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

Internal Audit Annual Report 2023-24

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 Chartered Institute of Internal Auditors (CIIA) 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.

In accordance with the Public Sector Internal Audit Standards (the Standards), the Head of Audit & Counter Fraud provides Members with update reports detailing the work and findings of the internal audit 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 Internal Audit Charter was approved by Medway's Audit Committee in January 2023 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 internal audit team had an establishment of nine officers (8.43FTE), made up of the Head of Internal Audit & Counter Fraud (0.65FTE), one Internal Audit Manager, one Principal Internal Auditor, five Internal Auditors (4.78FTE) and one Internal Audit Apprentice.

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 Plans for 2023-24 were prepared, this establishment was forecasted to provide a total of 1,112 days available for internal audit work (net of allowances for leave, training, management, administration etc.). The Internal Audit Plans for Medway were prepared with a resource budget of 712 days, plus an additional 79 days of internal audit management time.

During the year one Internal Auditor reduced their working hours, those undertaking apprenticeships had to spend more time on professional qualification training than was accounted for when estimating the

resource budget at the beginning of the year and administrative time associated with the Medpay review project also impacted on the level of resource.

As of 31 March 2024, the net staff days available for Medway for 2023-24 amounted to 645.8 days and equates to 91% of estimated audit resources (712 days) delivered. An additional 69.6 days were spent on review of internal audit work by the Internal Audit Manager. Of this overall time, 614.5 days (95%) was spent on audit assurance work and 31.3 days (5%) was spent on consultancy 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 (including apprenticeships), formal skills training, job-shadowing/mentoring and 'on the job' training. Team meetings have taken place throughout the year, 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 Internal Audit Charter and the specific scope of work for the year 2023-24 was detailed in the Internal Audit Plans, which were approved by the Finance & Audit Committee. The Plans 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. The opinion that follows is based on all work completed since the last annual opinion was delivered, including overrunning reviews from 2022-23 and work outlined in the 2023-24 Plans.

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 following:

- The outcomes of work completed by the Internal Audit team since the last annual opinion,
- The findings of previous years' internal audit work carried out,
- The risk management processes of the council,
- The monitoring of progress to implement agreed actions identified in earlier reviews to ensure that control weaknesses identified by the Internal Audit team have been mitigated,
- The outcomes of consultancy work completed by the Internal Audit team, and
- The outcomes of counter fraud and investigation work completed by the Counter Fraud team.

There were no matters identified through the counter fraud work carried out which have a material impact upon the corporate governance, risk, and internal control framework of the council. 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. The Internal Audit team can only provide reasonable and not complete assurance of effectiveness. The work completed as part of the Internal Audit Plans for 2023-24, and reviews overrunning from the 2022-23, 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.

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 September 2023, 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 2023-24

Corporate Governance

Corporate Governance is defined as being the structure of rules, practices, and processes.
that direct and control the Council. The reviews of Procurement Compliance and Risk Management Framework undertaken in 2022-23, however the planned review of Code of conduct could not take place during 2023-24. As such we can only place limited assurance in relation to corporate governance, although this is caveated with the fact that there has been nothing to indicate that the council has failed to comply with corporate governance guidance.

Risk Management

The council has a risk management strategy that is approved by Cabinet and maintains a corporate risk register that is regularly reviewed. A review of risk management compliance was conducted in 2022-23, resulting in an Amber opinion and the one action arising has been completed.
I am satisfied that we can place adequate assurance on the council's risk management arrangements for 2023-24.

Internal control

Fieldwork was completed in relation to 24 assurance reviews during 2023-24, 17 of which have been finalised with client services, along with a further nine reviews from 2022-23 that were finalised in 2023-24 after the last annual opinion was delivered. Of these finalised reviews, 22 resulted in Amber or Green opinions, indicating that all key risks were being managed effectively.
Where actions for improvement were agreed, these were subject to a follow up process to ensure that they had been implemented appropriately. This follow up process identified that 80.8% of all actions due to be implemented in 2023-24 (80 of 99 actions) have been completed.
I am satisfied that the we can place adequate assurance on the aspects of the system of internal control tested and in operation during 2023-24.

Overall Opinion

It is my opinion that during the year ended 31 March 2024, Medway Council's framework of governance, risk management, and system of internal control, were adequate, 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 Internal Audit work

The six-monthly Internal Audit Plans for 2023-24 for Medway were approved by the Audit Committee in March 2023 and September 2023. The Plans were intended to provide a clear picture of how the council would use the Internal Audit resources, reflecting all work planned for the team for Medway during the financial year in the highest areas of risk to the council.

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-plans 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 factors that were unknown at the time the plan was agreed, including pressures in client services and changes in the level of internal audit resource available. Members agreed revisions to the original plans for 2023-24 to remove planned reviews of:

- Code of Conduct,
- Facilities Management,
- Therapeutic Outreach And Support Service.

The tables below provide details of the work from 2022-23 that was finalised in 2023-24, since the 2022-23 annual report was presented to the Committee, and the progress of work undertaken as part of the 2023-24 plans.

2022-23 Internal Audit Assurance work finalised in 2023-24 (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
3	*Adult Social Care – Residential Care Placements*	*15*	*18.1*	*Final report issued*	*The review considered the following risk management objective:* ***RMO1 - Arrangements exist to establish residential care and supported living placements.*** *The review found there is a Medway Council Adult Care Strategy 2021-2025 in place with information available on the Medway Council Website. An assessment is required to be completed by a Social Worker for anyone seeking residential care or supported living, and testing confirmed that all placements in the sample had an assessment completed. There are processes in place to obtain a cost breakdown from Providers, agreement to be obtained via Panel, purchase orders to be raised and contracts to be issued to the provider, which should be signed and returned. Audit testing identified that 39 contracts were missing from the 186 active cases. Since the audit was undertaken a member of staff has been chasing outstanding contracts. A financial assessment is required to decide whether the client will need to pay a contribution to their care costs and testing identified that some cases did not have a Financial Referral and Financial Assessment completed. Audit testing of clients that had Third Party Top-Up in 2022, also identified that a number of cases did not have all the required documentation within Mosaic. Under the Deferred Payments Scheme, a client may be able to use the value of a property to pay for their care and support costs, and in such cases, a 12-week disregard may be applied. Audit testing confirmed that this was dealt with correctly in eight of the nine cases identified. Under the Care Act 2014, Section 27, a local authority must review the care plan. These reviews should take place after 28 days and then annually. Audit testing identified that a large number had not been reviewed within the initial 28 days and no cases in the sample had an annual review recorded in Mosaic. Audit testing confirmed that both Supported Living and Older People had the service ended appropriately when placements ended.* ***Opinion: Amber. Overall Opinion: Amber. Actions: Four high and one medium priority. Actions relate to ensuring that staff are reminded about the return of sign provider contracts, ensuring that all clients receive a financial assessment, ensuring that all documents are completed and uploaded for Third Party Top-Up and Medway Top-Up, arrangements being put in place to ensure that 12-week disregards are followed up and recorded within the agreed timeframe,***

Ref	Activity	Number of Days allocated	Number of Days Used	Current status	Opinion, summary of findings & actions agreed
					arrangements being put in place to ensure that placement reviews are completed within required timescales.
15	*Deprivation of Liberty*	*20*	*27.6*	*Final report issued*	*The review considered the following risk management objective:* ***RMO1 - Arrangements are in place to ensure Deprivation of Liberty Safeguards (DoLS) for adults living in the community is managed in accordance with legislation.*** *The review found training for social workers in the DOLS in the community procedure is available from both i-share and the Adult Social Care (ASC) Lawyer involved in the application process to the Court of Protection (COP). However, due to the high turnover in social workers, there is a continual need for training that is not always available via i-share due to the number of attendees that are needed to make running courses feasible.* *Under Article 5, of the European Convention on Human Rights (ECHR), the council is legally obliged to assess anyone who lacks the capacity to give consent to whatever arrangements are in place for them and it is the responsibility of the council to identify clients who may be in need of DOLS authorisation in the community and then raise an application that is passed to the ASC Lawyers for review and onward submission to the COP.* *Currently there is no way of tracking the Community DOLS process on the social care system Mosaic and details are only retained within case notes which are not reviewed unless an assessment / review is undertaken. This can lead to the procedure not progressing as it should, and annual renewals not being processed. It is also not possible to identify clients in the community who have DOLS authorisation in place which has led to limitations on audit assurance due to the inability to identify cases for audit testing purposes.* *Relevant teams update a weekly spreadsheet with the number of DOLS in the community applications that are waiting to be processed and this information is provided to the Head of Service (ASC).* ***Opinion: Red.*** ***Overall Opinion: Red. Actions: Two high and four medium priority.*** ***Actions relate to exploring training options available in relation to both identifying and processing Community DOLS and identifying social care staff that should attend the training; the potential for adding relevant questions connected to Community DOLS to review / assessment forms; creating workflows within Mosaic relating to the Community DOLS process, with an***

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					interim process put in place for renewal reminders, and the number of renewals waiting to be processed included in reporting figures.
19	*Staff Travel & Subsistence*	*16*	*18.6*	*Final report issued*	*The review considered the following risk management objectives:* ***RMO1 - There are policies and procedures in place for the reimbursement of staff travel and subsistence claims.*** *The review found that there are policies and procedures in place and available to employees, though these have not been reviewed for some time. In addition, with information available in different locations there is some differing, unclear, and incomplete information about what can be claimed and at what rate. Employees making travel & expenses claims are made aware of their roles and responsibilities when making claims, however there is no information provided to authorising managers about their roles and responsibilities when authorising these claims.* ***Opinion: Amber.*** ***RMO2 - There are procedures in place to verify, process and pay staff travel and subsistence claims.*** *The review found there are procedures in place to make reimbursements for travel and expenses, at the correct rate, and a process is in place to report the VAT element of mileage claims. There are also procedures in place for all travel & expenses claims to be authorised and for the Payroll Team to process authorised claims in a timely manner. However, a combination of non-mandatory system requirements relating to descriptions and the attachment of receipts, and a lack of training / guidance, mean that not all claims may be receiving the appropriate scrutiny to confirm accuracy and legitimacy.* ***Opinion: Red.*** ***Overall Opinion: Red. Actions: One high and one low priority.*** ***Actions relate to reviewing policies / guidance, updating information presented and training provided to authorising managers around their roles and responsibilities, reviewing mileage and expense claim forms to ensure appropriate mandatory information is captured and reviewing historic VAT reports.***
24	*HMO Licensing*	*15*	*19.7*	*Final report issued*	*The review considered the following risk management objective:* ***RMO1 - Arrangements are in place to ensure Houses of Multiple Occupation (HMOs) are licensed and enforcement action is undertaken where appropriate.*** *The review found that the service has a Housing Enforcement & Licensing Policy in place, though at the time of audit the policy still included fees and charges for 2019-20. Currently, HMO licence applications are made using a form that can be*

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					downloaded from the council's website, with applications processed once the appropriate supporting documentation and payment has been received. At the time of audit, the service was working through a backlog of applications. There is a requirement for a register of all licenced HMOs to be made available to the public and this is provided on the council's website, though audit testing identified significant differences between the public and master copies of the register. It was noted that the service is in the early stages of procuring a new system which will radically change the way the team works, including digitalising the processing of HMO licence applications and greater identification of unlicenced HMOs. Unlicenced HMOs, breaches of licence conditions or issues with the standard of HMOs can be notified by the public or by other internal teams and services. Arrangements exist for cases to be triaged and then investigated, where appropriate, with a number of enforcement tools available, with each case dealt with on a case-by-case basis. ***Opinion: Green.*** ***Overall Opinion: Green. Actions: One medium and one low priority. Actions relate to setting a review date for amending fees and charges in the Housing Enforcement and Licensing Policy, and making arrangements for the public HMO register to be updated and maintained regularly.***
25	*Legal Case Management*	*15*	*18.6*	*Final report issued*	*The review considered the following risk management objective:* ***RMO1 - There are appropriate arrangements in place to monitor the case management process for legal work.*** *The review found that there is a Legal Services Office Manual, however this requires reviewing and updating. There are arrangements in place for legal instructions to be received, reviewed, and allocated, with slightly different processes for People and Place instructions. Case files are opened on the case management system where necessary, with ongoing work to improve file structures. Client Care Memos are sent for all Place files, though testing identified several omissions. Arrangements exist for a risk level to be assigned for all cases, though testing identified several files where the risk level was not recorded. For high-risk cases and additional form must be completed and approved, and audit testing confirmed that these forms are being completed in practice. Fee Earners time code work that is completed, which enables workloads to be monitored via monthly Management Information Reports; file reviews are also completed. This also enables charges to be calculated for specific case types, which are not recharged via Service Level Agreements. Audit testing confirmed that such cases*

Ref	Activity	Number of Days allocated	Number of Days Used	Current status	Opinion, summary of findings & actions agreed
					are charged correctly. Arrangements exist for dormant files to be monitored and files closed where appropriate, though testing identified that not all cases are closed fully on the system in a timely manner. ***Opinion: Amber.*** ***Overall Opinion: Amber. Actions: Two medium and one low priority. Actions relate to reviewing and updating the Office Manual, ensuring that all files follow the appropriate file structure, ensuring Client Care Memos are sent to all relevant clients, ensuring the risk level is recorded on all files, and ensuring that files are fully closed in a timely manner.***
27	*Extra Care*	*15*	*17*	*Final report issued*	*The review considered the following risk management objective:* ***RMO1 - An effective commissioning process is in place in respect of Extra Care provision.*** *It was identified that the contract for the Support to Live at Home Service, which covers both Homecare and Extra Care was last commissioned in 2019 and the service were in the process of commencing a new tendering exercise. During the review it was found that the 2019 procurement followed all correct processes, and a framework of providers has been established for mini competition in the event that contracts need to be awarded for new sites. The service has clear visions and objectives, but these are not documented in any service plan, but as new contracts are procured it would be beneficial to capture these formally and measure progress. As part of the tender process, the service has been engaging with residents to seek views as well as using KPI data to inform tender specifications and establish KPI's for any new contracts. It was identified during the review that some of the actions were not SMART, and this was immediately addressed by the service with a further review of the KPI's. The specification document issued during the course of the review was found to have nothing relating to emergency planning or business continuity, but lessons learnt from the pandemic identified potential risks to the council if providers are not prepared. The Quality Assurance team are now obtaining business continuity plans from all prospective providers as part of the process.* ***Opinion: Green.*** ***Overall Opinion: Green. Actions: None.***
29	*Petty Cash*	*15*	*18.9*	*Final report issued*	*The review considered the following risk management objective:* ***RMO1 - Arrangements exist for petty cash accounts to be operated in line with the Councils Financial Procedure Rules.***

Ref	Activity	Number of Days allocated	Number of Days Used	Current status	Opinion, summary of findings & actions agreed
					The review found that what would traditionally be known as petty cash claims have been replaced by staff reimbursements which are paid straight into employee's bank accounts, therefore cash advances are now the only type of request processed via the main 'petty cash' tin. The main 'petty cash' tin is securely stored, though several opportunities were identified for security to be enhanced. Information / guidance regarding staff reimbursements and cash advances is available to all staff, along with the relevant forms, but would benefit from review. Arrangements exist for cash advances to be paid only when accompanied by a completed and appropriately approved request form, however staff are responsible for how the cash is spent. Receipts evidencing expenditure as well as any unspent cash must be returned within 28 days, with arrangements for these to be chased, though audit testing identified several missing receipts. There are appropriate records of all cash entering and leaving the main 'petty cash' tin and arrangements exist for the tin to be reconciled, though this process would be improved through greater segregation of duties. Arrangements exist to administer replenishment of petty cash accounts held by other council services. ***Opinion: Amber.*** ***Overall Opinion: Amber. Actions: One high priority.*** ***Action relates to reviewing use of petty cash and if to remain, ensuring its security, updating staff guidance and the cash advance form, and reviewing procedures for chasing receipts and reconciling the petty cash tin.***
31	*Highways - Maintenance & Repair*	*15*	*16.8*	*Final report issued*	*The review considered the following risk management objective:* ***RMO1 - There are processes in place to ensure that highways maintenance and repairs are being delivered in accordance with the contract and the contract is giving the value for money.*** *The review found that clear roles and responsibilities between the council and the contractor, Volker Highways, are defined in the Highways Infrastructure Contract (HIC).* *Arrangements are in place for the council to liaise with Volker Highways to monitor the delivery of services and we were able to see that regular meetings take place between the council and the contractor, discussing all areas of the contract. However, the Highways Key Meetings Terms of Reference was found to be out of date.* *Contractual spend and the overall budget is closely monitored, with invoices submitted by the contractor scrutinised and duly authorised before payment.*

Ref	Activity	Number of Days allocated	Number of Days Used	Current status	Opinion, summary of findings & actions agreed
					There are KPIs in place, which are used for service monitoring and extension of the contract. It was found that there were discrepancies in the scoring used for contract extensions and those listed in the contract. *Procedures are in place to report, escalate and resolve any problems with the service.* ***Opinion: Amber.*** ***Overall Opinion: Amber. Actions: One high and one medium priority.*** ***Actions relate to the Terms of Reference for key meetings being reviewed and updated, and KPIs being reviewed, agreed, and scoring amended where necessary.***
36	*Attendance Advisory Service to Schools & Academies*	*15*	*21.2*	*Final report issued*	*The review considered the following risk management objectives:* ***RMO1 - Arrangements exist to manage the Attendance Advisory Service to Schools and Academies (AASSA).*** *The review found that information regarding both school attendance and the AASSA can be found on the council's website, and information regarding the AASSA is also available on the Education Services Medway website and in an AASSA Service Description document. Schools and academies can purchase AASSA services through the Education Services Medway website, with full buy-in and non-buy back options available. Service Level Agreements (SLA) detail the services to be provided by the AASSA. Schools and academies that purchase the full buy-in service are allocated an Attendance Advisory Practitioner (AAP) who will provide tailored support and advice based on the school or academy's requirements and in line with the SLA. The hours that AAPs spend supporting a school or academy are logged and monitored in a timesheet against those purchased. Termly audits are completed to ensure all information is up to date and accurate. Overall school and academy attendance is monitored through the work of the AAPs. In addition, all schools and academies in Medway are written to three times a year, following census releases, detailing their attendance levels compared to national levels.* ***Opinion: Green.*** ***RMO2 - Arrangements exist to manage and address pupil non-attendance.*** *The review found that there is an AASSA Code of Practice which provides procedure guides and templates for schools and academies to use when managing absence. Schools and academies are responsible for making referrals to the AASSA if they have a concern about a pupil's attendance, with a template in place for this purpose. Arrangements exist for referrals to be logged, and for cases to be progressed on a case-by-case basis depending on the individual circumstances,*

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					with consideration given to the issuing of a Penalty Notice (PN) as an alternative to a full case (and potential prosecution) in appropriate instances where a pupil has had 10 or more sessions of unauthorised absence during a six-week period. Schools and academies are also responsible for making referrals to the AASSA where a pupil has had at least 10 sessions (five days) of unauthorised absence for holiday, in order for a PN to be issued, with a similar referral process in place. Where the issue of a PN is considered appropriate, arrangements exist for a PN to be issued to each parent. PNs issued are recorded and monitored within a PN spreadsheet, with each PN allocated a unique, consecutive number. Procedures are in place for payments to be made and recorded against the relevant PN, however the use of an online payment system is being explored with a view to increasing the efficiency and accuracy of allocating payments. If payments are not received within 28 days, arrangements exist for final warning letters to be issued and cases passed for prosecution where appropriate. Final warning letters are not required by statutory guidance but have been introduced to reduce the number of cases proceeding to prosecution. ***Opinion: Green.*** ***Overall Opinion: Green. Actions: None.***

2023-24 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
1	Complex Health Funding Panel (formerly Joint Access Panel)	17	15.5	Final report issued	The review considered the following risk management objectives: **RMO1 – There are effective arrangements in place to assess requests for complex health funding for children & young people.** The review found that the Complex Health Funding Panel (CHFP) has an agreed terms of reference, however it would benefit from some minor amendments to ensure clarity. There is guidance available about the CHFP and referral process, with further training planned. There are arrangements in place for referrals to be made to the panel and for all referrals to be reviewed / screened before presentation at monthly panel meetings. There are also arrangements in place to minute and retain details of the outcome of all decisions made by the panel, with outcomes reported back to the referrer and other relevant professionals. The outcome and copies of emails and other correspondence are also uploaded to the young person's Mosaic record, but testing identified additional detail could be included of the agreed funding. Processes are in place to review ongoing agreements for funding and to resolve any disputes. **Opinion: Green.** **RMO2 – There are arrangements in place to ensure all health funding agreed by the panel is recovered from the Integrated Care Board (ICB) where applicable.** The review found there are arrangements in place to ensure accurate records are kept of the agreed funding, as well as arrangements to raise the appropriate invoices. Several isolated calculation errors were identified through testing and reported to the team to be corrected. A new process was introduced during the course of the audit to monitor the receipt of income from the ICB. **Opinion: Green.** **Overall Opinion: Green. Actions: Three low priority.** **Actions relate to reviewing the CHFP terms of reference, preparing procedure notes, and ensuring Mosaic records are updated.**
2	*Management of Casual Staff*	*15*	*23*	*Final report issued*	*The review considered the following risk management objective:* ***RMO1 - There are arrangements in place manage & monitor the use of casual staff within Culture & Libraries.*** *The review found varying standards of record keeping across the four services reviewed, which meant that overall, it was not possible to give assurance that hours worked by casual staff and the associated payments are always accurate, or that appropriate training has been completed. There was also no documented guidance in some services to indicate how the required level of staffing for events*

Ref	Activity	Number of Days Allocated	Number of Days Used	Current status	Opinion, summary of findings & actions agreed
					was calculated in order to comply with minimum requirements for health and safety. *Within the Festivals & Events team it was identified that traffic management records for events are being stored externally, including personal data of casual employees, and therefore were not easily accessible for review and also not compliant with General Data Protection Regulations requirements.* ***Opinion: Red.*** ***Overall Opinion: Red. Actions: Three high and three medium priority.*** ***Actions relate to more accurate record keeping and ensuring all council data is held securely.***
3	*Children's Imprest Accounts*	*15*	*14.6*	*Final report issued*	*The review considered the following risk management objective:* ***RMO1 - The use and management of the imprest account is in accordance with the council's guidelines.*** *The review found there was guidance in place relating to the use of the imprest account; however, more clarity is required in relation to the financial limits of the account and the officers who can authorise transactions.* *The imprest account is primarily available for use to enable officers to reimburse or make payments of financial assistance to children in need of support to safeguard and promote their welfare; however, the audit testing identified significant volumes of transactions related to direct council expenditure and large volumes approved by officers without delegated authority.* *The processing of transactions is completed in a timely manner; however, evidence of the transaction was not always available to be reviewed on the young person's electronic file, as it was not being supplied to the administration team for scanning or not being recorded by the officer directly.* *The testing suggests that not all officers are following the guidance and that all officers that have dealings with the imprest account would benefit from more robust training.* *The imprest account is regularly replenished. Actions have been identified to improve security around this process.* ***Opinion: Red.*** ***Overall Opinion: Red. Actions: Three high and one medium priority.*** ***Actions relate to more robust guidance and training being made available to officers, ensuring appropriate delegated financial authority is in place, and ensuring better security of cash being transferred to the office.***
4	Brokerage Services	15	24.5	Final report issued	The review considered the following risk management objective:

Ref	Activity	Number of Days Allocated	Number of Days Used	Current status	Opinion, summary of findings & actions agreed
					RMO1 –The brokerage of adult social care services is appropriately managed and monitored. The review found there are up to date policies and procedures in place that are in line with legislative requirements. A training package is used for new staff, ensuring all aspects of the service are covered and is updated regularly. Arrangements are in place for referrals for services to be made to the Brokerage Team with all requests being duly authorised before the referral is actioned. Regular conversations take place between the Brokerage Team and Social Workers about required services and a detailed summary of actions taken is recorded Mosaic. Some information is also recorded in a Brokerage Teams channel, which does not comply with GDPR requirements. There are no mandatory timescales involved in brokering services, although there is an internal five-day turnaround target. Due to staff shortages and capacity within the market, they have not been able to continually meet this target. The Brokerage Team have very experienced officers who will challenge providers to get the best value for money possible to meet the clients' needs and details of savings made are recorded. The Mosaic system links to the council's payment systems and is used for both payment and budget monitoring purposes. Testing confirmed that the amounts entered for services were correct. Due to staff shortages in social work teams, the Transition and Review Team are currently conducting the reviews of client services to ensure that the care provided is still appropriate, and are targeting some of the bigger spends, such as 1-1 support and complex care cases. **Opinion: Green.** **Overall Opinion: Green. Actions: One high priority.** **Action relates to ensuring that all client information held in Teams is compliant with GDPR regulations for anonymisation and retention.**
5	*Code of Conduct*	*N/A*	*N/A*	*Removed from plan*	*The HROC service were reviewing and updating a number of key policies alongside the Medpay review and it was therefore determined that it was not an appropriate time for the assurance review to be conducted as changes in policy would also lead to changes in controls.*
6	*Asset management*	*15*	*18.7*	*Final report issued*	*The review considered the following risk management objective:* ***RMO1 - Arrangements are in place to manage and account for the council's land and property assets.***

Ref	Activity	Number of Days Allocated	Number of Days Used	Current status	Opinion, summary of findings & actions agreed
					The review found that work has started on a new Corporate Property Strategy, with high level information regarding the council's strategy included within the Capital Strategy 2024-25. *The service has an effective method of recording land and property assets, including those purchased or disposed of. Regular reconciliations are undertaken to an asset register maintained by Finance. Details of the directorate and service responsible for each asset are held and it is they who are responsible for the overall management of that asset. A process is in place to identify, on an annual basis, the land and property assets to be valued each year.* ***Opinion: Green.*** ***Overall Opinion: Green. Actions: One low priority.*** ***Action relates to ensuring data relating to land and building assets held by the council is published in line with transparency requirements.***
7	*Information requests (FOI, SAR, EIR)*	*15*	*18.3*	*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 there is information about information requests on the council's website, which includes a link to an online request form, though information regarding timescales requires updating.* *Guidance documents are in place, although some need finalising and all documents need to be made available to officers. Likewise, training is available, but a survey indicated it may be beneficial for officers to be reminded of its availability.* *Since October 2022, all Freedom of Information (FOI) / Environmental Information Regulation (EIR) requests made online have been automatically recorded on JADU, which provides a workflow for assigning and managing cases and authorising responses, as well as automating a number of tasks, including reminders. Audit testing confirmed that FOI/EIR requests are processed appropriately and responded to within statutory deadlines in the majority of cases, though a need to review procedures for contacting requesters when requests are overdue and recording the reason for any delay, was identified.* *Although Subject Access Requests (SARs) can be made using the online form on the council's website, currently the details must be manually entered onto the Legal Case Management system to enable performance reporting on timescales, with cases managed individually by services outside of the system. Although templates for SARs can be provided by the IG team, they are not readily available to officers.*

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					Performance reports indicate that the proportion of SARs responded to within the statutory deadline is significantly below the 90% target set by the Information Commissioners Office (ICO), though at the time of writing, we were advised that this has been increasing. An Improvement Plan has been put in place, which includes plans for a similar process to that used for FOI/EIR requests to be created on JADU. *Arrangements exist for regular reporting on information request performance, though this includes limited information and analysis about why information requests are overdue which would enable senior management to take appropriate action.* ***Opinion: Amber.*** ***Overall Opinion: Amber. Actions: One high, two medium, and six low priority. Actions relate to updating information request timescales on the council's website; finalising and publishing guidance documents; putting arrangements in place for evidence to be recorded when EAs/PAs are requested to authorise responses on the system on behalf of authorising officers; reviewing the FOI/EIR templates available to officers and making SAR templates available; reviewing procedures for requesters to be contacted when requests are overdue and recording the reason so this can be used in reporting to senior management; escalating the proposed move to managing SARs on JADU; reminding officers of the training courses available; and, reviewing arrangements for reporting information request performance.***
8	*Parking Permits - Residential*	*15*	*14.9*	*Final report issued*	*The review considered the following risk management objective:* ***RMO1 - Arrangements are in place to identify and mitigate risks associated with the administration of the resident parking permit scheme.*** *The review found that comprehensive information about resident parking permits can be found on the council's website, with both online and paper application forms available, and details provided in relation to the supporting documents required. There are a number of procedure documents available to support the processing of resident parking permit applications, with processes in place for eligibility to be checked, payments processed, and permits issued, which were confirmed to be working efficiently through audit testing. There is also appropriate oversight of application processing, including monitoring against an internal target to process applications within ten days of payment and a monthly audit to verify that a sample of ten randomly chosen resident parking permit applications have been processed correctly. In addition, a monthly report is run to monitor permits*

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					issued and income received, however there is currently no check on Integra to ensure income has been coded to the correct cost centre, with audit testing identifying some evidence of miscoding. Arrangements exist for data to be held in accordance with the Data Protection Act, though the relevant procedure document does not include the process for destroying paper files and / or removing data from systems that has exceeded the retention date. Renewals are appropriately managed, with a reminder email sent to applicants who have previously applied online, as well as renewal reminder letters being produced. It was noted that the letter does not identify the type of proof of address that is acceptable, and audit testing identified an instance in which invalid proof of address had been accepted as part of a renewal. ***Opinion: Amber.*** ***Overall Opinion: Amber. Actions: One high and five low priority.*** ***Actions relate to updating the postal application form and renewal reminder letter; reminding officers to only accept valid proof of address; undertaking a monthly income check on parking permit GL codes within Integra; and, producing a procedure document relating to the destruction of paperwork / system data.***
9	*Surveillance (RIPA)*	*15*	*12.5*	*Final report issued*	*The review considered the following risk management objective:* ***RMO1 - There are appropriate arrangements in place to ensure the council is compliant with RIPA.*** *The review found there is a Covert Surveillance Policy in place which was approved by Cabinet on 18 October 2022, however this has yet to be circulated to investigating and authorising officers. Supporting application, review, renewal, and cancellation forms are included as appendices within the policy but are not readily available as editable documents that staff can complete. There are five officers identified within the Covert Surveillance Policy as being able to issue authorisations for directed surveillance under RIPA, and 'RIPA Authorising Officer & Management Training' was completed by all five of these officers in June 2023. Four RIPA awareness training sessions were also run in 2023 and were attended by 44 investigating officers. The procedures for applying for, reviewing, renewing, and cancelling directed surveillance authorisation, and the availability of support and legal advice, are clearly set out within the Covert Surveillance Policy, and a paper-log of authorisations and accompanying paperwork is maintained by the Legal Team. We were advised that quarterly calendar reminders have been set by the Assistant Director – Legal & Governance, to review any authorisations and ensure*

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					the log is updated, and it is understood that there are intentions to report use of RIPA powers to council Members, however this has not yet taken place as there have been no recent authorisations. ***Opinion: Amber.*** ***Overall Opinion: Amber. Actions: One high and two low priority.*** ***Actions relate to the Covert Surveillance Policy and editable versions of the forms provided as appendices being circulated / made available to staff, and ensuring records of directed surveillance authorisations are held securely and are centrally retrievable.***
10	Caldicott Guardian	15	15.7	Final report issued	The review considered the following risk management objectives: **RMO1 – The council is compliant with its mandatory obligation to appoint a Caldicott Guardian and the Caldicott Guardian's responsibilities are met.** The review found there are arrangements in place for the Caldicott Guardian's details to be kept up to date on the Caldicott Guardian Register. There is also information available to all employees, Members, and the public on the Caldicott Guardian's identity, including suitable contact details, although the name of the Caldicott Guardian requires updating in the Data Protection Policy. There is Caldicott Principles training available to staff, however the training requires updating and information regarding the requirement to complete the training is inconsistent. In 2023, 21 members of staff completed the Caldicott Principles training. There is an appropriate Caldicott Plan in place, which is updated annually. The Caldicott Guardian has appointed deputies, who are detailed in the Caldicott Plan, although due to the availability of some of the deputies to attend Caldicott Guardian training in February 2024, the training was attended by some other senior management representatives instead, who will act as deputies in the meantime, should the need arise. The Caldicott Guardian and Senior Information Risk Officer (SIRO) are both members of CMT, and it was advised that any urgent matters would be addressed as necessary. The Caldicott Guardian and SIRO are both chairs of the Security and Information Governance Group, and the Information Governance Manager is also a member. Previously, there were monthly meetings held between the Caldicott Guardian, SIRO and Information Governance Manager, however it was found that this level of frequency was not required, although it was agreed that regular, documented meetings between the postholders would be of benefit. There is an appropriate register of all Caldicott Guardian decisions with arrangements in place to ensure that it is updated when

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					required. There is also a Caldicott Guardian Data Sharing Agreement Register, although this does not appear to have been updated since its initial creation. The Caldicott Guardian has sight of and signs off the Data Security Protection Toolkit annually. **Opinion: Green.** **RMO2 – Arrangements are in place to ensure compliance with the Caldicott Principles.** The review found there are appropriate policies / procedures in place to ensure officers can confidently share information in the best interest of service users. There are arrangements in place to ensure that access to confidential information is appropriately restricted, with audit testing confirming that training is undertaken, and Data Access Agreements are completed when system access is granted. There are also arrangements in place to ensure every proposed use or transfer of confidential information is justified, necessary and only includes essential information. **Opinion: Green.** **Overall Opinion: Green. Actions: One high and five low priority.** **Actions relate to updating the Caldicott Guardian details in the Data Protection Policy; reviewing the Caldicott Principles training; updating the information available on the staff intranet; ensuring consistent job descriptions are held for the Caldicott Guardian deputies; reinstating regular meetings between the Caldicott Guardian, Senior Information Risk Officer and Information Governance Manager; and, reviewing the Caldicott Guardian Data Sharing Agreement Register.**
11	HRA Void Repairs Contract & HRA Rechargeable Works	22	17.8	Final report issued	The review considered the following risk management objectives: **RMO1 – Arrangements are in place to manage the void repairs contract.** The review found that the current contract with Mears, which includes void repairs, is due for renewal in 2024 and the tendering process had started during the review. Concerns around mounting costs for items not in the agreed 'basket' of works that are carried out in each void property has meant that the service has now placed a council employed Building Inspector in the Mears team to accompany them on all visits to void properties. That officer is able to evidence and agree any additional works and also signs off the property once Mears have completed the works. This has already had a positive impact and is likely to see reduced or amended KPI's going forward as continuous monitoring is now taking place. The 'basket' will also

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					be reviewed as it has not been amended since the original Mears contract was signed a decade ago. **Opinion: Green.** **RMO2 – Measures are in place to ensure rechargeable repairs are dealt with appropriately.** The review found there is a policy in place, which is due for review in 2024. A new tenancy agreement, which includes a section relating to Recharges is under development. The Tenants' Handbook will also require refreshing to ensure the information provided in both documents is the same, and to ensure tenants understand that when they leave, they may be required to pay for recharge repairs. The Building Inspector advises the Income Team of the rechargeables once the property is ready for re-let. An invoice is then issued, though where possible the monies owed are recovered from credits on the Council Tax or main rent accounts. It was found that recharges were paused when the new Housing system was introduced and that these have now restarted, but some issues around reports have been identified and resolutions are being sought. **Opinion: Green.** **Overall Opinion: Green. Actions: One low priority.** **Action relates to updating information relating to recharges in the tenants' handbook.**
12	HRA Rechargeable Works	*N/A*	*N/A*	*N/A*	*Merged with item 11 – HRA Void Repairs Contract*
13	Grounds Maintenance & Greenspaces Contracts	18	25.3	Final report issued	The review considered the following risk management objective: **RMO1 – Arrangements are in place to ensure the effective governance of the ground maintenance and greenspaces contract held with Medway Norse.** The review found that the council entered a joint venture Service Agreement with Norfolk County Council (NCC) in June 2013, with Medway Norse to deliver "certain facilities and management services". Grounds Maintenance and Greenspaces were added in 2014, although it was noted that the Greenspace Services Management SLA was unsigned. The overall contract ran until 31 May 2023 and at the time of the review had since been on a rolling agreement while new terms and conditions were negotiated for a new contract. The Articles of Association for Medway Norse Ltd require two board members to be appointed by Medway Council, who are either a Councillor or an Officer, and three by NCC. At the time of the review, only one Medway employee had been

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					listed as a Director for Medway Norse since May 2023, Which does not conform to the Articles of Association. The Board composition is being addressed as part of the overall contract negotiations. The Grounds Maintenance and Greenspaces SLA, which will be reviewed once the overall contract is agreed, was set up with Medway Norse having a dual role in the responsibilities and delivery of the contract, taking on the roles of Authorised Officer and Council Representative. Although it was advised that transparency and scrutiny are maintained by open reporting and interaction with the Board and council officers, this arrangement does not allow for proper segregation of duty. There are three main Boards for Medway Norse; Operational Liaison Board, Full Board, and Strategy Board, with evidence to show that regular meetings take place in line with the agreement. Key Performance Indicators (KPIs) are set out in the agreement but there were no scores or targets to be achieved and it was confirmed by council officers that the KPI's do not accurately reflect the operational performance of the contract. There are arrangements in place for clear budgets to be set and monitored, to enable the authorisation and payment of the core contract amounts for the service, for any variations to the contract to be appropriately approved and implemented, and for complaints to be dealt with in accordance with the council's complaints procedures. **Opinion: Green.** **Overall Opinion: Green. Actions: One low priority.** **Action relates to the KPI framework being reviewed to reflect the overall operational performance.**
14	Health & Safety	15		Draft report with client for consideration	The review considered the following risk management objective: **RMO1 - There are arrangements in place to ensure the council remains compliant with Health and Safety legislation.**
15	Mobile Home Licencing	15		Fieldwork complete, in quality control	The review considered the following risk management objective: **RMO1 - Arrangements are in place to manage the licensing of mobile home sites.**
16	Complaints	15		Fieldwork complete, in quality control	The review considered the following risk management objective: **RMO1 - There are arrangements in place to effectively record, respond to and monitor complaints.**
17	*Facilities Management*	*N/A*		*Removed from plan*	*Following the emergency closure of Gun Wharf, the property services team were heavily involved in the ongoing work relating to the RAAC issues identified in the*

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					building. As such, the demands on the service meant it was not appropriate to conduct a review of Facilities Management.
18	High Needs Block Recovery Plan	15		Fieldwork complete, in quality control	The review considered the following risk management objective: **RMO1 - The council has an effective plan in place to fulfil the Department for Education's requirements as set out in the Dedicated Schools Grant 'Safety Valve' Agreement which covers the financial period from 2022-23 to 2026-27.**
19	Unregulated Placements	15		Fieldwork underway	The review considered the following risk management objectives: **RMO1 - Unregulated placements are only used as a last resort and are managed in accordance with set procedures.** **RMO2 - The council is looking at ways to reduce the need for unregulated placements.**
20	Fostering Payments (Previously Assessments, Reviews, Allowances & Expenses)	15	28.3	Final report issued	The review considered the following risk management objective: **RMO1 – Appropriate arrangements are in place to ensure correct payment to foster carers.** The review found that there is a Fostering Fees & Allowances policy, which includes payment schedules. As this has not been reviewed since 2021-22, it does not include uplifts to fees that were applied 2023. Ad-hoc payments are also not reflected in the policy and both issues are being addressed by the new Head of Service as part of a full review. There was no Business Continuity Plan (BCP) relating to the service, and while it was confirmed that the arrangements for the service are included a wider BCP for the Children in Care, Corporate Business Parenting Service, this has not been reviewed since 2021. It was found that the Create/Amend Care Package episodes on Mosaic are not completed promptly, causing delays in payments being made or amended, and also leading to under/overpayments. This can lead to urgent payments being required, which incur an additional £50 charge. This has been identified as a training issue by the service and work is being undertaken to review the forms on Mosaic, which will allow them to be used in a more effective way. It is understood that this will take up to 18 months due to the number of forms. The Head of Service is responsible for authorising daily payment sheets, who is now requesting confirmation that Team Managers have verified payments before authorising. Overpayments are usually identified by the Business Support Team, although this is usually due to contact from a foster carer to query payments. Although there is

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					reference to overpayment recovery within the policy, it is unclear whether any other information is provided to Foster Carers to confirm their responsibilities for repayment. **Opinion: Amber.** **Overall Opinion: Amber. Actions: One high, three medium and one low priority. Actions relate to reviewing and updating the Fostering Fees & Allowances policy, reviewing the service business continuity plan and making available to staff; training/guidance for staff to raise awareness of the need to complete the Create/Amend Care Package episodes on Mosaic; creating an escalation process for queried payments; and reminding staff to ensure Foster Carer Agreements are stored in Mosaic.**
21	SEND Transport	15		Fieldwork complete, in quality control	The review considered the following risk management objective: **RMO1 - Effective arrangements are in place for the delivery of Special Education Needs and Disabilities (SEND) Transport.**
22	*Therapeutic Outreach And Support Service*	*N/A*	*N/A*	*Removed from plan*	*The Therapeutic Outreach And Support Service was outsourced to an external provider some time after the plan was agreed. It was too early to conduct a review of the contract management processes, so this review was removed.*
23	Council Tax Administration	15	24.3	Final report issued	The review considered the following risk management objective: **RMO1 - Arrangements are in place to administer council tax.** The review found that there is appropriate information available to residents on the council's website regarding how to register and pay for council tax, and this information is reviewed annually. Reports are received from the Valuation Office Agency (VOA) up to twice a week and weekly reconciliations between the VOA report and records on NEC are completed. Testing found no discrepancies, although it was noted that there were delays in the countersigning of the reconciliations and a failure to complete the reconciliation within seven days in a small number of instances, which it was explained was due to directing resources to other priorities. Council tax accounts are set up on NEC and all reference numbers were found to be unique. Liable parties are identified through contact from the parties themselves or via tracing processes and a report is run monthly listing the properties without a liable party. The council tax base for 2023-24 was approved by Full Council in February 2023. Testing found no variances between the council tax base approved by Full Council and the figures input into NEC. Council tax bills are issued around February/March

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					time annually by FDM plc. Reconciliations are completed to ensure that the correct number of bills have been issued. Council tax payments are received to the ICON or Sagepay systems. Testing confirmed that payments received are credited to the correct account, and matched the amounts posted onto the General Ledger. The suspense account is reviewed weekly and there are appropriate arrangements for unidentified payments to be investigated further. Residents can register for 'My Council Tax Online' by following a link on the council's website. There are suitable arrangements in place for amendments to council tax details to be administered and monitored. **Opinion: Green.** **Overall Opinion: Green. Actions: One medium priority.** **Action relates to ensuring manager checks are being completed quarterly for weekly VOA reconciliations.**
24	Assessments & Reviews of Financial Support	15		Fieldwork underway	The review considered the following risk management objective: **RMO1 - Effective arrangements are in place to carry out adult social care financial assessments and reviews.**
25	IR35 Assessments	15	13.6	Final report issued	The review considered the following risk management objective: **RMO1 – There are arrangements in place to ensure compliance with the off-payroll working rules.** The review found there is some training and guidance material available on the council's Intranet and further advice can be obtained by contacting the Temporary Recruitment Team. However, the information available does not include guidance on how to use the government IR35 assessment tool to obtain a Status Determination Statement (SDS), which is required for roles of off-payroll workers. There is a process in place for the Recruitment Team to be involved in contracts entered into relating to employment of workers, however, instances of recruiters by-passing the IR35 assessment process were identified. All interim or temporary workers need to be setup as a supplier in the council's financial system Integra and there are processes in place to restrict who can authorise new suppliers. This process could be made more robust by ensuring the Temporary Recruitment Team are made aware of new workers to enable checks that the correct procedures are being followed by all. The council is required to supply both the worker and any 3rd party organisation involved in the recruitment process with a copy of the SDS, however,

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					documentation was not made available for testing and therefore no assurance can be given that this is being carried out. The team have recently introduced a process to deal with cases arising from disputed status determination outcomes to ensure challenges are fully investigated and escalated to senior managers. The team are planning to introduce a regular check to ensure that all identified workers have a new IR35 assessment if they have changed roles since the initial SDS was obtained. **Opinion: Amber.** **Overall Opinion: Amber. Actions: Five medium priority.** **Actions relate to providing more information and updating existing information on the Intranet; having a more robust process in place to ensure that no temporary or interim workers are employed without the Temporary Recruitment Team's knowledge; ensuring the status determination statements are issued correctly; and regularly checking all off-payroll workers roles have not changed.**
26	*Innovation Park Medway*	*N/A*	*N/A*	*Converted to Consultancy*	*Due to changes within the delivery of the project, this review was changed to one of consultancy rather than assurance.*
27	Homes for Independent Living Scheme	15		Fieldwork complete, in quality control	The review considered the following risk management objective: **RMO1 - There are appropriate arrangements in place to manage the Homes for Independent Living Scheme.**
28	Remote Sites Financial Management - Including Schools				Four 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
	Balfour Infant school	20	20.7	Final report issued	The review considered the following risk management objective: **RMO1 – The school has appropriate mechanisms in place to ensure it is in a sound financial position and that there are no material probity issues.** The review found there are appropriate governance arrangements at the school, with governor and staff Declarations of Interests being regularly updated.

Ref	Activity	Number of Days Allocated	Number of Days Used	Current status	Opinion, summary of findings & actions agreed
					Payroll services are delivered via a contract with the council and processes are in accordance with the council's requirements, including segregation of duties being maintained, and the Head Teacher taking overall responsibility for the monthly payroll. The School Finance Policy is regularly updated but lacked clarity and detail regarding authorisation limits, procurement processes, petty cash usage and stock control. The current bank mandate had not been updated recently and still contained details of staff no longer employed by the school, this has now been rectified and procedures implemented to prevent recurrence. A visual overview of the transactions did not highlight any probity issues but did identify an inconsistent approach to recording transactions, and collating and storing the required paperwork. There has been a more consistent way of working since January 2024. Various income streams were identified and the income from these activities was not being banked regularly, but banking is now carried out twice a month to ensure limited amounts of cash are held on site. There was evidence that the school trips were being costed but there was no reconciliation of the total income and expenditure of each event. Other income received was for the School Fund which the Head Teacher is planning to close and direct all income through the main school bank account in order to reduce costs, streamline processes and reduce workloads. At the time of the audit the school were only maintaining an asset register for the high value IT equipment, which had recently been reviewed. There was no record held of all other school equipment or details of an annual stock check. **Opinion: Amber.** **Overall Opinion: Amber. Actions: Two high and three medium priority. Actions relate to reviewing and updating the School Finance Policy, ensuring all documentation for purchases is maintained appropriately. All trip income is reconciled and reported to the governing body and the school's asset registers are complete and annual stock checks take place.**
	St Helens Church of England Primary School	20	27.7	Final report issued	The review considered the following risk management objective: **RMO1 – The school has appropriate mechanisms in place to ensure it is in a sound financial position and that there are no material probity issues.**

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					The review found there are appropriate governance arrangements at the school, with governor Declarations of Interests being regularly updated. Payroll services are delivered via a contract with the council and processes are in accordance with the council's requirements; including segregation of duty being maintained, and the Head Teacher taking overall responsibility for the monthly payroll. The School Finance Policy is regularly updated and shows the current spending limits and delegated authorities. A more consistent approach to staff time recording to provide more accuracy and transparency for overtime claims was suggested and taken on board. It was identified that a large number of Purchase Orders were being raised after the purchase had been made, however, during the audit all staff purchases were stopped. Although there is no definitive Contracts List, the school provided a Premises Management Policy which records most of the contractors used by the school, which is being updated to give a clear picture of all contractors used. Various Income streams were identified, which included school trips, although it was evident that parents were not being advised of what would happen to any excess money collected in relation to trips. The school aims to operate a cashless system, but we were able to see that the small amount of cash received was held securely. The current Asset Register was provided, and although some older items did not have all details recorded, it was evident that all recent purchases had all the relevant information in the register. **Opinion: Green.** **Overall Opinion: Green. Actions: None.**
	St William of Perth Roman Catholic primary School	20		Draft report with client for consideration	The review considered the following risk management objective: **RMO1 – The school has appropriate mechanisms in place to ensure it is in a sound financial position and that there are no material probity issues.**
	St Mary's Catholic Primary School	20	19.6	Final Report Issued	The review considered the following risk management objective: **RMO1 – The school has appropriate mechanisms in place to ensure it is in a sound financial position and that there are no material probity issues.** The review found the school's governing body is not currently in line with the School Governance (Constitution) (England) Regulations 2012. Declarations of interest were not available for all members of the governing body, although

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					meeting minutes do include opportunity for interests to be declared; and are not currently completed by staff. Payroll services are delivered via a contract with the council and processes are in accordance with the council's requirements, with appropriate segregation of duties, reconciliations, and checks. Inconsistencies were noted in relation to the recording and authorising overtime and payments for "additional duties", although testing of more recent claims demonstrated that approval and record keeping of claims have improved, and the Interim Head Teacher has implemented new processes with additional controls. The School Finance Policy requires updating and approval from the governing body. Enhancements to banking arrangements, including an additional bank signatory, were also identified. Changes are required to ensure an appropriate segregation of duties is maintained for purchasing and payments for goods and services; and better records maintained to confirm that processes have been followed appropriately, although testing of more recent transactions did demonstrate a more consistent way of working. There are appropriate processes in place to ensure security and reconciliation of the school credit card, checks and reconciliations of bank statements and reconciliation of breakfast club payments against attendance. The processes for trip costings and reconciliations for the period covered in this audit could not be confirmed by current staff therefore additional testing was not possible. The current process involves income for trips (along with other school events) being paid into the voluntary fund account, and then transferred to the school account to cover expenditure. However, consideration is being given to closing the voluntary fund account, which would also provide additional benefits through savings on the annual audit fee and any associated banking cost; and changing the process completely. There is a process for the management of assets included in the school's Finance Policy however it is understood that due to the staffing issues at the school these processes have not been maintained for some time and the latest asset register is dated May 2022. **Opinion: Amber.** **Overall Opinion: Amber. Actions: Six high, two medium and one low priority. Actions relate to making arrangements to ensure the governing body is constituted correctly, ensuring information available regarding the governing body is updated, making arrangements for governors and staff to sign annual**

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					declarations of interest, obtaining advice from HR to ensure payments to staff for additional duties are consistent, reviewing and updating the School Finance Policy, reviewing the banking arrangements and signatories, reviewing and updating the asset register and making arrangements for an annual, independent check of the register.

Other Assurance Activity

Ref	Activity	Number of Days Allocated	Number of Days Used	Current status	Opinion, summary of findings & recommendations made
	Finalisation of 2022-23 Planned Work	50	78.6	Complete	*All reviews from 2022-23 finalised.*
	Grant Validations	13	12.9	Complete	Validation work has been completed in relation to the following grant funding streams to enable sign off by appropriate officers: • Grant & Contacts: Kent & Medway Teaching Partnership • Family Hubs and Start for Life programme P1 Revenue & Capital (2022-23) • Multiply ring-fenced grant 2022 – 2023 • SuDS (Sustainable Urban Drainage Systems) in Schools Project • Local Transport Capital Funding 2022-23. • The Disabled Facilities Capital Grant (Dfg) Determination 2022-23. • Family Hub and Start for Life programme P1 Capital Grant Determination 2023-24. • Local Transport Fund (LTF). • Local Authority Bus Subsidy (Revenue) Grant: Specific Grant Determination 2022/23.
	Supporting Families Assessment Validation	25	17.1	Complete	The team provided independent verification of all monthly claims for funding and issued the appropriate assurance certificates to be included with the returns.
	Information Governance Action Plan Validation	15	1.0	In progress	Internal Audit are to provide independent validation of actions completed as part of the Information Governance Action Plan. This has evolved with the creation of a new corporate working group (Security & Information Governance Operational Group (SIGOG)), which Internal Audit will be a

Ref	Activity	Number of Days Allocated	Number of Days Used	Current status	Opinion, summary of findings & recommendations made
					part of, and will include validation work as part of the group's activities. This will form part of Internal Audit's business as usual and be recorded under corporate working group activity in future reports.
	Adult Social Care Self-Assessment Validation	15	2.8	In progress	From April 2023, the CQC has a new duty to assess local authorities' delivery of their adult social care duties under Part 1 of the Care Act 2014 through the new Assurance Framework. Completion of a self-assessment will form part of the preparation of evidence to support the CQC assessment. Internal audit will be reviewing the self-assessment and the evidence available to provide an independent view over the conclusions reached by the Adult Social Care teams prior to the CQC inspection. This work commenced in year, and a summary report will be provided to the service at the conclusion with findings and any recommendations as appropriate.
	Responsive Assurance Activity	17.5	0.6	Complete	The team have assisted with several ad-hoc requests for advice and information.

Other consultancy services including advice & information

Activity	Number of Days Allocated	Number of Days Used	Opinion, summary of findings & recommendations made
Business Continuity planning	15 (from responsive consultancy work budget)	15.4	A consultancy review to look at that council's approach to Business Continuity Planning was completed. A final report providing a summary of the findings, with suggested actions for their consideration was shared with the client.
SEND Education	12 (from responsive consultancy work budget)	7.1	A consultancy review to look at the proposed new arrangements for the provision of SEND Education was completed. A final report providing a summary of the findings, with suggested actions for their consideration was shared with the client.
Housing Finance Interface	4 (from responsive consultancy	4	The Housing Service identified potential discrepancies in rental income data transferring from the new housing system to the finance system. Automated reports were suspended, and independent checks were undertaken by Internal Audit, which identified discrepancies and

Activity	Number of Days Allocated	Number of Days Used	Opinion, summary of findings & recommendations made
	work budget)		missing data that could impact on financial forecasting and reporting; although the interface was suspended before this impacted on overall financial reporting. The work completed allowed data cleansing to be undertaken and also meant that the exact problems could be identified. Amendments to the reporting interface can only be undertaken by the software provider, which is as cost to the council, so this identification ensured that the costs could be kept to a minimum with changes targeted to the appropriate issues only.
Innovation Park Medway	10	In progress	A consultancy review to look at the governance arrangements surrounding the Innovation Park Medway project was commenced in year.
Attendance at Corporate Working Groups	4.5	0.5	The team were represented on the Strategic Information Governance Group throughout the year.

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 Internal Audit QAIP for 2023-24 was agreed by Medway's Audit Committee in March 2023.

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 13 performance indicators. Performance targets have been set for nine of the 13 indicators and outturns presented are those as of 31 March 2024.

Ref	Indicator	Target	Outturn for period
Non-LA Specific Performance Measurements			
IA1	Proportion of staff with professional qualification relevant to internal audit	N/A	67%
IA2	Proportion of non-qualified staff undertaking professional qualification training	N/A	0%
IA3	Time spent on professional qualification training:	N/A	242.7 days
IA4	Time spent on CPD/non-professional qualification training, learning & development (including corporate training)	40 days	40.2
IA5	Compliance with PSIAS	100%	Our January 2023 self- assessment showed full compliance with 97.5% of the standards, partial compliance with a further 2% and work required to address the remaining 0.5%. This shows improvement on our 2019 self-assessment and our latest external quality assessment received a Green opinion as well as improvements identified since the last assessment in 2018.
LA Specific Performance Measurements			
IA6	Average cost per agreed assurance review	<£5,000	£7,438
IA7	Proportion of estimated resources delivered	N/A	91%
IA8	Proportion of chargeable time spent on: a) Assurance work b) Consultancy work	N/A	 95% 5%
IA9	Proportion of agreed assurance reviews:		

Ref	Indicator	Target	Outturn for period
	a) Delivered b) Underway	95%	85% 15%
IA10	Proportion of completed assurance reviews subject to a second stage (senior management) quality control check in addition to the primary quality control review	10%	5% It should be noted that the HIACF has undertaken a significant amount of primary quality control during 2023-24.
IA11	Number of agreed actions that are: a) Not yet due b) Implemented c) Outstanding	N/A	 26 80 19
IA12	Proportion of actions implemented by agreed date	N/A	80.8%
IA13	Client, Management and Member satisfaction with internal audit services	90%	92.3% The annual survey asked those who had received services form internal audit in the last 12 months to rate their satisfaction on a scale of one to ten. Scores of eight or higher are considered to be positive satisfaction. 16 people responded to the annual survey, 13 of which had received services from internal audit in the last 12 months and 12 respondents scored eight or higher.

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 tables below set out the position of all agreed actions which have formed part of the follow-up process during the 2023-24 financial year.

Status of Agreed Actions (as of 31 March 2024)

Appendix 1

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.	All actions completed.
Tree Service	**Opinion: Red** Eight actions agreed: Seven **high** and one **medium** priority.	Eight actions due, six completed. Two high priority outstanding.
Disabled Facilities Grants	**Opinion: Amber** Two actions agreed: One **high** and one **low** priority.	All actions completed.
Looked After Children – Bank Account Provision	**Opinion: Red** Six actions agreed: four **high**, one **medium** and two **low** priority.	All actions completed.
Insurances	Opinion: **Amber**. Two **medium** priority actions agreed.	No actions due before 31 March 2024.
Payroll	Opinion: **Red**. Six actions agreed: Three **high**, two **medium** and one **low** priority.	All actions completed.
Market Income Collection	Opinion: **Green**. One action agreed: One **medium** priority.	All actions completed.
Kyndi – Governance & Accounting	Opinion: **Amber**. Two actions agreed: One **high** and one **medium** priority.	All actions completed.
Financial Planning & Budget Setting	Opinion**: Amber.** Three actions agreed: One **high**, one **medium** and one **low** priority.	Two actions due, none completed. One **high** and one **medium** priority outstanding.
VAT	Opinion: **Amber.** Four actions agreed: Two **high** and two **low** priority**.**	Four actions due, three completed. One **high** priority outstanding.
Emergency Planning	Opinion: **Green.** Four actions agreed: One **medium** and three **low** priority.	Four actions due, two completed. One **medium** and one **low** priority outstanding.
Planning Enforcement	Opinion: **Amber**. Three **medium** priority actions agreed.	All actions completed.
Hempstead Schools Federation	Opinion: **Amber**. Five actions agreed: Two **high** and three **medium** priority.	Five actions due, three completed. Two **medium** priority actions outstanding.
Service Charges for Leasehold properties	Opinion: **Green.** Two **low** priority actions agreed.	All actions completed.
Environmental Enforcement – Fly Tipping	Opinion: **Green.** One **medium** priority action agreed.	All actions completed.
Procurement Compliance	Opinion: **Amber**. Four actions agreed: Two **high,** one **medium** and one **low** priority.	Four actions due, three completed. One **low** priority action outstanding.

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
Risk Management Framework	Opinion: **Amber**. One **medium** priority action agreed.	One action due, none completed. One **medium** priority outstanding.
Greenvale Primary School	Opinion: **Amber**. Four actions agreed: One **high**, and three **medium** priority.	All actions completed.
HRA Development Projects	Opinion: **Green.** One **low** priority action agreed.	All actions completed.
IT Security & Access Controls	Opinion: **Green.** Three **medium** priority actions agreed.	Three actions due, two completed. One **medium** priority action outstanding.
Medway Integrated Community Health Equipment Service	Opinion: **Green.** One **medium** priority action agreed.	One action due, none completed. One **medium** priority action outstanding.
St Thomas of Canterbury Catholic School	Opinion: **Red**. Five **High** priority actions agreed.	All actions completed.
Sundry Debtors	Opinion: **Green.** Five actions agreed: Two **medium** and three **low** priority.	All actions completed.
Climate Change Action Plan	Opinion: **Green.** One **low** priority action agreed.	One action due, none completed. One **low** priority action outstanding.
Children In Need & Child Protection Service	Opinion: **Green.** One **low** priority action agreed.	All actions completed.
Business Continuity – IT Recovery	Opinion: **Amber**. Six actions agreed: Two **high**, two **medium** and two **low** priority.	Five actions due, two completed. Two **medium** and one **low** priority outstanding.
Legal Case Management	Opinion: **Amber**. Five actions agreed: Two **medium** and three **low** priority.	No actions due before 31 March 2024.
HMO Licencing	Opinion: **Green**. Two actions agreed. One **medium** and one **low** priority.	One action due, one completed.
Highways Maintenance & Repairs	Opinion: **Amber**. Two actions agreed: One **high** one **medium** priority.	All actions completed.
Petty Cash	Opinion: **Amber**. One **high** priority action agreed.	No actions due before 31 March 2024.
Adult Social Care Supported Living	Opinion: **Amber**. Five actions agreed: Four **high** and one **medium** priority.	Four actions due, four completed.
Staff Travel & Subsistence	Opinion: **Red**. Two actions agreed: One **high** and one **low** priority.	Two actions due, none completed. One **high** and one **low** priority outstanding.
Deprivation of Liberty Safeguards in the Community	Opinion: **Red**. Six actions agreed: Two **high** and four **medium** priority.	Four actions due, four completed.

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
Recruitment & Management of Casual Staff	Opinion: **Red**. Six actions agreed: Three **high** and three **medium** priority.	All actions completed.
Children's Imprest Account	Opinion: **Red**. Four actions agreed: Three **high** and one **medium** priority.	Four actions due, three completed. One **high** priority outstanding.
Information Requests	Opinion: **Amber**. Nine actions agreed: One **high**, two **medium** and six **low** priority.	Two actions due, two completed.
Residential Parking Permits	Opinion: **Amber**. Six actions agreed: One **high** and five **low** priority.	All actions completed.
Asset Management	Opinion: **Green**. One **low** priority action agreed.	All actions completed.
Surveillance (RIPA)	Opinion: **Amber**. Three actions agreed: One **high** and two **low** priority.	No actions due before 31 March 2024.
Complex Health Funding Panel	Opinion: **Green**. Three **low** priority actions agreed.	All actions completed.
HRA Void Repairs Contract & Rechargeable Works	Opinion: **Green**. One **low** priority action agreed.	No actions due before 31 March 2024.

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.

Priority	Definition
High	The findings indicate a fundamental weakness in control that leaves the council exposed to significant risk. The agreed 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.