, improve compliance with existing controls or improve the efficiency of operations.

High	The findings indicate a fundamental weakness in control that leaves the council exposed to significant risk. The recommended action addresses the weakness identified; to mitigate the risk exposure and enable the achievement of key objectives. Management should address the action as a matter of urgency.
Medium	The findings indicate a weakness in control, or lack of compliance with existing controls, that leaves the system open to risk, although it is not critical to the achievement of objectives. Management should address the action within a reasonable timeframe.
Low	The findings have identified an opportunity to enhance the efficiency or effectiveness of the system/control environment. Management should address the action as resources allow.