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

# Internal Audit Annual Report 2024-25

## 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 Internal Audit Standards, the Head of Internal 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 internal control.

# 2. Independence

The Internal Audit Charter was approved by Medway's Audit Committee in January 2024 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. The work completed has also been free from any inappropriate restriction or influence from senior officers and/or Members.

Given that the Head of Internal Audit & Counter Fraud has responsibility for counter fraud activities, the Internal Audit team 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 (4.59FTE) and one Trainee Internal Auditor.

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 2024-25 were prepared, this establishment was forecasted to provide a total of 1,070 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 685 days, plus an additional 73 days of internal audit management time.

As of 31 March 2025, the net staff days available for Medway for 2024-25 amounted to 519.3 days and equates to 76% of estimated audit resources (685 days) delivered. An additional 70 days were spent on review of internal audit work by the Internal Audit Manager. Of this overall time, 510.9 days (98%) were

spent on audit assurance work and 8.4 days (2%) were spent on consultancy work. The current status and results of all work carried out are detailed at section five of this report.

The shortfall of 165.7 days from the estimated resource is largely due to periods of staff sickness and vacancies experienced in year.

Learning and development needs and objectives were agreed through the 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 2024-25 was detailed in the Internal Audit Plans, which were approved by the 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 2023-24, and work outlined in the 2024-25 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 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 2024-25, and reviews overrunning from the 2023-24, 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 2024, 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.

The evidence used to draw a reasonable conclusion as to the adequacy and effectiveness of the organisation's risk management, internal control and governance processes, is however based upon a limited scope due to impacts on resourcing limiting the volume of work that the team have been able to complete.

**Annual Opinion 2024-25**

**Corporate Governance**

Corporate Governance is defined as being the structure of rules, practices, and processes.
that direct and control the Council. The review of Information Governance – Data Breaches falls within this category, although as this was the only review, we can only place limited assurance in relation to corporate governance, although this is caveated with the fact that been nothing has been identified in the course of work completed, nor has anything been brough to my attention from elsewhere, to suggest any failure in compliance 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. The Corporate Risk Register is populated with risks to the achievement of the Council's corporate objectives, which should be informed by service risk registers; however, risk registers were not identified in nine of the 15 reviews scheduled for 2024-25, and evidence only seen in three of the remaining six. As such only limited assurance can be provided that services have appropriate risk registers in place.

**Internal control**

Fieldwork was completed in relation to 12 assurance reviews listed in the 2024-25 Plans, only five of which have been finalised with client services, along with a further nine reviews from 2023-24 that were finalised in 2024-25 after the last annual opinion was delivered. Of these finalised reviews, ten resulted in Amber or Green opinions, indicating that all key risks were being managed effectively; however, four reviews (28.6%) resulted in Red opinions indicating that the overall control process was weak.

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 88% of all actions due to be implemented in 2024-25 (81 of 92 actions) have been completed.

Given the results of finalised assurance reviews, we can only place limited assurance on the aspects of the system of internal control tested and in operation during 2024-25.

**Overall Opinion**

**It is my opinion that only limited assurance can be provided that Medway Council's framework of governance, risk management, and system of internal control, during the year ended 31 March 2025, 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 2024-25 for Medway were approved by the Audit Committee in March 2024 and September 2024. 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 plans were amended to take into account changes in resource levels due to sickness and vacancy periods. Members agreed revisions to the original plans for 2024-25 to remove the planned reviews of:

- Medway Norse,
- Integrated Care Boards,
- Pentagon Centre,
- Medway Development Company,
- Approved Contractor Frameworks,
- Care Transitions,
- Urgent Care Provision,
- Staff Leave,
- Air Quality Monitoring,
- Treasury Management,
- St Thomas More Roman Catholic Primary School.

In addition, the planned assurance reviews of Establishment Management, Children in Need – Section 17 Financial Assistance, and Purchase Ledger, had not commenced by 31 March 2025. Approval was obtained from the Chair of the Audit Committee for these reviews to be deferred and reported as part of internal audit activity for 2025-26.

The tables below provide details of the work from 2023-24 that was finalised in 2024-25, since the 2023-24 annual report was presented to the Committee, and the progress of work undertaken as part of the 2024-25 Plans.

## 2023-24 Internal Audit Assurance work finalised in 2024-25 (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 |
|---|---|---|---|---|---|
| *14* | *Health & Safety* | *15* | *16.3* | *Final report issued* | *The review considered the following risk management objective:*<br>***RMO1 - There are arrangements in place to ensure the council remains compliant with Health and Safety legislation.***<br>*The review found that the council has a number of policies in place and Terms of Reference for the Corporate Health and Safety Committee and for Business Support Department, although a number require review and formal agreement.*<br>*Emergency evacuation procedures, including temporary procedures to account for the situation at Gun Wharf, are in place and training was delivered to service managers, although no records were maintained.*<br>*The Health and Safety pages on Medspace require updating and a number of posters require distribution around Gun Wharf once the building fully re-opens.*<br>*There are procedures in place relating to First Aiders, Fire Wardens, and Evac Chair Operators to comply with legislative requirements, along with requirements for them to sign in/out. However, there were discrepancies identified in these records, meaning it is not always possible to determine whether trained employees are available.*<br>*First aid kits are located at each stairwell and reception, although there are currently no checks on the contents.*<br>*There are a number of training platforms available to staff and managers, however records suggest that this training is not being completed by staff as required.*<br>*Building Risk Assessments for each site are held by the Emergency Planning Manager. However, there is currently no central record of service area risk assessments or their completion.*<br>*Staff are able to report H&S incidents via the service desk portal and other communication avenues, and H&S reports are reviewed at the Corporate Health and Safety Working Group.* ***Opinion: Red.***<br>***Overall Opinion: Red. Actions: Two high and seven medium priority.***<br>***Actions relate reviewing and updating H&S policies; building managers reviewing emergency procedures; updating the Terms of Reference for Corporate Health and Safety Committee and Business Support Department; updating the Health and Safety information available on Medspace; building managers reviewing responsibilities for staff that hold a Health and Safety role; reviewing procedures for allocating senior fire warden responsibility; completion and centralised*** |

| Ref | Activity | Number of days allocated | Number of days used | Current status | Opinion, summary of findings & actions agreed |
|---|---|---|---|---|---|
| | | | | | ***records of PEEPs; completion of mandatory training relating to Health & Safety; and completion and recording of Service risk assessments.*** |
| *15* | *Mobile Home Licencing* | *15* | *17.3* | *Final report issued* | *The review considered the following risk management objective:*<br>***RMO1 - Arrangements are in place to manage the licensing of mobile home sites.***<br>*The review found that the Mobile Homes Act 2013 introduced a new site licensing regime for "relevant protected sites". There are five relevant protected sites within Medway and this audit focused on the licensing process connected to these sites. Although licences are in place for all five sites, and fit and proper person tests have been undertaken for all site owners / managers, we were advised that prior to a specialist contractor being employed during 2022 to bring the information held up-to-date and put procedures in place to manage the licensing process, no work had been undertaken in this area for circa 12 years. There are now a number of template documents in place, however the specialist contractor's contract ended prior to procedure documents to support the licensing process being finalised. In line with best practice, there is information, aimed at both site owners and residents, provided on the council's website, including details of the license application procedure, although it was found there are elements of this information which need to be updated. There are three registers connected to mobile home site licensing that the council is required to maintain and make available to the public; these are all available on the council's website, though several minor queries have been raised around the content. The 2013 legislation introduced new powers allowing local authorities to charge fees for their licensing functions in respect of relevant protected sites; while a draft Fee Policy has been prepared, this has yet to presented for approval.*<br>*The 2013 legislation also gave local authorities more effective control of conditions on relevant protected sites, providing the tools required to take enforcement action to ensure residents' health and safety is protected, though any action taken is expected to be reasonable and proportionate. Best practice guidance states that local authorities should ensure efficient and effective approaches to regulatory inspection and enforcement are provided in line with their enforcement policies. However, currently the council does not have an enforcement policy relating to mobile home sites and, while a complaint would be investigated if it were received, no pro-active enforcement is undertaken, and inspections started when the specialist contractor was employed have not been completed.* ***Opinion: Amber.***<br>***Overall Opinion: Amber. Actions: Two high and three medium priority.*** |

| Ref | Activity | Number of days allocated | Number of days used | Current status | Opinion, summary of findings & actions agreed |
|---|---|---|---|---|---|
| | | | | | ***Actions relate to introducing procedure documents; updating the council's website (including the relevant registers); progressing the draft Fee Policy via the appropriate governance process; and reviewing enforcement / compliance arrangements.*** |
| *16* | *Complaints* | *15* | *20.0* | *Final report issued* | *The review considered the following risk management objective:*<br>***RMO1 - There are arrangements in place to effectively record, respond to and monitor complaints.***<br>*The review found that the council's website includes clear and detailed information about the council's corporate complaints procedure, as well as the separate procedures followed by specific services; the Medway Council Customer Pledge is also provided. The council does not currently have a complaints policy; however, work is underway on developing a policy, in line with a recently published Complaint Handling Code. Customer Complaints training is run on a quarterly basis for relevant staff and is well attended, though it would be beneficial for this to be made a mandatory requirement for specific roles. Guidance is available to staff within the Customer Relations Team as well as complaint handlers. The Customer Relations Team co-ordinate both the corporate and children and adult social care complaints procedures. The corporate complaints procedure has two stages, and there are arrangements in place for both stage one and two complaints to be logged, acknowledged, investigated and responded to in line with the procedure, with appropriate monitoring in place. Likewise, there are arrangements for stage one children's and adult social care complaints (both statutory and non-statutory) and adult social care 'further investigation' requests to be managed appropriately, although a query has been raised in relation to the start date recorded for complaints where further information or consent is required. Appropriate stage two and three procedures are in place for children's social care complaints, in line with legislation, although audit testing identified weaknesses in relation to achieving the statutory timescales; it was noted that there has been some improvement in response times from 2023-24 to 2024-25. Arrangements exist to co-ordinate referrals from the Local Government and Social Care Ombudsman (LGSCO) and respond appropriately where complaints are upheld. There are also arrangements to monitor the number and type of complaints received, including complaints made to the LGSCO, with regular performance reporting to senior management.* ***Opinion: Amber.***<br>***Overall Opinion: Amber. Actions: Three high, one medium and one low priority.*** |

| Ref | Activity | Number of days allocated | Number of days used | Current status | Opinion, summary of findings & actions agreed |
|---|---|---|---|---|---|
| | | | | | ***Actions relate to development of a complaints policy; amending the status of Customer Complaints training; clarifying the start date for stage one social care complaints; and, reviewing the procedure for managing and responding to stage two children's social care complaints, including updating timescales on the council's website.*** |
| *18* | *High Needs Block Recovery Plan* | *15* | *12.8* | *Final report issued* | *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.*** *The review found that an approved plan is in place, which focuses on five overarching priorities, with a nominated lead assigned to each of these. Appropriate governance structures are in place to monitor delivery of the plan, with oversight from a number of groups and boards. There are arrangements in place for budget and performance monitoring to be undertaken and for progress against plan delivery and the required financial savings to be reported to the Department for Education, in line with the DSG 'Safety Valve' Agreement, in order for the agreed funding to be released.* ***Opinion: Green.*** ***Overall Opinion: Green. Actions: None.*** |
| 19 | Unregistered Placements | 15 | 21.6 | Final report issued | The review considered the following risk management objective: **RMO1 - Unregistered placements are only used as a last resort and are managed in accordance with set procedures.** The council has an Unregistered Placement Procedure outlining the process for placing children in unregistered provision when no suitable alternatives are available. While the procedure is accessible via Tri.x, multiple versions exist and some content requires updating. Approval and funding processes are in place, along with measures to ensure child safety, notify Ofsted, and establish Individual Placement Agreements. These placements are short-term, with ongoing efforts to find suitable alternatives and support providers in registering with Ofsted. A significant reduction in unregistered placements was noted during the audit period. Monitoring arrangements are in place and generally effective, with weekly reviews of outstanding actions. **Opinion: Green.** **Overall Opinion: Green. Actions: One medium priority.** **Action relates to reviewing and updating the Unregistered Placement Procedure and ensuring only the current version is available on Tri.x.** |

| Ref | Activity | Number of days allocated | Number of days used | Current status | Opinion, summary of findings & actions agreed |
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| *21* | *SEND Transport* | *15* | *22.3* | *Final report issued* | *The review considered the following risk management objective:*<br>***RMO1 - Effective arrangements are in place for the delivery of Special Education Needs and Disabilities (SEND) Transport.***<br>*The review found the council has an Education Travel Assistance Policy in place for both SEND and mainstream pupils, which was last updated in September 2023. The policy clearly defines the eligibility criteria for SEND travel assistance and provides a framework for how SEND travel assistance is delivered throughout Medway. Information is also available on the council's website, along with a copy of the policy, and a link to an online application form. Arrangements exist for all SEND travel assistance applications to be logged and processed, ensuring that eligibility is determined, and the most appropriate type of travel assistance is identified, before parents and carers are notified of the decision. The types of travel assistance available are identified within the Policy. Arrangements exist for fuel allowances to be calculated / paid and records are maintained of all commissioned transport providers / routes, and the number of children and young people being transported, which are used to check the invoices received. Due to the level of available resources, attendance checks are not undertaken on the children and young people that are receiving SEND travel assistance, with reliance placed on schools and providers to notify the council of non-attendance. Although the Policy refers to submission of annual applications, in practice, new applications are only requested where there has been a change of circumstances, or when the child or young person is transitioning between primary, secondary or post-16 education. However, all other SEND travel assistance arrangements are reviewed annually to ensure the arrangement remains suitable. There are also arrangements for solo transport to be reviewed every six weeks.*<br>*A monthly return is completed to track spend across the different types of SEND travel assistance and is used to inform budget monitoring.* ***Opinion: Green. Overall Opinion: Green. Actions: None.*** |
| 24 | Adult Social Care - Assessments & Reviews of Financial Support | 15 | 16.5 | Final report issued | The review considered the following risk management objective:<br>**RMO1 - Effective arrangements are in place to carry out adult social care financial assessments and reviews.**<br>The review found there is an appropriate Charging and Financial Assessment for Adult Social Care and Support Services Policy in place, which is available on the council's website, alongside information regarding adult social care charging and financial assessments. There are arrangements in place for Social Workers to |

| Ref | Activity | Number of days allocated | Number of days used | Current status | Opinion, summary of findings & actions agreed |
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| | | | | | initiate financial assessment referrals on completion of their care assessments, ensuring appropriate contact details are obtained and communicated. Arrangements also exist for financial assessments to be carried out accurately, in line with legislation and in a timely manner, with appropriate records maintained on Mosaic, and service users notified of the outcome. It was noted that there is a declaration to be completed at the point of application and once the assessment has been completed, however these are not consistent with each other and require reviewing to ensure appropriate safeguards are in place to prevent fraud. Outcomes of financial assessments are also communicated with the correct teams, to ensure any necessary payment plans are set up and/or adjustments applied to payments. There is an appropriate appeals procedure in place and there are arrangements in place for reviews / reassessments to be undertaken in appropriate circumstances. **Opinion: Green.**<br>**Overall Opinion: Green. Actions: One medium priority.**<br>**Action relates to updating the declarations on the SS27 form and subsequent declaration forms to ensure they clearly show service users and/or their representatives the consequences of providing false information.** |
| 27 | Homes for Independent Living Scheme | 15 | 15.2 | Final report issued | The review considered the following risk management objective:<br>**RMO1 - There are appropriate arrangements in place to manage the Homes for Independent Living Scheme.**<br>The review found that while information on the Homes for Independent Living Scheme is available on the council's website, several linked policies and documents require updating. Roles and responsibilities are clearly defined, and a staff training matrix exists but needs review. The application and allocation processes align with the council's Allocations Policy, and tenancy sign-ups are appropriately managed. Tenant reviews follow the Tenant Review Policy, though improvements are needed in review meeting procedures. Rent accounts are set up with advance payments, and arrears are managed per policy. Safety checks are routinely conducted across all sites. Guest room bookings at six locations revealed inconsistencies in booking and payment records. **Opinion: Amber.**<br>**Overall Opinion: Amber. Actions: One high, three medium and one low priority.**<br>**Actions relate to updating information published on the council's website; reviewing the staff training matrix; reminding officers to ensure needs assessment and estate inspection records are completed in full; reviewing processes for undertaking review meetings / visiting introductory tenants; and,** |

| Ref | Activity | Number of days allocated | Number of days used | Current status | Opinion, summary of findings & actions agreed |
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| | | | | | **reviewing use of guest rooms, including ensuring robust booking and payment arrangements are in place.** |
| *28* | *St William of Perth Roman Catholic primary School* | *20* | *24.0* | *Final report issued* | *The review considered the following risk management objective:*<br>***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.***<br>*The review found that the school's governing body was not in line with the School Governance (Constitution) (England) Regulations 2012. Although all governors sign declarations of interest annually staff at the school do not routinely complete declarations of interest.*<br>*While there are appropriate arrangements in place for payroll reports to be reviewed and signed off by the Head Teacher, and for overtime to be approved in advance by the Head teacher, a number of anomalies and inconsistencies were identified.*<br>*The school has a Finance Policy, which is reviewed annually, although a number of changes were suggested. Bank accounts were found to have been appropriately reconciled and approved but the Chair of Governors was a signatory to the school cheque book, which is not permitted. The school has a voluntary (school) fund, and inconsistencies in records were noted.*<br>*While goods and services listed on the transaction reports all appeared to be for the benefit of the school, very few had associated purchase orders.*<br>*There were a number of staff reimbursement linked to breakfast club expenditure and a loyalty card linked to these transactions that could not be identified as belonging to the school.*<br>*The school's software company maintains the asset register; however, this does not list all the school's assets and checks are currently not completed.* ***Opinion: Red.***<br>***Overall Opinion: Red. Actions: Five high, six medium and three low priority. Actions relate to the constitution of the Governing Body and updating information relating its membership; staff Declarations of interest; accuracy of information relating to staff, reviewing and updating the School Finance Policy; reviewing the bank signatories; reviewing the process for purchasing goods/services; investigating the option of a school credit card; ensuring loyalty points are used for the benefit of the school; ensuring that cash is kept securely; and, reviewing and updating the asset register and making arrangements for an annual, independent check of the register.*** |

## 2024-25 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 | Out Of Hours Service | 15 | N/A | Fieldwork complete, in quality control | The review considered the following risk management objective:<br>**RMO1 - There are arrangements in place to ensure that the Out of Hours service is being delivered in accordance with the contract and is giving the council value for money.** |
| 2 | Children in Care - Savings Provision | 15 | N/A | Fieldwork complete, in quality control | The review considered the following risk management objective:<br>**RMO1 - There are appropriate arrangements to manage Junior ISA and Child Trust Funds for Looked After Children.** |
| 3 | Adult Social Care Debt Recovery | 15 | 18.9 | Final report issued | The review considered the following risk management objective:<br>**RMO1 - There are arrangements in place to manage the recovery of adult social care debt.**<br>The council has an Adult Social Care Debt & Recovery Policy, though it and related procedures are outdated due to resourcing challenges. Clients assessed to contribute to care costs are invoiced every four weeks, with around 3,200 invoices per cycle. Current billing processes are under review to improve efficiency. Staffing shortages have limited the ASC Finance Operations Team to basic functions, delaying full debt recovery and debt write-offs since 2022. However, recent staffing improvements have enabled debt letters to be issued and follow-up actions to be recorded and monitored monthly. **Opinion: Red.**<br>**Overall Opinion: Red. Actions: Four high and one medium priority.**<br>**Actions relate to, reviewing and updating the ASC Debt & Recovery Policy and procedure notes; reviewing all existing ASC debts to identify those which require recommending for write-off; reviewing and updating the ASC write-off document, and ensuring outstanding ASC write-offs are approved and processed.** |
| 4 | Homelessness | 20 | N/A | Fieldwork complete, in quality control | The review considered the following risk management objective:<br>**RMO1 - There are arrangements in place to manage approaches for homelessness assistance, including assessment of duty.** |
| 5 | Planning Obligations | 15 | 24.7 | Final Report Issued | The review considered the following risk management objectives:<br>**RMO1 - There are appropriate arrangements in place to administer planning obligations.**<br>The review found that Medway Council's Local Plan guides land development and is supported by the Medway Guide to Developer Contributions and Obligations, outlining the council's policy on developer contributions. Relevant documents and templates are available on the council's website, along with internal procedure documents for staff. There are established processes for identifying developer |

| Ref | Activity | Number of Days Allocated | Number of Days Used | Current status | Opinion, summary of findings & actions agreed |
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| | | | | | contributions during planning applications, negotiating Heads of Terms, and maintaining records. Agreements are prepared and signed post-decision, with decision notices issued within 14 days of signing.<br>**RMO2 - There are appropriate arrangements in place to monitor planning obligations.**<br>The review confirmed that a procedure document outlines post-agreement processes and monitoring responsibilities. Agreements are tracked using Exacom, with covenants and trigger points entered into the system. Developers must comply, including submitting commencement notices, while the council monitors site progress and issues demand notices when triggers are met. Non-compliance is addressed through established actions. Dedicated cost codes are used for each agreement, ensuring received funds are tracked and spent appropriately and promptly. Annual Infrastructure Funding Statements are produced as required, with regular reporting to the Planning Committee. **Opinion: Green.**<br>**Overall Opinion: Green. Actions: None.** |
| 6 | Medway Virtual School | 15 | 16.9 | Final Report Issued | The review considered the following risk management objective:<br>**RMO1 - There are arrangements in place to manage the pupil premium funding provided to the council for children in their care.**<br>There are established arrangements to manage pupil premium funding for children in care via Medway Virtual School, which comprises 11 posts including a Virtual School Head responsible for promoting educational achievement. The school maintains an up-to-date roll of children in care and monitors their education through statutory Personal Education Plans (PEPs), which must be initiated within 20 working days of care status and reviewed termly.<br>A workflow in the Mosaic system supports PEP completion, jointly managed by Social Workers and Designated Teachers, with oversight and quality assurance provided by Medway Virtual School. Despite these controls, only 61% of summer term PEPs were completed as of 10 June 2025, indicating non-compliance with statutory requirements. No additional controls were identified to improve completion rates.<br>Pupil Premium+ requests are integrated into the PEP process and reviewed by a weekly panel. An annual report on educational outcomes for children in care is presented to the Corporate Parenting Board, fulfilling reporting obligations.<br>**Opinion: Green.**<br>**Overall Opinion: Green. Actions: None.** |

| Ref | Activity | Number of Days Allocated | Number of Days Used | Current status | Opinion, summary of findings & actions agreed |
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| 7 | Establishment Management | 15 | N/A | Deferred to 2025-26 | As this review had not commenced by 31 March 2025, approval was sought from the Chair of the Audit Committee for it to be deferred and reported as part of 2025-26 internal audit activity. |
| *8* | *Medway Norse* | *15* | N/A | *Removed from Plan* | *Removal agreed at September 2024 committee meeting.* |
| *9* | *Integrated Care Boards* | *15* | N/A | *Removed from Plan* | *Removal agreed at September 2024 committee meeting.* |
| 10 | Pentagon Centre | 15 | N/A | *Removed from Plan* | *Removal agreed at January 2025 committee meeting.* |
| *11* | *Medway Development Company (MDC)* | *15* | N/A | *Removed from Plan* | *Removal agreed at September 2024 committee meeting.* |
| 12 | Information Governance - Data Breaches | 15 | N/A | Fieldwork complete, in quality control | The review considered the following risk management objective:<br>**RMO1 - Arrangements are in place to prevent, manage. report and monitor data breaches.** |
| 13 | Approved Contractor Frameworks | 15 | N/A | *Removed from Plan* | *Removal agreed at January 2025 committee meeting.* |
| 14 | Private Housing Enforcement | 15 | 28.2 | Final report issued | The review considered the following risk management objective:<br>**RMO1 - There are appropriate arrangements in place to enforce private housing standards.**<br>The review found there is a Housing Enforcement and Licensing Policy which is in line with the relevant legislation, however this has not been updated to account for the current Housing Strategy, and contains reference to fees for the previous year, and there is no indication of when this document was reviewed/approved. Procedure documents were found to contain outdated information and are not in line with the expected process. While there are no set timescales within legislation for the allocation of cases and assessments, a lack of set timescales within procedures exposes the council to risks around worsening disrepair, with testing identifying excessive and unreasonable timeframes in some cases, although this had improved. The Service conduct case reviews but currently there is no set timescale to measure performance against.<br>While appropriate records are maintained throughout the process, audit testing identified instances of undercharging of fees that were not picked up during the authorisation process, a case involving a vacated tenant outstanding since 2023, |

| Ref | Activity | Number of Days Allocated | Number of Days Used | Current status | Opinion, summary of findings & actions agreed |
|---|---|---|---|---|---|
| | | | | | delays with the issue of final notices, and failure to issue final notices that relate to potential income totalling £134,500, with conflicting information provided leading to an inability to verify the decisions made. **Opinion: Red.**<br>**Overall Opinion: Red. Actions: Eight high, one medium and one low priority. Actions relate to reviewing and updating relevant policies and procedures, incorporating realistic timescales; ensuring fees within the policy and template documents are updated annually; pursuing cases in a timely manner after tenant vacation; reviewing authorisation procedures; reviewing historic notices; reviewing cases where no Final Notice has been served; and serving Final Notices in a timely manner.** |
| 15 | Housing Benefit & CTR Administration | 15 | 44.4 | Final report issued | The review considered the following risk management objective:<br>**RMO1 - Arrangements are in place to process and ensure the accuracy of Housing Benefit & Council Tax Reduction claims.**<br>The review found that information regarding Housing Benefit and Council Tax Reduction is available on the council's website and is regularly reviewed. The claim form is accessible online, and a paper version is also available on request, with information provided on the supporting documentation required. Online claim forms and supporting documents are received in a work tray on the document management system, with paper claim forms and supporting documents scanned to the system, though access would benefit from review. The system is used to manage the workflow, and this is tracked via regular reports. All officers are provided with adequate training and guidance in regard to assessing claims. Claims are assessed and calculated on the revenues & benefit system, with arrangements in place to deal with defective claims, and sample checking of claims undertaken. All claimants are notified of the decision reached and payments are made in line with an agreed schedule. Claimants are made aware of the requirement to report changes in circumstances on both the decision notice, and on the council's website, with a reporting form available. Reported changes of circumstances are assessed, with claims recalculated as necessary. **Opinion: Green.**<br>**Overall Opinion: Green. Actions: One medium and one low priority. Actions relate to reviewing security of the archive room and access levels assigned to documents on the document management system.** |
| 16 | Special Guardianship Orders | 15 | N/A | Fieldwork complete, in quality control | The review considered the following risk management objective:<br>**RMO1 - Arrangements are in place to manage financial support relating to special guardianship orders (SGOs) in accordance with the Special Guardianship** |

| Ref | Activity | Number of Days Allocated | Number of Days Used | Current status | Opinion, summary of findings & actions agreed |
|---|---|---|---|---|---|
| | | | | | **Regulations 2005 (as amended by the Special Guardianship (Amendment) Regulations 2016).** |
| 17 | Payroll | 15 | N/A | Fieldwork complete, in quality control | The review considered the following risk management objective:<br>**RMO1 - There are appropriate arrangements in place to calculate and pay Medway Council staff salaries, including uplifts, allowances and overtime.** |
| 18 | Children in Need - Section 17 Financial Assistance | 15 | N/A | Deferred to 2025-26 | As this review had not commenced by 31 March 2025, approval was sought from the Chair of the Audit Committee for it to be deferred and reported as part of 2025-26 internal audit activity. |
| 19 | Care Transitions | 15 | N/A | *Removed from Plan* | *Removal agreed at January 2025 committee meeting.* |
| 20 | Urgent Care Provision | 15 | N/A | *Removed from Plan* | *Removal agreed at January 2025 committee meeting.* |
| 21 | Staff leave | 15 | N/A | *Removed from Plan* | *Removal agreed at January 2025 committee meeting.* |
| 22 | Housing Rent Recovery | 15 | N/A | Draft report with client for consideration | The review considered the following risk management objective:<br>**RMO1 - There are appropriate arrangements to recover rent arrears, including former tenant arrears.** |
| 23 | Purchase Ledger | 10 | N/A | Deferred to 2025-26 | As this review had not commenced by 31 March 2025, approval was sought from the Chair of the Audit Committee for it to be deferred and reported as part of 2025-26 internal audit activity. |
| 24 | Street Lighting | 15 | N/A | Fieldwork complete, in quality control | The review considered the following risk management objective:<br>**RMO1 - Arrangements are in place to manage the street lighting contract.** |
| 25 | Air Quality Monitoring | 15 | N/A | *Removed from Plan* | *Removal agreed at January 2025 committee meeting.* |
| 26 | Floating Support | 15 | N/A | Fieldwork complete, in quality control | The review considered the following risk management objective:<br>**RMO1 - There are arrangements in place to manage and monitor children's floating support.** |
| 27 | Treasury Management | 15 | N/A | *Removed from Plan* | *Removal agreed at January 2025 committee meeting.* |

| Ref | Activity | Number of Days Allocated | Number of Days Used | Current status | Opinion, summary of findings & actions agreed |
|---|---|---|---|---|---|
| 28 | Remote Sites Financial Management - Including Schools | | | | Three schools were selected as part of a risk assessment looking at budgets and the date of the last internal audit review. The objective of each review is to provide assurance that the school has appropriate mechanisms in place to ensure it is in a sound financial position and that there are no material probity issues. Key areas for review include:<br>• Governance<br>• Payroll<br>• Budget planning and control<br>• Procurement, purchasing and payments<br>• Income and cash management<br>• Asset management |
| | St Marys Island CofE (Aided) Primary School | 20 | N/A | Draft report with client for consideration | |
| | St Augustine of Canterbury Catholic Primary School | 20 | N/A | Draft report with client for consideration | |
| | St Thomas More Roman Catholic Primary School | 20 | N/A | *Removed from Plan* | *Removal agreed at January 2025 committee meeting.* |

## Other assurance work, including advice & information (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 & recommendations made |
|---|---|---|---|---|---|
| | Finalisation of 2023-24 Planned Work | 50 | 87.4 | Complete | All reviews from 2023-24 finalised. |
| | Grant Validations | 12.5 | 29.4 | Complete | Validation work was completed in relation to the following grant funding streams to enable sign off by appropriate officers:<br>• The Disabled Facilities Capital Grant (DFG) Determination (2023-24) and the Disabled Facilities Capital Grant Determination Additional Funding (2023-24). |

| Ref | Activity | Number of Days Allocated | Number of Days Used | Current status | Opinion, summary of findings & recommendations made |
|---|---|---|---|---|---|
| | | | | | • The Family Hubs and Start for Life Programme – Interim Statement of Grant Usage (2).<br>• The Local Transport Capital Block Funding (Integrated Transport And Highway Maintenance Blocks) Specific Grant Determination (2023/24).<br>• Local Transport Capital Block Funding (Pothole Fund) Specific Grant Determination (2023/24).<br>• The Multiply Local Allocations Grant Determination for FY (2023-24).<br>• The Local Authority Bus Subsidy (Revenue) Grant Determination (2023/24).<br>• The High Street HAZ Grant.<br>• The Food Waste Collection Grant Determination 2024. |
| | Supporting Families Assessment Validation | 25 | 13.9 | Complete | The team provided independent verification of all claims for funding and issued the appropriate assurance certificates to be included with the returns. |
| | *HRA Compliancy Validation* | *3 (from responsive assurance budget)* | *2.7* | *Complete* | *As part of preparations for an inspection by the Social Housing regulator, the Housing Division conducted an in-house audit to assess compliance with the 'Big 6' areas, namely Asbestos, Landlord Gas Safety Record (LGSR), Water, Fire Risk Assessment (FRA) (Review & Survey), Periodic Inspection Report (Communal & Domestic) and Passenger Lifts.*<br>*The team were asked to provide an independent view over the findings and provide validation of the conclusions and whether they were reflective of the true situation, as well as determine whether there were any improvements to be made to the overall process of ensuring compliance within HRA.*<br>*This review concluded that the findings of the in-house audit were accurate and also provided additional verification through further sample checking to support the original results. Some recommendations were also made to help streamline the process to evidence compliance in the future.* |
| | *Adult Social Care Self-Assessment Validation* | *12.2 (from responsive assurance budget)* | *4.8* | *Complete* | *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* |

| Ref | Activity | Number of Days Allocated | Number of Days Used | Current status | Opinion, summary of findings & recommendations made |
|---|---|---|---|---|---|
| | | | | | *formed part of the preparation of evidence to support the CQC assessment.*<br>*The team reviewed 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.*<br>*This review concluded that a clear and well-presented self-assessment had been developed and that any areas for improvement or requiring further work had been and appropriately detailed in the respective narrative document.* |
| | FIT Plan Validation | 10 (from responsive assurance budget) | 1.5 | Complete | The agreed One Medway Financial Improvement and Transformation Plan (FIT Plan) states that Internal Audit will provide continuous independent assurance of plan delivery by validating the work undertaken in respect of key actions, to ensure it has progressed/been completed as agreed, before being signed off as complete.<br>For 2024-25, it was agreed that a sample of key actions that had been marked as complete would be selected and reviewed by Internal Audit to validate that there was suitable evidence of completion available.<br>The review found that for all of the key actions reviewed, there was suitable evidence available to validate their completion. |
| | Advice & Information | 0.5 (from responsive assurance budget) | 0.5 | Complete | The team have assisted with several ad-hoc requests for advice and information. |

## Follow Up Work

| Ref | Activity | Number of Days Allocated | Number of Days Used | Current status | Opinion, summary of findings & recommendations made |
|---|---|---|---|---|---|
| | Follow Up of Agreed Actions | 17.5 | 9.4 | Complete | Responsible officers were contacted about outstanding actions on a monthly basis, with all updates/evidence of completion recorded.<br>Full details of the outcomes from follow up activity can be found in section 7. |

## Consultancy work (items in italics have been detailed in previous update reports)

| Activity | Number of Days Allocated | Number of Days Used | Opinion, summary of findings & recommendations made |
|---|---|---|---|
| Innovation Park Medway | 7.6 (from responsive consultancy budget) | 6.7 | A consultancy review was undertaken to evaluate the governance / decision making arrangements relating to the Innovation Park Medway project.<br>Although it was not possible to fully establish the historic governance and decision-making arrangements in place for the project, prior to the pause of the project it appeared that robust processes had been established to provide a sound basis for governance going forward. It was suggested that several further actions be taken once the future of the project had been determined. |
| *Abbey Court School* | *2 (from responsive consultancy budget)* | *1.4* | *Following a session for school bursar's where the internal audit process was explained and information provided about the common control areas identified in school reviews, Abbey Court school requested that internal audit take a look at some of their current processes following a change in staffing, to provide some general advice for potential improvements. The Principal Internal Auditor attended the school and offered advice on ways to streamline processes while ensuring that there was sufficient internal control to manage risks, highlighting best practice previously identified.* |
| Attendance at Corporate Working Groups | 2.5 | 0.4 | The Head of Internal Audit & Counter Fraud has attended meetings for the following:<br>• DWP Audit Working Group<br>• Climate Oversight and Implementation Board<br>• Security & Information Governance Group (Strategic)<br>The Principal Internal Auditor has also attended meetings of the Security & Information Governance Operational Group. |

# 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 2024-25 was agreed by Medway's Audit Committee in March 2024.

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 six of the 13 indicators and outturns presented are those as of 31 March 2025.

| Ref | Indicator | Target | Outturn for period |
|---|---|---|---|
| **Non-LA Specific Performance Measurements** | | | |
| IA1 | Proportion of staff with professional qualification relevant to internal audit | N/A | 44% |
| IA2 | Proportion of non-qualified staff undertaking professional qualification training | N/A | 20% |
| IA3 | Time spent on professional qualification training: | N/A | 136.4 days |
| IA4 | Time spent on CPD/non-professional qualification training, learning & development (including corporate training) | 40 days | 37 days |
| 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%.<br>Work during 2024-25 was focused on an assessment against the new Global Internal Audit Standards, which identified conformance with 46 of 52 Standards, partial conformance with a further five and non-conformance with one. An action plan has been drafted to address gaps in conformance. |
| **LA Specific Performance Measurements** | | | |
| IA6 | Average cost per agreed assurance review | <£5,000 | £7,295 |
| IA7 | Proportion of estimated resources delivered | N/A | 76% |
| IA8 | Proportion of chargeable time spent on:<br>a) Assurance work | N/A | <br>98% |

| Ref | Indicator | Target | Outturn for period |
|---|---|---|---|
| | b) Consultancy work | | 2% |
| IA9 | Proportion of agreed assurance reviews:<br>a) Delivered<br>b) Underway | 95% | <br>63%<br>16% |
| 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% | 0%<br>Only five reviews from 2024-25 have been finalised, one of which was subject to primary review by the HIACF. |
| IA11 | Number of agreed actions that are:<br>a) Not yet due<br>b) Implemented<br>c) Outstanding | N/A | <br>19<br>81<br>11 |
| IA12 | Proportion of actions implemented by agreed date | N/A | 88% |
| IA13 | Client, Management and Member satisfaction with internal audit services | 90% | 88.2%<br>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.<br>34 people responded to the annual survey, 17 of which had received services from internal audit in the last 12 months, and 15 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 2024-25 financial year.

## Status of Agreed Actions (as of 31 March 2025)



| 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 |
|---|---|---|
| Tree Service | **Opinion: Red**<br>Eight actions agreed: Seven **high** and one **medium** priority. | Eight actions due, seven completed.<br>One **high** priority outstanding. |
| Insurances | Opinion: **Amber**.<br>Two **medium** priority actions agreed. | All actions completed. |
| Financial Planning & Budget Setting | Opinion**: Amber.**<br>Three actions agreed: One **high**, one **medium** and one **low** priority. | All actions completed. |
| VAT | Opinion: **Amber.**<br>Four actions agreed: Two **high** and two **low** priority**.** | All actions completed. |
| Emergency Planning | Opinion: **Green.**<br>Four actions agreed: One **medium** and three **low** priority. | All actions completed. |
| Hempstead Schools Federation | Opinion: **Amber**.<br>Five actions agreed: Two **high** and three **medium** priority. | All actions completed. |
| Procurement Compliance | Opinion: **Amber**.<br>Four actions agreed: Two **high,** one **medium** and one **low** priority. | All actions completed. |
| Risk Management Framework | Opinion: **Amber**.<br>One **medium** priority action agreed. | All actions completed. |
| IT Security & Access Controls | Opinion: **Green.**<br>Three **medium** priority actions agreed. | All actions completed. |
| Medway Integrated Community Health Equipment Service | Opinion: **Green.**<br>One **medium** priority action agreed. | All actions completed. |
| Climate Change Action Plan | Opinion: **Green.**<br>One **low** priority action agreed. | All actions completed. |
| Business Continuity – IT Recovery | Opinion: **Amber**.<br>Six actions agreed: Two **high**, two **medium** and two **low** priority. | All actions completed. |
| Legal Case Management | Opinion: **Amber**.<br>Five actions agreed: Two **medium** and three **low** priority. | All actions completed. |
| HMO Licencing | Opinion: **Green**.<br>Two actions agreed. One **medium** and one **low** priority. | All actions completed. |
| Petty Cash | Opinion: **Amber**.<br>One **high** priority action agreed. | No actions due before 31 March 2025. |
| Adult Social Care and Supported Living | Opinion: **Amber**.<br>Five actions agreed: Four **high** and one **medium** priority. | Four actions due, four completed. |
| Staff Travel & Subsistence | Opinion: **Red**. | Two actions due, none 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 |
|---|---|---|
| | Two actions agreed: One **high** and one **low** priority. | One **high** and one **low** priority outstanding. |
| Deprivation of Liberty Safeguards in the Community | Opinion: **Red**.<br>Six actions agreed: Two **high** and four **medium** priority. | All actions completed. |
| Children's Imprest Account | Opinion: **Red**.<br>Four actions agreed: Three **high** and one **medium** priority. | All actions completed. |
| Information Requests | Opinion: **Amber**.<br>Nine actions agreed: One **high**, two **medium** and six **low** priority. | All actions completed. |
| Surveillance (RIPA) | Opinion: **Amber**.<br>Three actions agreed: One **high** and two **low** priority. | All actions completed. |
| HRA Void Repairs Contract & Rechargeable Works | Opinion: **Green**.<br>One **low** priority action agreed. | All actions completed. |
| Caldicott Guardian | Opinion: **Green**.<br>Six actions agreed: One **high** and five **low** priority. | Six actions due, five completed.<br>One **low** priority outstanding. |
| Council Tax Administration | Opinion: **Green**.<br>One **medium** priority action agreed. | All actions completed. |
| Grounds Maintenance & Greenspaces Contract | Opinion: **Green**.<br>One **low** priority action agreed. | All actions completed. |
| IR35 Assessments | Opinion: **Amber**.<br>Five **medium** priority actions agreed. | All actions completed. |
| Brokerage Services | Opinion: **Green**.<br>One **high** priority action agreed. | All actions completed. |
| Fostering Payments | Opinion: **Amber**.<br>Five actions agreed: One **high**, three **medium** and one **low** priority. | Five actions due, four completed.<br>One **low** priority outstanding. |
| Balfour Infant School | Opinion: **Amber**.<br>Five actions agreed: Two **high** and three **medium** priority. | Five actions due, four completed.<br>One **medium** priority outstanding. |
| St Marys Catholic Primary School | Opinion: **Amber**.<br>Nine actions agreed: Six **high**, two **medium** and one **low** priority. | Nine actions due, five completed.<br>Three **high** and one **medium** priority outstanding. |
| St William of Perth Catholic Primary School | Opinion: **Red.**<br>14 actions agreed: Five **high,** six **medium** and three **low** priority. | Two **medium** and one **low** priority completed before report finalised.<br>Nine actions due, nine completed. |
| Health & Safety | Opinion: **Red.**<br>Nine actions agreed: Two **high** and seven **medium** priority. | Three **medium** priority completed before report finalised.<br>No other actions due before 31 March 2025. |
| Complaints | Opinion: **Amber**. | One action due, none 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 |
|---|---|---|
| | Five actions agreed: Three **high**, one **medium** and one **low** priority. | One **high** priority outstanding. |
| Residential Mobile Home Site Licencing | Opinion: **Amber**.<br>Five actions agreed: Two **high** and three **medium** priority. | No actions due before 31 March 2025. |
| Adult Social Care - Assessments & Reviews of Financial Support | **Opinion: Green.**<br>One **medium** priority action agreed. | All actions completed. |

# 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. |