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

Internal Audit Annual Report 2025-26

Medway Council

1. Introduction

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

The Chartered Institute of Internal Auditors (CIIA) defines internal auditing as an independent, objective assurance and advisory function designed to add value and improve an organisation's operations. It supports the achievement of organisational objectives by applying a systematic and disciplined approach to evaluate and enhance the effectiveness of risk management, control, and governance processes.

In accordance with the Global Internal Audit Standards (GIAS) and the Application Note: GIAS in the UK Public Sector ('the 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 Head of Internal Audit & Counter Fraud, in his capacity as Chief Audit Executive, must deliver an annual internal audit opinion and report to support the organisation's Annual Governance Statement. This opinion provides a conclusion on the overall adequacy and effectiveness of the organisation's arrangements for governance, risk management, and internal control.

2. Independence

The Internal Audit Charter, approved by Medway's Audit Committee in March 2025, defines the purpose of the internal audit function, its commitment to conformance with the Global Internal Audit Standards, and its mandate, organisational position, and reporting relationships. The Charter also sets out the arrangements in place to safeguard the independence and objectivity of the function, including direct reporting lines to senior management and Members, and controls to ensure that officers are not assigned operational responsibilities or engaged in activities that could impair their professional judgement.

The work of the Internal Audit team during the period covered by this report has been carried out in accordance with these arrangements. Internal audit activity has been undertaken with full independence and without any inappropriate restriction, interference, or influence from senior officers or Members.

As the Head of Internal Audit & Counter Fraud also has responsibility for counter fraud activities, the Internal Audit team is not able to provide independent assurance over these arrangements. To maintain independence, assurance over the effectiveness of counter fraud activity is obtained periodically from an external provider.

The most recent independent review of counter fraud arrangements was undertaken by Tonbridge & Malling Borough Council in 2018–19.

However, Medway Council is part of a group of local authorities approved by the Public Sector Fraud Authority (PSFA) to assess staff against the professional standards of the Government Counter Fraud Profession and support their accreditation within the Profession.

As part of this approval, the service is subject to periodic peer review through the PSFA's membership assurance process. These reviews are designed to confirm that the service continues to meet the standards required to act as an accredited assessor and to ensure that staff maintain their professional standing within the Government Counter Fraud Profession.

The most recent peer review was conducted by Maidstone Borough Council in October 2025. While this review does not provide assurance over the Council's internal control framework, it does provide independent assurance regarding the quality and robustness of the service's investigative practices.

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 (8.24FTE), made up of the Head of Internal Audit & Counter Fraud (0.65FTE), one Internal Audit Manager, one Principal Internal Auditor, and five Trainee/Internal Auditors (4.59FTE), with one Trainee/Internal Auditor post vacant. Shortly after the beginning of the year, one Internal Auditor (0.81 FTE) retired and two Trainee Internal Auditors were appointed to fill the two vacant posts, increasing the establishment to 8.43 FTE.

The Shared Service Agreement sets out the basis for apportioning resources between the two authorities, with approximately 64% allocated to Medway and 36% to Gravesham. When the Internal Audit Plans for 2025-26 were prepared, this establishment was forecasted to provide a total of 1,020 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 653 days, plus an additional 83 days of internal audit management time.

As of 31 March 2025, a total of 654.4 chargeable audit days (including management and review of IA work) had been delivered for Medway. Of this time, 626.8 days (97%) were spent on audit assurance work and 27.6 days (3%) were spent on advisory work. The outcomes and current status of this work are set out in Section 5 of this report.

The shortfall of 98 days against the estimated resource is attributable to the start date for one of the two new Trainee Internal Auditors being later than anticipated, an underestimate in the number of training days required for the induction of the two new Trainee Internal Auditors, as well as additional time spent on some reviews to provide the necessary levels of assurance. The increased training requirements are also a contributing factor to the outturn against IA1 being below target, as set out in Section 7 of this report.

Learning and development needs were identified and agreed through the appraisal process and addressed through a combination of formal professional training (including apprenticeships), technical skills development, job shadowing and mentoring, and on-the-job learning. Regular team meetings were held throughout the year, and all officers received ongoing support through structured one-to-one supervision with their line managers to monitor progress against work plans.

4. Opinion of the Chief Audit Executive

The Accounts and Audit Regulations 2015 require local authorities to maintain a sound system of internal control that:

(a) facilitates the effective exercise of its functions and the achievement of its aims and objectives;
(b) ensures that financial and operational management is effective; and
(c) includes effective arrangements for the management of risk

In my capacity as Chief Audit Executive, I am required to provide the council, and the Chief Executive, with an independent opinion on the adequacy and effectiveness of the council's framework of governance, risk management, and internal control. This opinion is intended to inform and support the Council's Annual Governance Statement.

The overall scope of internal audit activity is defined within the Internal Audit Charter. The programme of work for 2025-26 was set out in the Internal Audit Plans, which were approved by the Audit Committee. Whilst the Plans cannot provide coverage of all risks faced by the council, audit resources have been directed towards the areas assessed as presenting the highest risk, particularly those linked to the council's strategic and corporate objectives.

This opinion is based on the work completed throughout the year, including any audits carried forward from 2024-25, alongside assurance work delivered as part of the 2025-26 Internal Audit Plans.

Internal audit work has been conducted in accordance with the Standards and methodologies set out in the Internal Audit Manual. All assignments are subject to appropriate supervisory review processes. I am therefore satisfied that the work of the Internal Audit team complies with the requirements of the Standards and is supported by an effective Quality Assurance and Improvement Programme.

In forming my opinion, I have taken into account:

- The outcomes of internal audit work completed since the last annual opinion;
- The findings and assurances arising from previous years' audit work;
- The council's approach to risk management;
- The progress made by management in implementing agreed actions to address identified control weaknesses;
- The outcomes of advisory engagements undertaken by the Internal Audit team; and
- The results of counter fraud and investigation activity completed by the Counter Fraud team.

No issues arising from counter fraud work have been identified that have a material impact on the council's overall governance, risk management, or internal control framework. While no formal reliance is placed on external assurance providers, where available, their findings have been considered in forming this opinion.

The council has a statutory duty to ensure that its resources are managed in a proper, economic, efficient, and effective manner. Internal controls are designed to manage risk to an acceptable level; however, it should be recognised that they cannot eliminate all risk. Accordingly, the Internal Audit team can provide reasonable, but not absolute, assurance.

Based on the work undertaken, I am satisfied that, in the majority of areas reviewed since my last opinion in September 2025, appropriate internal controls are in place and generally operating effectively. However, some areas have been identified where controls require strengthening, or where compliance with established processes needs to be improved. In all such cases, management has agreed appropriate actions to address these findings, and arrangements are in place to monitor their timely implementation.

Whilst not all risks have been subject to direct audit review, I am satisfied that alternative sources of assurance provide sufficient coverage to support a reasonable level of confidence in those areas not examined.

Annual Opinion 2025-26

Corporate Governance

Assurance over corporate governance has been informed by a range of reviews completed during the year, including Governance Framework, GDPR, Transparency, Information Governance – Data Breaches and Budget Monitoring. These reviews identified opportunities to strengthen governance documentation, policy management, accountability arrangements and compliance monitoring. Recurring themes included out-of-date policies and procedures, inconsistencies in governance documentation, weaknesses in the communication of responsibilities and gaps in the monitoring of compliance with governance requirements. However, the reviews also confirmed that the council has established governance structures in place and management has responded positively to findings arising from audit work.

Based on the work completed, I am satisfied that reasonable assurance can be placed upon the council's corporate governance arrangements, although further work is required to improve consistency and strengthen compliance monitoring arrangements.

Risk Management

The council has continued to operate an established risk management framework throughout 2025-26 and maintains a corporate risk register which is subject to regular review.

Audit work completed during the year identified weaknesses in some monitoring and assurance arrangements, including limitations in performance information, compliance monitoring and oversight processes. Resource pressures, organisational change and evolving service delivery models were also identified as factors impacting several areas reviewed. However, audits generally found that risks had been identified and were being managed, albeit with varying levels of maturity and effectiveness across services.

On this basis, I am satisfied that reasonable assurance can be placed on the council's risk management framework for 2025-26.

Internal control

Internal audit work completed during 2025-26 identified a number of control weaknesses requiring improvement, most commonly relating to record keeping, data quality, audit trails, compliance with established procedures, authorisation arrangements and the consistent operation of existing controls. These themes were identified across multiple reviews and indicate that further work is required to strengthen aspects of the control environment.

Only one review finalised during the year resulted in a Red audit opinion. This review identified significant weaknesses in governance, record management, reconciliation processes and the administration of savings arrangements for children in care. Whilst this represents a significant issue requiring management attention, the weaknesses identified were largely confined to a specific service area rather than being indicative of a systemic failure of internal control across the organisation.

Follow-up work undertaken during the year has demonstrated positive progress in implementing agreed actions arising from both current and previous audit work. A substantial proportion of actions due for implementation have been completed, including those linked to audits that resulted in Red opinions. This provides additional assurance regarding management's commitment to addressing identified weaknesses and strengthening the control environment.

I am therefore satisfied that reasonable assurance can be placed on the council's system of internal control, although improvements remain necessary in a number of areas.

Overall Opinion

It is my opinion that reasonable assurance can be provided that the council maintained a generally adequate and effective framework of governance, risk management and internal control during the year ended 31 March 2026, which 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 2025-26 for Medway were approved by the Audit Committee in March 2025 and September 2025. These Plans set out how Internal Audit resources would be deployed during the year, focusing on the areas of highest risk to the Council and providing a clear framework for the delivery of audit work.

Arrangements to monitor delivery of the Plans are embedded within the team's processes. Officer time-recording data feeds into an automated performance monitoring tool, which tracks progress against the shared service work programmes and enables supervisory staff to effectively plan, manage, and support delivery of individual and team objectives.

During the year, the Plans were revised to reflect changes in available resources. The Audit Committee approved amendments to remove the following planned reviews:

- Urgent Care Provision,
- Local Plan.

In addition, the planned assurance review of Children in Care - Assessments & Reviews was deferred to 2026-27.

The tables below set out details of work carried forward from 2024-25 and finalised during 2025-26 (following the previous annual report), alongside progress against the 2025-26 Internal Audit Plans.

2024-25 Internal Audit Assurance work finalised in 2025-26 (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*	*22.1*	*Final report issued*	*The review considered the following Risk Management Objective:* ***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.*** *The review confirmed that a rolling, annually renewed contract is in place with Kent County Council (KCC) for delivery of the Out of Hours service, managed by the Commissioning Lead for Children. At the time of audit, only an unsigned copy of the 2025–26 contract was available; however, assurances were provided that signatures from all parties were imminent.* *Roles and responsibilities for service management and monitoring are clearly defined within the contract, alongside Key Performance Indicators (KPIs). Usage and performance are monitored through quarterly meetings, and plans are in place to revise KPIs to better reflect service performance. Testing of monitoring data identified some miscoding of cases to Medway rather than other authorities.* *Annual spend is calculated based on prior-year usage and the government earnings index. Under the contract, the Council pays an agreed 18.5% share, with a 1% tolerance for over/under usage. The total contract value is apportioned between Children's and Adults services, with Children's bearing the larger share. Evidence confirmed that uplifts for usage above the agreed share are discussed and agreed by all parties.* *A process exists for quarterly contract payments, which are appropriately approved.* ***Opinion: Green.*** ***Overall Opinion: Green. Actions: One low priority.*** ***Action relates to checks of the monitoring data.***
2	Children in Care - Savings Provision	15	34.8	Final report issued	The review considered the following Risk Management Objective: **RMO1 – There are appropriate arrangements to manage Junior ISA and Child Trust Funds for Looked after Children.** The review found that arrangements are in place to administer savings for children in care, including a Children in Care Savings Policy and the use of Share Foundation accounts for eligible children. Most eligible children were found to have savings accounts established, and processes exist for managing accounts and notifying providers when children leave care or reach adulthood. However, a number of control weaknesses were identified. The Savings Policy was not readily accessible and evidence of formal approval could not be provided.

Ref	Activity	Number of days allocated	Number of days used	Current status	Opinion, summary of findings & actions agreed
					Weaknesses in record keeping and reconciliation processes reduced assurance over the completeness and accuracy of account records, while inconsistencies were identified in the submission of eligibility information to the account provider. The audit also found that savings contributions were not being made consistently in accordance with the council's policy, resulting in some eligible children not receiving contributions. In addition, arrangements for children with Child Trust Funds not managed through the council's provider were not fully addressed. Record keeping relating to notifications provided to children and young people was also inconsistent. Historic issues relating to unpaid savings remain unresolved. A previous review identified significant amounts of savings that may not have been allocated to eligible current and former children in care; however, no documented decision or long-term resolution was evidenced, and there is currently no agreed process or funding strategy for addressing these balances. Overall, improvements are required to strengthen governance, record keeping, reconciliation processes and assurance that all eligible children receive the savings support intended under the council's policy. ***Opinion: Red.*** ***Overall Opinion: Red. Actions: Ten high priority.*** **Actions relate to reviewing and updating the Children in Care Savings Policy; confirming whether all currently eligible children in care have a JISA or CTF and taking the appropriate resulting action; confirming and documenting the criteria for children in care to receive savings contributions from the council and consequently determining whether a historic review is required; implementing the use of a workflow episode within the social care system to assist with accurate calculations, valuation records and documents relating to JISAs and CTFs; introducing a documented process for making savings contributions to eligible children without an account with The Share Foundation; reviewing previously rejected payments and identifying and appropriate resolution; and, revisiting the historic savings project to ensure the agreed approach and procedure for investigating and resolving cases is documented and applied consistently.**
4	Homelessness	20	36.0	Final report issued	The review considered the following risk management objective: **RMO1 - There are arrangements in place to manage approaches for homelessness assistance, including assessment of duty.**

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					The review found that an approved Homelessness Prevention and Rough Sleeping Strategy is in place, which is available on the council's website. To support staff, a training matrix is in place, but this requires review to ensure consistent completion of training. In addition, various procedure notes are available, but these have not been reviewed for some time, although updates are planned to align with the Renters Rights Act 2025. Detailed information and advice regarding homelessness support is available on the council's website, with telephone and in-person contact options available. There are also arrangements in place to receive and respond to referrals from relevant public bodies regarding service users that may be homeless or threatened with homelessness. Procedures are in place to establish whether clients approaching the council are homeless or threatened with homelessness and are eligible for assistance, as well as (in appropriate circumstances) having a priority need, having a local connection, and being unintentionally homeless, via a needs assessment interview process, which includes making necessary enquiries and obtaining evidence documents. Needs assessment interviews are booked by the Customer and Business Support (CABS) team, and it may be beneficial for an evidence checklist to also be sent at this point, to reduce delays caused by evidence documents needing to be chased, having not been supplied by the client before or at the interview. Arrangements exist for the information obtained via the needs assessment interview process to be used to determine what duties, if any, are owed to the client, with clients appropriately notified of the decisions reached. Procedures are also in place for the relevant duties to be discharged, with regular case reviews undertaken to ensure compliance with legislation. ***Opinion: Green.*** ***Overall Opinion: Green. Actions: Two medium and one low priority.*** **Actions relate to reviewing the team's training matrix and procedure notes, and investigating the possibility of providing clients with an evidence checklist at the point of booking the needs assessment.**
12	Information Governance - Data Breaches	15	23.5	Final report issued	The review considered the following Risk Management Objective: **RMO1 – Arrangements are in place to prevent, manage, report and monitor data breaches.** The review found that the council has established arrangements for managing and reporting personal data breaches, supported by an up-to-date Data Breach Policy, clear reporting procedures, and defined responsibilities for incident assessment and escalation. The Information Governance Team reviews and risk assesses reported incidents, maintains records of breaches, and undertakes reporting to the

Ref	Activity	Number of days allocated	Number of days used	Current status	Opinion, summary of findings & actions agreed
					Information Commissioner's Office where required. Information on data breaches is also routinely reported through governance arrangements, providing management oversight of incidents and trends. The audit identified a number of areas where controls could be strengthened. Testing found that some incidents were not reported to the Information Governance Team within the timescales required by policy, increasing the risk that statutory reporting deadlines could be missed in the event of a reportable breach. In addition, arrangements for distributing the Data Breach Policy to staff in certain shared services do not fully align with the documented process. Opportunities were also identified to improve the consistency of data recorded within the breach management system and to enhance management information through more detailed analysis of incidents. Overall, the council has a sound framework for managing personal data breaches; however, improvements are required to strengthen compliance with reporting timescales, improve data quality within breach records, and enhance oversight and analysis of incidents. **Opinion: Amber.** **Overall Opinion: Amber. Actions: Two medium and one low priority.** **Actions relate to clarifying Data Breach policy distribution requirements for shared services; reporting on the number of data breaches not reported within the agreed timeframe to SIGG for this to be reiterated with their own management teams; and, reminding officers and introducing compliance checks to ensure case records are completed in full.**
16	*Special Guardianship Orders*	*15*	*35*	*Final report issued*	*The review considered the following risk management objective:* ***RMO1 - Arrangements are in place to manage financial support relating to special guardianship orders (SGOs) in accordance with the Special Guardianship Regulations 2005 (as amended by the Special Guardianship (Amendment) Regulations 2016).*** *The review found that while documentation exists to support financial assessments for Special Guardianship Orders, it requires updating. Eligibility processes are in place, but record-keeping is inconsistent, and some safeguards, such as signed declarations, are outdated and lack the detail needed to support potential fraud investigations.* *Arrangements are in place to help special guardians access benefits and tax credits, and this information is considered during means testing. However, audit testing*

Ref	Activity	Number of days allocated	Number of days used	Current status	Opinion, summary of findings & actions agreed
					identified non-compliance with assessment procedures and further inconsistencies in record maintenance. *Financial support and ad-hoc payments are appropriately approved, but key controls, including declarations of interest and fully signed Support Plans, are not consistently completed. Although assessment outcomes are communicated, change-of-payment declarations are not always returned, and there is no process to monitor this.* *An appeals process is reported to exist, but no central record is maintained, preventing audit verification. Annual review processes are in place, though resourcing challenges resulted in no reviews being completed during 2024–25; these have since been brought up to date.* ***Opinion: Amber.*** ***Overall Opinion: Amber. Actions: Three high, five medium, and one low priority. Actions relate to reviewing the processes and documentation that support Special Guardianship Orders – Financial Support, ensuring all procedure documents and financial assessment forms are accurate, up to date and compliant with current legislation and benefits, rationalising existing records, implementing retention guidance for documents and creating a central log for appeals, annual declarations of interest, workflow alerts for missing documentation and escalation processes for incomplete support plans.***
17	*Payroll*	*15*	*20.4*	*Final report issued*	*The review considered the following risk management objective:* ***RMO1 - There are appropriate arrangements in place to calculate and pay Medway Council staff salaries, including uplifts, allowances and overtime.*** *The review found that online forms are generally completed by line managers to notify Payroll of starters, leavers, contractual changes, allowances and uplifts. For new starters, forms are first routed to the Recruitment Team to set up the employee on the HR and payroll system before being passed to Payroll for pay details. Unique employee reference numbers are allocated appropriately. Required evidence must be submitted where applicable, and workflow controls ensure forms are routed to designated approvers before reaching Payroll.* *The employee self-service portal is used for personal data changes, expenses and overtime, with built-in manager approval. Deductions are typically notified by the employee or the requesting organisation. Payroll undertakes all necessary processing ahead of the monthly cut-off, and the system calculates pay accordingly. While system access to their own records is restricted for Payroll staff, declarations to identify other potential conflicts of interest are not completed.*

Ref	Activity	Number of days allocated	Number of days used	Current status	Opinion, summary of findings & actions agreed
					Audit testing confirmed that processing was correctly completed in most sample cases; however, some gaps were identified in the storage of starter, leaver and pension opt-out documentation, along with an anomaly in how leave dates are recorded. Automated and manual exception reports are run each pay cycle, with final sign-off by two managers. These controls were found to operate effectively, and payments were accurately recorded in the general ledger within the correct accounting period. ***Opinion: Green.*** ***Overall Opinion: Amber. Actions: Four medium priority. Actions relate to, ensuring all documents relating to new starters and leavers are held in the agreed location, reviewing current practices regarding the application of leave dates, and completion of declarations of interests.***
22	*Housing Rent Recovery*	*15*	*22.9*	*Final report issued*	*The review considered the following Risk Management Objective:* ***RMO1 - There are appropriate arrangements to recover rent arrears, including former tenant arrears.*** *The review confirmed that the Council has up-to-date Rent Arrears and Former Tenant Arrears Policies, supported by process documents. However, the current Rent Arrears Policy and tenant arrears process document require publication on the Council's website and intranet respectively. Detailed information on rent arrears and available support is already provided online. Current tenant arrears are identified using analytical software linked to the housing management system, with accounts reviewed weekly and appropriate actions taken. Audit testing confirmed that the process for managing current tenant arrears is being followed in practice. Former tenant arrears are identified through system reports; however, testing found that recovery action was not consistently undertaken in line with the documented process, despite evidence of contact with former tenants. Payments can be made via multiple methods using unique reference numbers, with arrangements in place to ensure correct posting to rent accounts and the General Ledger. Processes exist to monitor debt levels and identify write-offs, although these are not currently approved in accordance with the financial limits set out in the Council's Constitution.* ***Opinion: Amber.*** ***Overall Opinion: Amber. Actions: One high, one medium, and two low priority. Actions relate to publishing the current versions of the Rent Arrears Policy and current tenant arrears process document; reviewing responsibilities for***

Ref	Activity	Number of days allocated	Number of days used	Current status	Opinion, summary of findings & actions agreed
					monitoring and managing former tenant arrears; and, ensuring write offs are approved in line with the council's Constitution.
24	*Street Lighting*	*15*	*13.5*	*Final report issued*	*The review considered the following risk management objective:* ***RMO1 - Arrangements are in place to manage the street lighting contract.*** *The review found that the Highways Street Lighting policy is outdated and scheduled for review as part of the 2025–26 work programme. Current working practices have evolved beyond the scope of the Highways Infrastructure Contract (HIC), and the service is working closely with the contractor to determine how these practices will be formalised following completion of the LED upgrade.* *The service has acknowledged these issues and plans to undertake further investigatory work before the new tendering process begins. This will include reviewing KPI's to ensure they remain relevant and effective. Regular meetings between the service and the contractor are taking place, with open dialogue to address emerging issues.* *Budget monitoring takes place and while this has identified an overspend in one cost code, this has been more than offset by savings achieved through the LED conversion, and further savings are anticipated as the project progresses.* ***Opinion: Amber.*** ***Overall Opinion: Amber. Actions: One medium priority.*** ***The action relates to reviewing the policy and ensuring it captures current working procedures.***
26	*Floating Support*	*15*	*17.5*	*Final report issued*	*The review considered the following Risk Management Objective:* ***RMO1 - There are arrangements in place to manage and monitor children's floating support.*** *The review confirmed that floating support is delivered through a framework of vetted providers under a Dynamic Purchasing System (DPS), administered by the Access to Resources Team (ART). While there are no dedicated policies for floating support, Care Act 2014 guidelines are followed. Standard Operating Procedures were last reviewed in September 2023; however, the panel member list includes staff who no longer appear to be employed by the Council.* *Processes for requesting and authorising support are in place and operating effectively. Audit testing confirmed that decisions are appropriately documented and services monitored by Social Workers. Costs vary based on provider expertise, and ART officers demonstrated efforts to secure best value.*

Ref	Activity	Number of days allocated	Number of days used	Current status	Opinion, summary of findings & actions agreed
					The current DPS is slow and unsuitable for urgent requests, and a replacement system is being procured. Invoices are checked against case logs, but manual entry into Integra is required due to limited system integration. A longstanding coding issue between Mosaic and Integra results in payments being routed through a suspense account before recoding by Finance. Monthly budget monitoring arrangements are in place. ***Opinion: Green.*** ***Overall Opinion: Green. Actions: One low priority.*** ***Action relates to procedures being reviewed and updated.***
28.1	*St Marys Island CofE (Aided) Primary School*	*20*	*23.7*	*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 Governing Body's composition complies with statutory requirements, and meetings are properly quorate and minutes taken. However, the Terms of Reference are not fully aligned with current practice, particularly regarding the Pay Committee. Annual declarations of interest are not consistently completed or updated for governors or staff, and several lack adequate detail.* *Core financial policies are up to date, and payroll, budgeting and reconciliation processes are operating with appropriate controls. However, segregation of duties within banking, purchasing and payment processes is insufficient, and spend limits for credit card and petty cash use are not defined.* *Procurement documentation is generally held, though evidence of approval prior to purchasing is not always recorded. Income processes, lettings arrangements and cash handling are appropriately managed, though the 2024 residential trip lacked retained approval evidence.* *Asset registers are maintained, but do not meet the standards set out in the Medway Council School Finance Manual. Independent asset checks are not carried out, and disposals are handled by the same staff responsible for maintaining the registers.* ***Opinion: Amber.*** ***Overall Opinion: Amber. Actions: Three high, four medium, and three low priority.*** ***Actions relate to reviewing the Governing Body terms of reference and updating to reflect current practice; ensuring all governors and staff complete declarations of interests, with adequate detail, annually; spend limits for credit card and petty cash transactions being determined; reviewing the bank mandate and Bankline signatories to ensure segregation of duties is maintained when ordering and***

Ref	Activity	Number of days allocated	Number of days used	Current status	Opinion, summary of findings & actions agreed
					paying for goods; approval being obtained prior to purchasing and documented; Headteacher and Governing Body approval of trip costings being appropriately documented; updating asset registers in line with the Medway Council School Finance Manual; assets being independently checked annually, with the review being documented; and asset write-offs being independently approved, with records of approval and disposal retained.
28.2	*St Augustine of Canterbury Catholic Primary School*	*20*	*26.5*	*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 confirmed that the Governing Body's composition meets legislative requirements. Meetings are quorate, appropriately minuted, and annual declarations of interest are completed. While key policies exist, some are overdue for review, and evidence of formal approval was not always available.* *Payroll processes are robust, with secure storage, authorisation controls, and regular reconciliations. Annual budgets are approved, and monitoring updates are provided. Responsibilities for financial controls are clearly allocated, and records are securely maintained.* *The school operates a main bank account with an approved provider; however, weaknesses were noted in segregation of duties for purchasing and payments, including debit card usage. Spend limits for debit card and petty cash are not defined in the Finance Policy, and evidence of pre-order approvals was limited, though corrective action has begun.* *Income management is generally sound, with reconciliations in place. A voluntary fund account has not been independently audited since 2020, but steps are underway to close it. Improvements during the review included a school trip costing form and an asset register. Annual asset checks occur, but independence requires strengthening, and iPad security should be reviewed.* ***Opinion: Amber.*** ***Overall Opinion: Amber. Actions: Four high, two medium, and two low priority. Actions relate to ensuring Terms of Reference are in place for the Governing Body and governor committees; reviewing the Whistleblowing Policy in line with stated review date and ensuring that the Finance Policy is approved by the Governing Body following review by the Resources Committee; amending bank signatories and reviewing the use of debit/credit cards to ensure segregation of duties; documenting spending limits in the Finance Policy and ensuring Governing Body approval of purchases over the spending limit is followed up***

Ref	Activity	Number of days allocated	Number of days used	Current status	Opinion, summary of findings & actions agreed
					with confirmation in writing; undertaking independent annual asset checks; and, improving security arrangements for iPads.

2025-26 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	Insurance	15	N/A	Draft report with client for consideration	The review considered the following risk(s): **Risk One - Arrangements are not in place to maintain appropriate insurance cover.** **Risk Two – Arrangements are not in place to ensure insurance claims received by the council are appropriately processed.**
2	Corporate Credit Cards	20	N/A	Draft report with client for consideration	The review considered the following risk(s): **Risk One – Corporate credit cards are not used / managed appropriately.**
3	Managed Moves, Mutual Exchanges, Successions	17	N/A	Supervisory review complete, draft report being prepared	The review considered the following risk(s): **Risk One - The council fails to comply with legal requirements and/or existing policies around managed moves.** **Risk Two - The council fails to comply with legal requirements and/or existing policies around mutual exchanges.** **Risk Three - The council fails to comply with legal requirements and/or existing policies around successions.**
4	*Urgent Care Provision*	*15*	*N/A*	*Removed from Plan*	*Removal agreed at September 2025 Audit Committee meeting.*
5	*Business Rates Administration & Collection*	*20*	*21.5*	*Final report issued*	*The review considered the following risk(s):* ***Risk One – The arrangements in place to administer, bill and collect business rates are ineffective.*** *The review confirmed that processes in place to identify chargeable properties through regular monitoring of Valuation Office Agency (VOA) schedules, planning applications and building control notifications. Weekly reconciliations between VOA and council records are undertaken, however, some long-standing discrepancies were noted without documented explanations or resolutions.* *Liable parties can notify the council of occupancy changes via phone, email, or an online form. Properties without a recorded liable party are monitored, though further guidance for officers on the expected level and frequency of enquiries would*

Ref	Activity	Number of days allocated	Number of days used	Current status	Opinion, summary of findings & actions agreed
					be beneficial. Liable parties, properties and business rates accounts are uniquely identifiable and linked within the revenues & benefits system. Additional guidance for staff to ensure checks for existing Personal Identification Numbers (PINs) before creating new ones would be beneficial. *Testing confirmed that business rates accounts are accurately maintained. Processes ensure correct calculation of business rates through system parameters, and bills are issued to all chargeable properties annually and as required. Bills contain all statutory information, and multiple payment options are available via the bill and the council's website. Payments are correctly allocated to business rates accounts and the general ledger, with regular clearance of suspense accounts. Refunds require multi-level authorisation, ensuring segregation of duties, and all sampled refunds complied with council procedures.* ***Opinion: Green.*** ***Overall Opinion: Green. Actions: Three low priority.*** ***Actions relate to investigations into long term discrepancies between VOA and council records and the creation of procedures notes for identifying liable parties and setting up liable party PINs.***
6	*Building Safety Compliance (Non-HRA)*	*17*	*17.8*	*Advisory review completed*	*After the audit plan for 2025-26 was agreed, a decision was taken to transition from the arrangements with Medway Norse to a new Hybrid Delivery Model for Facilities Management. As such an assurance review was no longer appropriate but an advisory review was completed.* *The new model will combine insourced services with directly managed outsourced specialist services. The change provides an opportunity to redefine roles and responsibilities between the council and its contractors, strengthen contract terms and monitoring arrangements, and ensure robust processes for building compliance checks across all non-HRA properties.* *A number of actions were recommended to the service to ensure that strong controls were in place from the outset of the new working practices.* *It should be noted that Medway Norse will continue to provide some services until 31 March 2026. As a result, risks linked to current gaps in monitoring will remain until the new arrangements are fully implemented. Every effort should therefore be made to work with Medway Norse to ensure compliance with all relevant legislation and regulations during this interim period.*
7	General Data Protection Regulation	20	26.4	Final report issued	The review considered the following risk(s): **Risk One – Effective Leadership & Governance, Policy Framework and Training & Awareness arrangements are not in place to ensure compliance with GDPR.**

Ref	Activity	Number of days allocated	Number of days used	Current status	Opinion, summary of findings & actions agreed
					The review found that appropriate governance arrangements are in place for data protection and information governance, including clear organisational responsibilities, statutory roles, and oversight through established governance groups. A comprehensive suite of policies is in place and largely up to date, and mandatory training arrangements have been established with processes for monitoring and escalating non-compliance. A number of control improvements were identified. Attendance at the Security and Information Governance Group (SIGG) was below expected levels during the period reviewed, and several meetings were cancelled, limiting the effectiveness of governance oversight. In addition, inconsistencies were identified in the publication and monitoring of policies, including some policies being held on systems that do not support completion monitoring, one policy awaiting publication, and outdated versions of two policies remaining accessible. The audit also identified weaknesses in training governance and compliance monitoring. Discrepancies were found between documented training requirements, and current monitoring arrangements only report completion rates for the People Directorate, requiring review to ensure organisational compliance can be effectively demonstrated. Furthermore, a data accuracy project resulted in the temporary removal of a significant number of training courses and policies from the learning platform, creating a backlog and restricting the ability of new and existing staff to complete mandatory training. **Opinion: Amber.** **Risk Two – There are ineffective action plans in place to ensure compliance with GDPR.** The review identified good practice in the development of a GDPR Action Plan, which was approved in July 2025 following a gap analysis against the Information Commissioner's Office Accountability Framework. The Plan contains clear actions, realistic timescales, and defined accountability arrangements, with completion subject to independent verification by the Head of Information Governance before sign-off. However, the effectiveness of governance oversight arrangements requires strengthening. The Action Plan is intended to be monitored through quarterly reporting to the Security and Information Governance Group (SIGG), but the two most recent meetings were cancelled and evidence of ongoing monitoring was not demonstrated through the alternative governance arrangements reviewed. This

Ref	Activity	Number of days allocated	Number of days used	Current status	Opinion, summary of findings & actions agreed
					creates a risk that progress against planned GDPR improvements may not receive sufficient scrutiny and challenge to ensure timely delivery. **Opinion: Green. Overall Opinion: Amber. Actions: One high, three medium, and two low priority. Actions relate to regular review / approval of the SIGG TOR, ensuring all policies are published and accessible, aligning the Training Needs Analysis with the Corporate Mandatory & Recommended Training document, re-launching the data protection / information governance courses and policies on MetaCompliance, reviewing the reporting criteria for the Data Security Protection Toolkit and ensuring completion of the GDPR Action Plan is regularly reviewed by SIGG.**
8	*Budget Monitoring (Revenue)*	*20*	*17.8*	*Final report issued*	*The review considered the following risk(s):* ***Risk One – Monitoring of the council's revenue budget is ineffective.*** *The review found that roles and responsibilities for budget monitoring are clearly defined and communicated to relevant staff, along with a timetable for the monthly budget monitoring process, which is largely set based on the deadlines for reporting to senior management and Members. Although some training and guidance is available, a survey of staff involved in the budget monitoring process, indicated that further training and guidance would be welcomed. Arrangements exist for Budget Managers and Service Managers to review and provide a forecast for all cost centres assigned to them, in each monthly budget monitoring cycle, including providing an explanation for any significant variances, and for Accountants to check and challenge the forecasts provided, as necessary. Rules regarding budget virements and transfers are included within the council's Constitution, including the relevant approval limits, and testing confirmed that adjustments are approved and processed in an accurate and timely manner. Budget monitoring reports are produced regularly and shared with Divisional Management Teams, Corporate Management Team, Cabinet, and the Overview and Scrutiny Committees. Audit testing confirmed that all relevant reports were presented in 2024-25.* ***Opinion: Green.*** ***Overall Opinion: Green. Actions: One medium and one low priority. Actions relate to introducing a more formal process for identifying changes that affect the roles assigned in Integra, and reviewing the budget monitoring training and guidance available to staff involved in this process.***
9	*Governance Framework*	*15*	*12.3*	*Final Report Issued*	*The review considered the following risk(s):*

Ref	Activity	Number of days allocated	Number of days used	Current status	Opinion, summary of findings & actions agreed
					Risk One – Arrangements are not in place to ensure Medway Council's governance framework is effective. *The council has a Code of Corporate Governance within its Constitution; however, the description of the local governance structure could be better aligned to the 2016 CIPFA/SOLACE Delivering Good Governance in Local Government Framework ("the Framework"). The Accounts and Audit Regulations 2015 require an annual review of the effectiveness of the internal control system and the preparation of an Annual Governance Statement (AGS). In practice, these activities are undertaken together, and a process is in place that meets these statutory requirements.* *Audit testing for the 2022–23, 2023–24 and 2024–25 AGS processes confirmed that draft statements were shared with statutory and relevant officers for comment and were approved by the Audit Committee. However, no evidence could be found that the 2023–24 AGS was presented to CMT, unlike the other years, resulting in the published version not containing the Chief Executive's signature.* *Review of the three AGS documents confirmed that they included most elements required by the Framework, including an overview of governance arrangements. However, they were less explicit regarding the effectiveness of these arrangements in achieving the council's planned outcomes. Audit testing confirmed that evidence was available to demonstrate compliance with a sample of Framework sub-principles and the council's Code of Corporate Governance.* *CIPFA/SOLACE issued an addendum to the Framework in May 2025, applying from 2025–26 AGS onwards. Some preparatory changes have already begun, including a report to the Audit Committee outlining the updates. The Committee noted the addendum and requested that the Monitoring Officer review and update the AGS process and the local Code of Governance, with any revisions requiring Full Council approval. The actions identified in this audit can be incorporated into that wider review.* ***Opinion: Amber.*** ***Overall Opinion: Amber. Actions: Three medium priority.*** ***Actions relate to reviews of the Code of Corporate Governance and AGS template in line with the CIPFA/SOLACE Framework, and a review of the criteria for the Chief Executive's sign-off of the AGS.***
10	SEND Education - Education, Health & Care Needs	17	N/A	Draft report awaiting supervisory review	The review considered the following risk(s): **Risk One - Ineffective arrangements are in place for Education, Health Care (EHC) needs assessments to be undertaken and plans prepared.**

Ref	Activity	Number of days allocated	Number of days used	Current status	Opinion, summary of findings & actions agreed
	Assessments & Planning				
11	*Rough Sleeping Services*	*15*	*35*	*Final report issued*	*The review considered the following risk(s):* ***Risk One – The Rough Sleeping Strategy is not delivered effectively.*** *The review confirmed that a Medway Homelessness & Rough Sleeping Strategy to 2030 is in place, supported by annual action plans. A Severe Weather Emergency Protocol (SWEP) exists but requires updating to reflect recent changes to winter provision.* *The service receives referrals from multiple sources through 24/7 mechanisms. Outreach visits take place at least twice weekly to known rough sleepers, with arrangements to verify new referrals. Once verified, initial contact and consent forms are completed, and rough sleepers are invited to undertake needs and risk assessments. The service then seeks to identify an appropriate accommodation pathway and support package.* *An approval process is in place for accommodation and support referrals, although approvals are often given verbally rather than formally recorded. Commissioned accommodation and support services are available, though some contract gaps were identified. Weekly Complex Needs Meetings support case management.* *Audit testing found that interactions and support journeys were generally well recorded. Monthly reporting to the Ministry of Housing, Communities and Local Government is undertaken, with data collated on a central spreadsheet; minor inconsistencies were identified between the spreadsheet and two monthly submissions reviewed.* *Monthly budget monitoring is carried out, and central government funding has been confirmed until March 2028, supporting improved forward planning.* ***Opinion: Amber.*** ***Risk Two – Measures to operationally manage the service are not effective.*** *The review found that although a large number of procedure documents are available to staff, several do not reflect current practice, and some contain contradictions. Training records showed gaps in completion of mandatory training for managers and limited uptake of recommended courses; however, it is noted that the records provided had not been updated for some time and additional training may have since been completed.* *The service is structured into two teams, Outreach and Navigators, but these currently operate under two separate reporting lines, with three managers involved*

Ref	Activity	Number of days allocated	Number of days used	Current status	Opinion, summary of findings & actions agreed
					in allocating and monitoring work. While each team has distinct roles, high caseloads and limited resources often lead to overlap in duties. ***Opinion: Amber. Overall Opinion: Amber. Actions: One high, four medium, and one low priority. Actions relate to ensuring approvals of accommodation pathways and support plans / packages are documented, ensuring contracts / SLAs are in place with all providers of accommodation for rough sleepers, and introducing accuracy checks on the figures included in monthly reports to MHCLG, reviewing and consolidating all procedure documents, promoting completion of training courses identified in the Corporate Mandatory and Recommended Training Programme and ensuring training records are kept up to date, and reviewing the split of duties across the Outreach and Navigator teams.***
12	Children in Need – Section 17 Financial Assistance (deferred from 2024-25 after Q1-Q2 plan agreed)	15	N/A	Supervisory review complete, draft report being prepared	The review considered the following risk(s): **RMO1 - There are arrangements in place to ensure prompt and accurate assessment of claims for Section 17 financial assistance.** **RMO2 - There are arrangements in place to control expenditure.**
13	IT Asset Management	15	N/A	Fieldwork complete, awaiting supervisory review	The review considered the following risk(s): **Risk One – There are insufficient arrangements in place to manage the councils IT assets.**
14	UK Shared Prosperity Fund Management	17	N/A	Changed to Advisory review	This work will now be completed as an advisory review of the Medway Together Fund.
15	Performance, Progression & Pay Assessments	17	N/A	Supervisory review complete, draft report being prepared	The review considered the following risk(s): **Risk One – Arrangements to undertake performance appraisals are ineffective.** **Risk Two – Arrangements to implement MedPay progression and pay assessments are ineffective.**
16	Temporary Accommodation	20	30	Final report issued	The review considered the following risk(s): **Risk One – The arrangements to manage temporary accommodation properties are ineffective.**

Ref	Activity	Number of days allocated	Number of days used	Current status	Opinion, summary of findings & actions agreed
					The review found that effective arrangements are in place for securing and managing temporary accommodation, with provision from both council-owned stock and private providers regularly reviewed to meet demand. Good practice was identified in the controls used to ensure accommodation is safe and suitable, including monitoring of statutory safety certificates and the use of property inspection checklists completed by accommodation providers. A number of opportunities to strengthen controls were identified. Assurance over property standards could be improved through closer alignment of inspection checklists with Housing Health and Safety Rating System (HHSRS) requirements, enhanced landlord declarations, greater consistency in checklist completion, and additional guidance or training for officers responsible for assessing property conditions. It was also identified that formal agreements are not in place with private accommodation providers. This creates a risk that responsibilities, service standards and pricing arrangements are not clearly defined, potentially affecting value for money, service continuity and the council's ability to manage future cost increases. **Opinion: Amber.** **Risk Two – The arrangements to manage temporary accommodation placements are ineffective.** The review found that effective arrangements are in place for the management of temporary accommodation, supported by comprehensive procedures, robust eligibility and suitability assessments, effective rent collection processes, and regular budget monitoring. Good practice was also identified in the provision of financial support to clients, including affordability assessments, housing benefit advice and access to housing support services. A number of opportunities to strengthen controls were identified. While a range of training and guidance is available to staff, training is not mandatory and document control arrangements for procedures could be improved. Weaknesses were also identified in obtaining signed licence agreements and in evidencing some aspects of the property vacation process. It was further identified that oversight of clients in temporary accommodation relies largely on information provided by accommodation providers, with no routine programme of placement visits currently in operation. In addition, former tenant arrears are not currently subject to active recovery arrangements, although work is planned to address this. **Opinion: Amber.**

Ref	Activity	Number of days allocated	Number of days used	Current status	Opinion, summary of findings & actions agreed
					Overall Opinion: Amber. Actions Two high, six medium and three low priority. Actions relate to formal training and guidance on hazards, aligning the TA standards checklist with the HHSRS, enhancing landlord declarations, ensuring consistent use across all providers, reviewing the risk and implications associated with the absence of formal agreements with providers, implementing a consistent document control process, implementing processes to collect signed licences and former tenant arrears, implementing a visit and monitoring process, ensuring auto bidding is in place for home choice applications, and implementing random quality checks on cases.
17	Procurement Compliance	15	N/A	Draft report with client for consideration	The review considered the following risk(s): **Risk One – The council does not have effective procedures in place to ensure compliance with the Procurement Act 2023.**
18	Waste Disposal (Veolia Contracts)	15	N/A	Fieldwork complete, awaiting supervisory review	The review considered the following risk(s): **Risk One – The council does not have effective measures in place to manage the waste disposal contracts.**
19	Medway Adult Education - Financial Support	17	15	Final report issued	The review considered the following risk(s): **Risk One – Arrangements are not in place to effectively administer the Discretionary Learner Support Fund.** The review found that Medway Adult Education has effective arrangements in place for administering the Discretionary Learner Support Fund (DLSF). Good practice was identified through the existence of a comprehensive and regularly reviewed policy, clear eligibility and payment criteria, strong learner guidance and accessibility arrangements, and effective processes for assessing applications and authorising payments. Robust attendance monitoring, reconciliation processes and budget oversight arrangements also provide assurance that funding is being administered appropriately and in accordance with Department for Education requirements. Only a small number of administrative and procedural improvements were identified. These relate primarily to further strengthening the documentation of processes and recently introduced arrangements, including the formal appeals process, which has not yet been tested in practice. **Opinion: Green.** **Risk Two – Arrangements are not in place to effectively administer concessions for eligible adult education courses.**

Ref	Activity	Number of days allocated	Number of days used	Current status	Opinion, summary of findings & actions agreed
					The review found that Medway Adult Education has effective arrangements in place for administering learner concessions. Concession arrangements are clearly defined within the annually approved Fees and Charges Policy, which aligns with Department for Education funding requirements and is supported by clear guidance for learners and staff. Good practice was identified through robust eligibility verification processes, appropriate evidence requirements, and effective checks to ensure concessions are applied consistently and accurately. The audit identified only minor opportunities for improvement. While information on concessions is readily available through the website and staff support, some inconsistencies were identified between printed learner information and more up-to-date online content, creating a risk that learners may access outdated information. Improvements were also recommended to further enhance the accessibility of concession information. **Opinion: Green.** **Overall Opinion: Green. Actions: Three low priority.** **Actions relate to implementing controls for the appeals process to ensure consistency for future appeals and creating an up-to-date digital version of the prospectus.**
20	Temporary Recruitment	17	N/A	Fieldwork complete, awaiting supervisory review	The review considered the following risk(s): **Risk One – Temporary recruitment procedures are ineffective.** **Risk Two – Vetting procedures for temporary workers are ineffective.**
21	Transparency	15	14.9	Final report issued	The review considered the following risk(s): **Risk One - The council fails to comply with the Local Government Transparency Code.** The review found that responsibility for publishing data under the Code falls to the Heads of Service responsible for each dataset. There is no specific communication, guidance or training, but the staff members surveyed appeared comfortable with their roles and responsibilities. Transparency data is published on a central 'Transparency and open data' page on the council's website, although audit testing identified that out of 15 mandatory datasets, six were not being published at the required frequency, and six did not contain all required information. It is noted however that there has been some improvement in compliance with the Code since the last audit undertaken in 2019-20. The Information Governance Team is responsible for monitoring compliance with the Code, and a compliance tracker

Ref	Activity	Number of days allocated	Number of days used	Current status	Opinion, summary of findings & actions agreed
					spreadsheet is held, but this has not been updated since 2021-22. A review was planned for 2025-26 but has been impacted by resourcing issues in the team. **Opinion: Amber.** **Overall Opinion: Amber. Actions: Two medium priority.** **Actions relate reviewing responsibilities for publishing data under the Code and ensuring these have been communicated to the relevant staff members, and establishing a mechanism for monitoring compliance.**
22	STG Building Control	15	20.6	Final report issued	The review considered the following risk(s): **Risk One - Delivery of services via the South Thames Gateway Building Control Partnership is ineffective.** The review found that the Service has an established control framework, supported by a range of policies, procedures and process maps, which are subject to regular review. Minor weaknesses were identified in document management arrangements, including one process map that did not contain a review date. The review confirmed that appropriately qualified and registered Building Inspectors/Surveyors are in place and that registration records are accurately maintained. Arrangements also exist to provide information to customers and enable applications and service requests to be submitted through a range of channels. Audit testing found that key controls relating to application validation, inspections, record-keeping, and the management of dangerous structures and unauthorised works are generally operating effectively. However, improvements are required to ensure extensions of time are consistently agreed and documented in accordance with legislative requirements and that records of related discussions are retained. Opportunities were also identified to strengthen governance arrangements through the review and updating of enforcement-related policies, procedures and process maps to reflect legislative changes. Sample testing provided assurance that fire risk assessment records contain the required information and that statutory fire door checks are being completed. The review also confirmed that arrangements are in place for the charging and recovery of fees, supported by appropriate records. **Opinion: Green.** **Overall Opinion: Green. Actions: One medium and one low priority.** **Actions relate written agreement to extensions of time and associated evidence, and a review of enforcement related policies, procedure and process map to ensure alignment with legislative amendments.**

Ref	Activity	Number of days allocated	Number of days used	Current status	Opinion, summary of findings & actions agreed
23	Establishment Management	20	N/A	Fieldwork complete, awaiting supervisory review	The review considered the following risk(s): **Risk One – The council's staffing establishment is not managed effectively.** **Risk Two – The council's staffing budget is not managed effectively.**
24	*Local Plan*	*15*	N/A	*Removed from Plan*	*Removal agreed at January 2026 Audit Committee meeting.*
25	*Children in Care - Assessments & Reviews*	*20*	N/A	*Deferred to 2026-27*	*Deferral agreed at January 2026 Audit Committee meeting.*
26	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: • Governance • Payroll • Budget planning and control • Procurement, purchasing and payments • Income and cash management • Asset management
26.1	St Peter's Infant School	20	13.5	Final report issued	The review considered the following risk(s): **Risk 1 – The school does not have adequate and effective financial controls in place.** The review found that the school has a generally strong governance and financial control framework in place. Governance arrangements are well established, with the governing body constituted in accordance with legislative requirements, supported by appropriate terms of reference, effective conduct of meetings, and transparent arrangements for declaring and managing interests. Required governance information is published appropriately, key financial policies are in place, and compliance with the Schools Financial Value Standard is demonstrated through annual completion and approval of the self-assessment. Good practice was identified across a number of financial management processes. Payroll changes and additional payments are subject to appropriate approval arrangements, regular budget monitoring and forecasting are undertaken and

Ref	Activity	Number of days allocated	Number of days used	Current status	Opinion, summary of findings & actions agreed
					reported to governors, and robust banking controls are in place, including dual authorisation of payments. Income collection arrangements are operating effectively, supported by cashless payment systems, and appropriate oversight is maintained over contracts, leases, staff reimbursements and insurance arrangements. A small number of control improvements were identified. The Finance Policy requires minor updates to reflect current roles and practices, and a formal record of monthly payroll report reviews is not currently retained. Procurement controls would also benefit from strengthening, as purchase orders are not routinely raised through the school's financial management system and there was limited evidence of prior approval for some service purchases or verification that services had been received before payment. In addition, while asset registers are maintained, independent verification checks of recorded assets are not undertaken. **Opinion: Green.** **Overall Opinion: Green. Actions: One high, two medium, and one low priority. Actions relate to reviewing and updating the Finance policy to ensure all roles and responsibilities are accurate; maintaining a record of checks and Headteacher approval of monthly full payroll reports; ensuring appropriate approval is obtained prior to purchasing, with evidence of approval and checks on goods / services received being retained; and, undertaking annual independent asset checks against the asset register(s).**
26.2	Abbey Court School	20	25.7	Final report issued	The review considered the following risk(s): **Risk 1 – The school does not have adequate and effective financial controls in place.** The review found that the school has a generally effective governance and financial control framework in place. Governing body arrangements comply with legislative requirements, key financial policies have been approved, and appropriate budgeting, financial monitoring and reporting arrangements are operating effectively. Audit testing confirmed that key controls over payroll, banking, purchasing, income collection and asset management are generally operating as intended. Appropriate segregation of duties is in place in most areas, financial transactions are subject to approval and oversight, and accounting records are appropriately maintained.

Ref	Activity	Number of days allocated	Number of days used	Current status	Opinion, summary of findings & actions agreed
					The review identified a number of opportunities to strengthen the control environment. These include ensuring governor declarations of interests are completed by all relevant individuals, improving compliance with statutory website publication requirements, strengthening supporting evidence for certain staff payments, increasing the use of purchase orders for applicable transactions, and enhancing petty cash, safe log and asset management records. In addition, improvements are required to provide a more complete audit trail for asset verification and disposal activities and to ensure all asset registers contain sufficient and consistent information. **Opinion: Amber.** **Overall Opinion: Amber. Actions: Six medium and two low priority.** **Actions relate to strengthening declaration of interest processes; updating governor information on the school's website; supporting evidence for overtime claims; enhancing petty cash reconciliation processes; improving a safe register / log; updating the Specialist Equipment asset register; introducing an asset review schedule; and, reminding staff of asset disposal requirements.**
26.3	Burnt Oak Primary	20	13.8	Final report issued	The review considered the following risk(s): **Risk 1 – The school does not have adequate and effective financial controls in place.** The review found that governance and financial management arrangements at Burnt Oak Primary School are generally operating effectively. Appropriate governance structures are in place through the Bluebell Federation, supported by approved terms of reference, regular meetings, financial policies, annual Schools Financial Value Standard compliance, and robust budget planning and monitoring arrangements. Good practice was also identified in payroll administration, banking controls, income collection processes, contract oversight, and the operation of cashless payment systems. A number of control improvements were identified. Governance records require strengthening, including ensuring governor declarations of interest are reviewed annually, extending declarations of interest requirements to staff, and improving compliance with statutory governance information requirements across the school's website, federation website and national records. Clarification is also required regarding Governing Board membership arrangements and authorised bank signatory records. Some weaknesses were noted within financial control processes. While procurement and payment controls are generally effective, isolated departures

Ref	Activity	Number of days allocated	Number of days used	Current status	Opinion, summary of findings & actions agreed
					from established procedures were identified. In addition, controls over the school's credit card require strengthening, including formal approval of the cardholder, restricting card usage to the authorised holder and setting transaction limits. Evidence of approval for certain policies could not be located. Asset management arrangements are still being embedded following a recent transfer of responsibilities. Although asset registers are maintained, some records were incomplete and evidence of independent asset verification and write-off processes was not yet available. **Opinion: Amber.** **Overall Opinion: Amber. Actions: None.** **As the school are due to become part of an Academy Trust from September 2026, formal actions were not agreed. Instead, a number of recommendations were made for the school to consider in the future.**

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 2024-25 Planned Work	70	82.2	Complete	All reviews from 2024-25 finalised.
	Grant Validations	10	10.7	Complete	Validation work was completed in relation to the following grant funding streams to enable sign off by appropriate officers: • Multiply Local Allocations Grant Determination 31/7121 (2024-25 Statement of Grant Usage) • Local Authority Bus Subsidy (Revenue) Grant: Determination 2024/25: No 31/7227. • Local Transport Capital Block Funding (Integrated Transport and Highway Maintenance Blocks) Specific Grant Determination (2024/25): No.31/7318 and Local Transport Capital Block Funding (Pothole Fund) Specific Grant Determination (2024/25): No.31/7319. • Local Transport Network North Reallocated HS2 Capital Funding 2024-25 • 2024-25 The Disabled Facilities Capital Grant (Dfg) Determinations 317271 and 317605.

Ref	Activity	Number of Days Allocated	Number of Days Used	Current status	Opinion, summary of findings & recommendations made
	FIT Plan Validation	7.5	2.3	Complete	The agreed One Medway Financial Improvement and Transformation Plan (FIT Plan) states that the Internal Audit team 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. The team has provided validation of key actions identified as complete in FIT plan monitoring to provide CMT with independent assurance of progress. During 2025-26, the internal audit team has carried out independent validation, checking evidence to provide CMT with assurance regarding completed key actions. A small number remain outstanding while evidence is awaited.
	Supporting Families Assessment Validation	6	N/A	No longer required	Funding changed and this assurance work was no longer required.
	LATCo Self-Assessment Validation	15	14.7	Underway	It is good practice for local authorities to periodically review the governance arrangements of their Local Authority Trading Companies (LATCos) and joint venture partnerships to ensure they remain effective, proportionate, and aligned with recognised good practice. To obtain assurance over these arrangements, the companies were asked to complete a governance self-assessment, which was subsequently subject to validation by the Internal Audit team. Completed self-assessments were received from Medway Norse, Medway Development Company (MDC), and Kyndi. As of 31 March 2026, validation work had been completed for MDC and Medway Norse, although the final report for Medway Norse was not issued until mid-April. Validation of the Kyndi self-assessment remained in progress. Validation of the MDC self-assessment concluded that its governance arrangements were broadly aligned with recognised good practice. Whilst some opportunities for improvement were identified, the overall framework was found to be operating effectively. The report was presented to the Cabinet Sub-Committee in June 2026, at which point MDC had already made good progress in implementing the majority of the actions recommended by the Internal Audit team.

Ref	Activity	Number of Days Allocated	Number of Days Used	Current status	Opinion, summary of findings & recommendations made
					The narrative responses provided within the Medway Norse self-assessment indicated a commitment to aligning governance arrangements with recognised good-practice standards. However, limited supporting evidence was provided across a number of areas, restricting the Internal Audit team's ability to independently verify the arrangements described. Consequently, it was not possible to reach a sufficiently robust conclusion regarding the effectiveness of the governance framework or to provide detailed, evidence-based recommendations for improvement.
	Responsive Assurance Work	7.5	0	N/A	No responsive assurance work was undertaken during the year.

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	12.5	9.9	Complete	Responsible officers were contacted about outstanding actions on a monthly basis, with all updates/evidence of completion recorded. Full details of the outcomes from follow up activity can be found in section 8.

Advisory 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
Attendance at Corporate Working Groups	2.5	0	The Head of Internal Audit & Counter Fraud has attended meetings for the following: • Climate Oversight and Implementation Board • Security & Information Governance Group (Strategic) • Corporate Risk Management Group.
Responsive Advisory Work	15	0.6	Ad hoc advice & guidance has been provided to a number of services by the Internal Audit Manager over the course of the year, as well as the Principal Internal Auditor providing advice to St Mary's Island School regarding IR35 requirements and attending a meeting about a new

Activity	Number of Days Allocated	Number of Days Used	Opinion, summary of findings & recommendations made
			non-purchase order invoice approval system, offering advice on internal control arrangements in the new processes.

6. Themes & Root Causes

Standard 11.3 Communicating Results of the Standards includes a section on 'Themes', which states *"The findings and conclusions of multiple engagements, when viewed holistically, may reveal patterns or trends, such as root causes. When the chief audit executive identifies themes related to the organisation's governance, risk management, and control processes, the themes must be communicated timely, along with insights, advice, and/or conclusions, to the board and senior management"*.

The findings from all reviews finalised since 1 April 2025 (including those commenced in 2024-25) have been analysed using co-pilot AI to search for any common themes or root causes and this has identified the following.

Governance Themes

Audit work completed during the year identified recurring weaknesses relating to the maintenance, review and communication of governance documentation, including policies, procedures, terms of reference, supporting guidance and formal agreements. While governance frameworks are generally established, a number of reviews found that documentation was outdated, inconsistently controlled, not readily accessible or did not fully reflect current operating arrangements. Reviews also identified weaknesses in the communication of roles and responsibilities, governance oversight arrangements and the monitoring of compliance with governance requirements. Collectively, these issues increase the risk of inconsistent practice and reduce assurance that governance arrangements are operating as intended.

Likely root causes: These weaknesses often arose where ownership and accountability for governance arrangements were not clearly defined, governance documentation had not kept pace with organizational, operational or legislative change, or monitoring arrangements were insufficient to ensure that governance requirements continued to be reviewed and maintained consistently. Reviews receiving stronger assurance opinions generally demonstrated clear ownership, effective document control and established review arrangements. Resource pressures were also a contributory factor in some areas.

Risk Management Themes

A recurring theme identified through audit work relates to the effectiveness of monitoring, assurance and oversight arrangements. Several reviews identified weaknesses in the monitoring of compliance, performance and action plan implementation, alongside limitations in management information and reporting. Whilst most services had mechanisms in place to identify and manage risk, findings often demonstrated that assurance mechanisms were not operating consistently or were not sufficiently developed to provide timely identification and escalation of issues. Resource pressures, service transformation activity and changes to operating models were also identified as factors increasing risk exposure in several service areas.

Likely root causes: In many cases, monitoring and assurance arrangements had not evolved at the same pace as changes to services, systems or demand pressures. Weaknesses were also linked to reliance on manual monitoring processes, limitations in management information, insufficient quality assurance activity and a lack of proactive oversight.

Internal Control Themes

The most common internal control weaknesses identified during the year related to the quality and consistency of control operations rather than the absence of controls. Recurring issues included weaknesses in record keeping, maintenance of audit trails, reconciliations, data quality, evidencing of decisions and retention of supporting documentation. A number of reviews also identified weaknesses in authorisation arrangements, segregation of duties, quality assurance processes and compliance with established procedures. Several audits found controls were operating but were not always applied consistently, evidenced adequately or subject to sufficient supervisory review. These findings increase the risk of error, inconsistency, financial loss, regulatory non-compliance and difficulty demonstrating that decisions have been taken appropriately.

Likely root causes: These weaknesses frequently stem from inconsistent application of established procedures, over-reliance on manual processes and local practices, and control activities becoming dependent on individual knowledge rather than embedded and documented processes. Weaknesses in data management, record keeping and supervisory review also contributed to deficiencies in the effectiveness and consistency of controls.

Appropriate actions have been identified and agreed in individual reviews to address the weaknesses identified.

7. Performance Monitoring

The Standards require that: The chief audit executive must develop objectives to evaluate the internal audit function's performance.

To meet this requirement, arrangements to monitor progress against delivery of the agreed Internal Audit Plan(s) are built into the working processes of the team, including progress against the performance indicators in the table below.

Ref	Indicator	Target	Outturn for period
IA1	Proportion of available resources spent on chargeable work	70%	62%
IA2	Proportion of chargeable time spent on: Assurance work Advisory work	 95% 5%	 97% 3%
IA3	Proportion of agreed assurance reviews: Delivered Underway	 95% N/A	 87% 13%
IA4	Number of agreed actions that are: a) Not yet due b) Implemented c) Outstanding	 N/A N/A N/A	 51 58 15
IA5	Proportion of agreed actions implemented	90%	79.5%

8. Follow up of agreed actions

Where internal audit work identifies opportunities to strengthen the council's risk management, governance, and control arrangements, actions for improvement are agreed with heads of service. In line with the Standards, a follow-up process is in place to monitor the implementation of these actions and to confirm whether management actions have been effectively completed, or where appropriate, whether the associated risks have been formally accepted by senior management. As with all internal audit work, resources should be prioritised based on risk.

Heads of Service are required to provide monthly updates on progress in implementing agreed actions. In addition, evidence must be provided to support the completion of all High priority actions, which is subject to independent verification by the Internal Audit team.

The table below summarises the status of all agreed actions that have been subject to the follow-up process during the 2025-26 financial year.

Status of Agreed Actions (as of 31 March 2026)

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**. Eight actions agreed: Seven **high** and one **medium** priority.	Although eight actions were originally agreed, one has since been cancelled with the service tolerating the level of risk. The one remaining high priority action had a revised implementation date of 31 December 2026 agreed by the Audit Committee in January 2026.
Petty Cash	Opinion: **Amber**. One **high** priority action agreed.	One action due, none completed. One **high** priority outstanding
Adult Social Care Residential Care and Supported Living	Opinion: **Amber**. Five actions agreed: Four **high** and one **medium** priority.	All actions completed.
Staff Travel & Subsistence	Opinion: **Red**. Two actions agreed: One **high** and one **low** priority.	One action due, one completed. The one remaining high priority action had a revised implementation date of 30 November 2026 agreed by the Audit Committee in January 2026
Caldicott Guardian	Opinion: **Green**. Six actions agreed: One **high** and five **low** priority.	All actions completed.
Fostering Payments	Opinion: **Amber**. Five actions agreed: One **high**, three **medium** and one **low** priority.	All actions completed.
Balfour Infant School	Opinion: **Amber**. Five actions agreed: Two **high** and three **medium** priority.	All actions completed.
St Marys Catholic Primary School	Opinion: **Amber**. Nine actions agreed: Six **high**, two **medium** and one **low** priority.	All actions completed.
St William of Perth Catholic Primary School	Opinion: **Red.** 14 actions agreed: Five **high,** six **medium** and three **low** priority.	All actions completed.
Health & Safety	Opinion: **Red.** Nine actions agreed: Two **high** and seven **medium** priority.	All actions completed.
Complaints	Opinion: **Amber**. Five actions agreed: Three **high,** one **medium** and one **low** priority.	All actions completed.
Residential Mobile Home Site Licencing	Opinion: **Amber**. Five actions agreed: Two **high** and three **medium** priority.	Three actions due, three completed. The remaining high priority action had a revised implementation date of 30 September 2026, and the low priority action a revised date of 30 April 2026 agreed by the Audit Committee in January 2026

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
Homes for Independent Living Scheme	Opinion: **Amber**. Six actions agreed: One **high**, three **medium** and two **low** priority.	All actions completed.
Adult Social Care – Debt Recovery	Opinion: **Red**. Five actions agreed: Four **high** and one **medium** priority.	All actions completed.
Housing Benefit & CTR Administration	Opinion: **Green**. Two actions agreed: One **medium** and one **low** priority.	All actions completed.
Unregistered Placements	Opinion: **Green**. One **medium** priority action agreed.	All actions completed.
Private Housing Enforcement	Opinion: **Red**. Ten actions agreed: Eight **high**, one **medium** and one **low** priority.	Two actions completed before report finalised. Eight actions due, one completed. Seven **high** priority actions outstanding.
Housing Rent Recovery	Opinion: **Amber**. Four actions agreed: One **high**, one **medium** and two **low** priority.	All actions completed.
Business Rates Administration & Collection	Opinion: **Green**. Three **low** priority actions agreed.	Two actions due, two completed.
Out Of Hours Service	Opinion: **Green**. One **low** priority action agreed.	All actions completed.
Floating Support	Opinion: **Green**. One **low** priority action agreed.	No actions due in reporting period.
St Augustine of Canterbury Catholic Primary School	Opinion: **Amber**. Eight actions agreed: Four **high**, two **medium** and two **low** priority.	One action completed before report finalised. Five actions due, none completed. Three **high**, one **medium** and one **low** priority outstanding.
Homelessness	Opinion: **Green**. Three actions agreed: Two **medium** and one **low** priority.	One action completed before report finalised. Two actions due, none completed. Two **medium** priority outstanding.
Payroll	Opinion: **Green**. Four **medium** priority actions agreed.	One action completed before report finalised. No actions due in reporting period.
Governance Framework	Opinion: **Amber**. Three **medium** priority actions agreed.	No actions due in reporting period.
Street Lighting	Opinion: **Amber**. One **medium** priority action agreed.	No actions due in reporting period.
Special Guardianship Orders	Opinion: **Amber**. Nine actions agreed: Three **high**, five **medium** and one **low** priority.	No actions due in reporting period.
St Marys Island CofE (Aided) Primary School	Opinion: **Amber**. Ten actions agreed: Three **high**, four **medium** and three **low** priority.	Two actions completed before report finalised. One action due, one 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
Budget Monitoring (Revenue)	Opinion: **Green**. Two actions agreed: One **medium** and one **low** priority.	No actions due in reporting period.
Rough Sleeping Services	Opinion: **Amber**. Six actions agreed: One **high,** four **medium** and one **low** priority.	No actions due in reporting period.
Information Governance - Data Breaches	Opinion: **Amber**. Three actions agreed: Two **medium** and one **low** priority.	One action completed before report finalised. No actions due in reporting period.
Children in Care - Savings Provision	Opinion: **Red**. Ten **high** priority actions agreed.	One action completed before report finalised. No actions due in reporting period.
General Data Protection Regulation	Opinion: **Amber**. Six actions agreed: One **high,** three **medium** and two **low** priority.	Two actions completed before report finalised. No actions due in reporting period.

Definitions of audit opinions

Red	Limited assurance can be provided that effective governance, risk management and control processes are in place within the activity under review. The combination of control weaknesses identified are considered to present significant risk to the achievement of the objectives for the activity under review, or the council's wider strategic objectives, and/or expose the council to significant risk of legal / legislative / regulatory breaches, unacceptable levels of fraud / loss / error, or reputational damage.
Amber	Reasonable assurance can be provided that governance, risk management and control processes are in place within the activity under review, but improvements are required to ensure their effectiveness and/or to address gaps in coverage. The combination of control weaknesses identified are considered to present moderate risk to the achievement of the objectives for the activity under review, or the council's wider strategic objectives.
Green	Reasonable assurance can be provided that effective governance, risk management and control processes are in place within the activity under review. The combination of control weaknesses identified (if any) are considered to present minimal risk to the achievement of the objectives for the activity under review, or the council's wider strategic objectives.

Action Priorities

High	The action addresses a control weakness that presents a significant risk (i.e. the likelihood of the risk occurring and/or impact on the council's governance, risk management and control processes is considered to be high). Management should address the action as a matter of priority.
Medium	The action addresses a control weakness that presents a moderate risk (i.e. the likelihood of the risk occurring and/or impact on the council's governance, risk management and control processes is considered to be medium). Management should address the action within a reasonable timeframe.
Low	The action addresses a control weakness that presents a small risk (i.e. the likelihood of the risk occurring and/or impact on the council's governance, risk management and control processes is considered to be low). Management should address the action as resources allow.