Internal Audit Update

Gravesham Borough Council

For the period:

1 October – 31 December 2022

1. Introduction

1.1 The Audit & Counter Fraud Shared Service for Medway Council & Gravesham Borough Council was established on 1 March 2016. The team provides internal audit assurance and consultancy, proactive counter fraud and reactive investigation services, and the Single Point of Contact between both authorities and the Department for Work & Pensions Fraud & Error Service for their investigation of Benefits Fraud

1.2 The Public Sector Internal Audit Standards (the Standards) require that: *The chief audit executive must report periodically to senior management and the board on the internal audit activity's purpose, authority, responsibility, and performance relative to its plan. Reporting must also include significant risk exposures and control issues, including fraud risks, governance issues and other matters needed or requested by senior management and the board.*

2. Executive Summary

2.1 Work has continued since the last update with nine planned assurance reviews for 2022-23 having had fieldwork completed, six of which are currently going through the quality control process. A further two have draft reports with clients for consideration and one has been finalised.

- Planning Obligations – Opinion: **Amber**.

2.2 In addition, a further review is underway and commencement of a number of others is being arranged with the clients. As a consequence of this work, plan delivery as of 31 December 2022 was 47% complete, with a further 5% underway. Full details of the individual reviews can be found in section 5 of this report

2.3 Follow up of agreed recommendations has continued and performance as of 31 December stood at 88.2%, with 45 of 51 actions due in the period having been completed. Four remain outstanding and are being monitored in line with the agreed follow up process. Full details of the progress made in relation to action follow up can be found at section 8.

2.4 There has been significant impact on planned resources, mainly due to the extended vacancy for an Internal Auditor due to the shortage of qualified auditors nationally, and the fact that it took three attempts to recruit an apprentice, who started in late November. We are currently projecting a loss of approximately 64 days from the estimated 442 available at the start of the year.

3. Independence

3.1 The Internal Audit Charter was approved by the Finance & Audit Committee in February 2022 and sets out the purpose, authority, and responsibility of the Internal Audit team. The Charter sets out the arrangements to ensure the team's independence and objectivity through direct reporting lines to senior management and Members, and through safeguards to ensure officers remain free from operational responsibility and do not engage in any other activity that may impair their judgement. The work of the team during the period covered by this report has been free from any inappropriate restriction or influence from senior officers and/or Members.

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

4. Resources

4.1 The Internal Audit & Counter Fraud Shared Service reports to the Section 151 Officers of Medway Council and Gravesham Borough Council. The Internal Audit team consists of; the Head of Internal Audit & Counter Fraud (0.65FTE), one Internal Audit Manager, one Senior Internal Auditor, five Internal Auditors (4.78FTE) and one Internal Audit Apprentice.

4.2 The Shared Service Agreement sets out the basis for splitting the available resources between the two councils, approximately 64% for Medway, with the remaining 36% for Gravesham. The establishment at the beginning of 2022-23 was forecasted to provide a total of 1,219 days available for internal audit work (net of allowances for leave, training, management, administration etc.) with the share for Gravesham being 442 days.

4.3 Net staff days available for Gravesham for the period 1 October to 30 December 2022 amounted to 71.5 days and 55.5 days (78%) were spent on chargeable internal audit work. Of this chargeable time, 53.4 days (96%) was spent on audit assurance work and 2 days (4%) was spent on consultancy work. The current status and results of all work carried out are detailed at section 5 of this report.

4.4 As previously reported, the resignation of an Internal Auditor and the first two of three attempts to recruit an apprentice being unsuccessful affected the level of resources. Our most recent projections suggest a loss of around 64 days from the projected internal audit resource available at the start of the year.

5. Results of planned Audit & Counter Fraud work

5.1 The Internal Audit Plans Q1-Q2 and Q3-Q4 2022-23 for Gravesham were approved by the Finance & Audit Committee in March 2022 and September 2022 respectively. The Plans are intended to provide a clear picture of how the council will use the Internal Audit resource, reflecting all work to be carried out by the team for Gravesham during the financial year.

5.2 The tables below provide details the progress of work undertaken as part of the 2022-23 plans.

2022-23 Internal Audit assurance work

Ref	Activity	Day budget	Days used	Current status	Opinion, summary of findings & recommendations made
1	IT Security & Access Controls	15		Fieldwork Underway	The review will consider the following Risk Management Objective: **RMO1 - There are arrangements in place to ensure that access to the council's network is secure.**
2	Communications Strategy	15		Fieldwork complete, in quality control	The review considered the following Risk Management Objective: **RMO1 - Effective arrangements are in place to deliver the council's Communications Strategy 2020-2023.**
3	NNDR Reliefs	15		Fieldwork complete, in quality control	The review considered the following Risk Management Objective: **RMO1 - Arrangements are in place for the administration of discretionary and mandatory NNDR relief.**
4	Right to Buy			Fieldwork complete, in quality control	The review considered the following Risk Management Objective: **RMO1 - There are adequate arrangements in place to allow Right to Buy applications to be processed.**
5	Procurement Compliance	15		Fieldwork complete, in quality control	The review considered the following Risk Management Objective: **RMO1 - Processes are in place to ensure the council complies with the requirements of the Public Contracts Regulations 2015 and the council's own Contracts Procedure Rules.**
6	Planning Obligations	15	18.2	Final Report Issued	The review considered the following Risk Management Objectives: **RMO1 - Planning obligations are appropriately used to ensure that development does not adversely impact the borough.** The review found that there is a limited number of S106 agreements arranged each year and many of the current Planners have not been involved in arranging them. We were advised that the majority of S106 requests come from consultees, either internal or external. No evidence could be identified of an up to date and agreed/documented procedure to support officers with this, though arrangements must exist to identify and assess instances in which S106 agreements will be used, simply because there are agreements in place. S106 agreements are prepared by Legal Services and contain all necessary information, with a document recently introduced for the Planners to instruct Legal Services to draw up an agreement. There is a standard form available for applicants to request amendments or vary a S106 agreement, with such changes made by way of a Deed of Variation prepared by Legal Services when required. The council's requirement to publish an annual Infrastructure Funding Statement (IFS) is overdue with the last IFS published

Ref	Activity	Day budget	Days used	Current status	Opinion, summary of findings & recommendations made
					relating to 2019-20. This has been delayed because the record held of all S106 agreements was found to be incomplete and work is currently underway to rectify this. **Opinion: Amber.** **RMO2 - Appropriate monitoring is undertaken of all planning obligation agreements.** The review found that there is limited monitoring of the financial contributions received relating to S106 agreements to ensure they are drawn down, spent, or returned as necessary. The record held of all S106 agreements is currently incomplete and work is underway to rectify this. Once the record of S106 agreements is complete and accurate, the role of recording new S106 agreements and identifying and monitoring those with a financial contribution, including notifying the relevant parties that a contribution they requested has been received, will be allocated to another officer. **Opinion: Amber.** **Overall Opinion: Amber. Actions: Two high and three medium priority. Actions relate to preparing guidance notes to support the processes for arranging and amending S106 agreements, making arrangements to publish the required Infrastructure Funding Statements, preparing accurate records of S106 agreements and allocating responsibility for maintaining and monitoring these records, and putting arrangements in place to monitor unspent contributions.**
7	Financial Planning and Budget Setting (General Fund)	15		Fieldwork complete, in quality control	The review considered the following Risk Management Objectives: **RMO1 - The council has an ongoing plan to balance the General Fund revenue budget both in the current year and going forward**
8	Whistleblowing	15		Draft report with client for consideration	The review considered the following Risk Management Objective: **RMO1 - There are appropriate arrangements in place to manage whistleblowing.**
9	Void Property Management	15		Fieldwork complete, in quality control	The review considered the following Risk Management Objective: **RMO1 - There are appropriate arrangements for void properties to be managed.**
10	Food Safety Inspections (rating scheme)	15		Draft report with client for consideration	The review considered the following Risk Management Objective: **RMO1 - There are arrangements in place to ensure food safety inspections are conducted in line with the appropriate legislation.**
11	*Housing Development Strategy*	*N/A*	*N/A*	*Removed from Plan*	*Removal agreed at September 2022 meeting*

Ref	Activity	Day budget	Days used	Current status	Opinion, summary of findings & recommendations made
12	*Information Requests (FOI, SAR, EIR)*	*N/A*	*N/A*	*Removed from Plan*	*Removal agreed at September 2022 meeting*
13	Homelessness			Terms of reference being prepared	
14	Planned & Major Works Programme			Terms of reference being prepared	
15	Rent Deposit Scheme			Terms of reference being prepared	
16	Emergency Planning			Terms of reference being prepared	
17	Digital Strategy				
18	Climate Change Action Plan			Terms of reference being prepared	
19	Write-offs			Terms of reference being prepared	
20	Regeneration				
21	Housing Rent Recovery			Terms of reference being prepared	

Other assurance activity

Ref	Activity	Day budget	Days used	Current status	Opinion, summary of findings & recommendations made
	Finalisation of 2021-22 Planned Work	*20*	*70.4*	*Complete*	*All details provided in September update.*
	Validation of Performance Data	*10*	*8.6*	*Complete*	*All details provided in September update.*
	Grant Validations	6	N/A	In progress	No activity in the period

Responsive assurance activity

Activity	Opinion, summary of findings & recommendations made
No activity during the period.	

Other consultancy services including advice & information

Activity	Opinion, summary of findings & recommendations made
Rosherville Servicing	A consultancy review was finalised in December 2022, looking at arrangements relating to charge and invoice the company for services provided by the council. The review concluded that there were appropriate arrangements in place, however, several suggested actions were identified to further enhance those arrangements.
Woodville	A consultancy review is currently in progress but is not yet concluded.

6. Quality Assurance & Improvement Programme

6.1 The Standards require that: *The chief audit executive must develop and maintain a quality assurance and improvement programme that covers all aspects of the internal audit activity. A Quality Assurance & Improvement Programme (QAIP) has been prepared to meet this requirement.* The Internal Audit QAIP was agreed by the Finance & Audit Committee in February 2022.

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

6.3 In line with the QAIP, the team monitor performance against a suite of 14 performance indicators. The table below sets out the performance targets, which are grouped into measures for the service and those that are specific to the individual authority. Targets have been set for nine of the 14 indicators; however, it should be noted that these are for full year outturns; as such outturns at present are not to target levels but are provided for Members information.

Ref	Indicator	Target	Outturn for period
Non LA Specific Performance Measurements			
IA1	Proportion of staff with professional qualification relevant to internal audit	65%	30%
IA2	Proportion of non-qualified staff undertaking professional qualification training	25%	29%
IA3	Time spent on professional qualification training:	N/A	2.4 Days
IA4	Time spent on CPD/non-professional qualification training, learning & development	40 days	3.7 Days
IA5	Compliance with PSIAS	100%	There are 211 elements in PSIAS, and the latest self-assessment indicates the service is fully compliant with 205 elements (97.2%), partially compliant with a further five (2.3%) and non-compliant with one element (0.5%). This shows some improvement since the last self-assessment, which was 94% compliance, 4% partial, and 2% non-compliance. An external assessment is shortly to be conducted, part of which will provide validation for the self-assessment.
LA Specific Performance Measurements			
IA6	Average cost per agreed assurance review	<£5,000	Annual Outturn
IA7	Proportion of available resources spent on chargeable work	N/A	78%
IA8	Proportion of chargeable time spent on: a) Assurance work	N/A	96%

Ref	Indicator	Target	Outturn for period
	b) Consultancy work		4%
IA9	Proportion of agreed assurance reviews: a) Delivered b) Underway	95%	 47% 5%
IA10	Proportion of completed assurance reviews subject to a second stage (senior management) quality control check in addition to the primary quality control review	10%	0% (Calculation based on finalised reviews)
IA11	Proportion of actions agreed by client management to address control weaknesses	90%	100%
IA12	Number of agreed actions that are: a) Not yet due b) Implemented c) Outstanding	N/A	 14 45 6
IA13	Proportion of actions implemented by agreed date	N/A	88.2%
IA14	Client, Management and Member satisfaction with internal audit services	90%	A satisfaction survey will be issued at the end of 2022-23.

7. Review of Internal Audit Plan

7.1 Monitoring of the delivery of planned work is built into the team's processes with individual officer time recording data feeding into an automated performance monitoring workbook; this tracks the performance of the team against the internal audit work plans and enables the Internal Audit Manager to plan and support officers to deliver their individual work plans.

7.2 Projection of the resources that will be available to the year-end are calculated at least quarterly and compared to the original forecasts. This determines any impacts on projected resources that would impact on delivery of the internal audit plan.

7.3 As detailed in paragraph 4.5, we are currently projecting a loss of approximately 64 days from forecasted audit resources for 2022-23. Previous changes to the plan have already accounted for 30 days and the remaining time is being covered by the adjustment of other allowances.

8. Follow up of agreed Actions

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

8.2 Service managers are asked to provide an update on action taken towards implementing all actions due on a monthly basis and are also asked to supply evidence in respect of all completed High priority actions, which is verified by the Internal Audit Team.

8.3 The first of the two tables below details the current position in relation to the follow up process and the second details actions that are now more than six months over their planned implementation date; along with an update from the relevant Service Manager/Assistant Director/Director. Some may also contain details of revised implementation dates that have been agreed by Management Team.

Status of agreed actions

Audit title	Overall opinion and number of actions of each priority agreed with management	Number of actions due for implementation where a positive management response has been received
Leaseholder Management	Opinion: **Amber**. Four actions agreed: One high and three medium priority. Actions relate to the Leaseholders' Handbook being updated, procedure notes being reviewed, the arrangements in place to calculate interim service charges being reviewed, and reviewing the arrangements in place to respond to requests to view the accounts which can be made available for the inspection of leaseholders.	Two actions due, two completed. Revised implementation dates agreed for the other two actions.
Risk Management Compliance	Opinion: **Amber**. Three actions agreed: One high and two medium priority. Actions relate to reviewing the processes in place for assessing and recording operational risks; reviewing the arrangements in place for providing consistent risk management training to staff; and, reviewing the arrangements in place for reviewing Service Risk Registers.	All actions completed.
Temporary Accommodation – Out of Area Placements	Opinion **Red**. Eight actions agreed: Seven high and one medium priority. Actions relate to the Temporary Accommodation Out of Area Placement policy (or an equivalent policy) being agreed and reviewed/signed off regularly; up-to-date workflows/procedures for managing temporary accommodation being put in place; procedures being reviewed to ensure compliance with the Homelessness Code of Guidance for local authorities can be demonstrated relating to the standard / suitability of accommodation for out of area placements; and arrangements being in put in place to ensure that costs are recovered for all temporary accommodation placements outside of the council's housing stock.	Eight actions due, seven completed. One high priority outstanding relating to arrangements being in put in place to ensure that costs are recovered for all temporary accommodation placements outside of the council's housing stock.
Council Tax Discounts, Disregards & Exemptions	Opinion: **Amber**. Three actions agreed: One high, one medium and one low priority. Actions relate to a review of the procedure notes/guidance for the administration of Council Tax DDEs; a review of applications (including online and paper forms), ensuring that appropriate applications are accompanied by a signed application form; and, a review of the arrangements in place to review Council Tax DDEs to ensure that they remain valid, with these reviews documented.	Two actions due, one completed. One medium priority outstanding relating to a review of applications (including online and paper forms), ensuring that appropriate applications are accompanied by a signed application form.
Accessibility Regulations	Opinion: **Amber**. Three actions agreed: One medium and two low priority. Actions relate to reviewing and updating a web accessibility action plan, investigating / agreeing arrangements for websites other than the main council website to be made compliant	All actions completed.

Audit title	Overall opinion and number of actions of each priority agreed with management	Number of actions due for implementation where a positive management response has been received
	with the Accessibility Regulations and publishing an accessibility statement on the council's intranet to explain that it is currently exempt from the regulations.	
GDPR	Opinion: **Amber**. Five actions agreed: Four high and one medium priority. Actions relate to the GDPR action plan being finalised; the most up to date versions of the Information Governance policies being shared with staff; planned training to be reviewed to consider the need for specific training on data incident handling; and, a review of the forms and processes in place to capture data incidents, to ensure a complete record is available of the incident and action taken.	Four actions due, two completed. Two high priority outstanding relating to a review of policies and also of the forms and processes in place to capture data incidents, to ensure a complete record is available of the incident and action taken.
Housing Allocations	Opinion: **Amber**. Two actions agreed: Two medium priority. Actions relate to a checklist being created to confirm all necessary documents have been obtained for each application; and, regular quality assurance checks being carried out.	Two actions due, one completed. One medium priority outstanding relating to regular quality assurance checks being carried out.
Council Housing – Disabled Adaptations	Opinion: **Amber**. Three actions agreed: Two high and one medium priority. Actions relate to the update and communication of the Aids & Adaptation Policy for Council Tenants, ensuring there is relevant information available to tenants and the process for tenants to request aids and adaptations being reviewed.	All actions completed.
Planning Applications	Opinion: **Amber**. Five actions agreed: Two high, two medium and one low priority. Actions relate to charging for pre-application advice being reviewed; invalid applications being monitored to ensure there are no significant delays; Timely completion of the pre-validation checklist being made a mandatory part of the validation process and monitored via the Planning Technical Support Team Leader; investigating if the recommendation approval tab on Uniform can be restricted to senior officers only; and, arrangements being made for approval arrangements for planning applications set out in the Constitution to be reviewed.	One action due, one completed.
Business Continuity Planning	Opinion: **Amber**. Five actions agreed: Two high, two medium and one low priority. Actions relate to the Business Continuity Management Framework and revised BCP templates being circulated to relevant staff and plan owners instructed to update their plans; an updated Corporate BCP being created; testing exercises being scheduled and carried out; and the Framework being updated in relation to arrangements for post incident reviews	Four actions due, four completed.
Planning Obligations	Opinion: **Amber**. Five actions agreed: Two high and three medium priority.	No actions due in report period.

Audit title	Overall opinion and number of actions of each priority agreed with management	Number of actions due for implementation where a positive management response has been received
	Actions relate to preparing guidance notes to support the processes for arranging and amending S106 agreements, making arrangements to publish the required Infrastructure Funding Statements, preparing accurate records of S106 agreements and allocating responsibility for maintaining and monitoring these records, and putting arrangements in place to monitor unspent contributions.	

Actions outstanding more than six months after scheduled implementation date

Directorate	Audit title	Action	Priority	Planned implementation date	Management update

Definitions of audit opinions & action priorities

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

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