Internal Audit Update

Gravesham Borough Council

For the period:

1 April – 31 July 2024

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 The first four months of 2024-25 have been productive with the following audit reviews finalised;
**Items in italics had full details of the review included in the 2023-24 annual report.*

- *Staff Travel & Subsistence – Opinion: **Red** (2023-24 review finalised in 2024-25)*
- *Risk Management Framework - **Amber** (2023-24 review finalised in 2024-25)*
- *Carbon Reduction Programmes – Opinion: **Green** (2023-24 review finalised in 2024-25)*
- *Information Requests (FOI, EIR, SAR) – Opinion: **Green** (2023-24 review finalised in 2024-25)*
- *Taxi & Private Hire Vehicle Licencing & Enforcement – Opinion: **Green** (2023-24 review finalised in 2024-25)*
- *Staff Flexible Working Arrangements – Opinion: **Amber** (2023-24 review finalised in 2024-25)*
- *HMO Licencing – Opinion: **Green** (2023-24 review finalised in 2024-25)*
- IT Asset Management – Opinion: **Amber** (2023-24 review finalised in 2024-25)

In addition, the remaining three reviews from 2023-24 continue to go through the quality control process, one review from 2024-25 has had fieldwork completed and is now going through the quality control process, three further reviews are currently underway and commencement of a number of others is being arranged with clients. As a consequence of this work, plan delivery as at 31 July was 5% complete, with a further 9% underway. Full details of the individual reviews can be found in section 5 of this report.

2.2 Follow up of agreed actions has continued and performance as of 31 July stood at 70.4%, with 19 of 27 actions due in the period having been implemented (based on responses received by report deadline). Eight remain outstanding and are being monitored in line with the agreed follow up process. Full details of the progress made in relation to follow up can be found at section 8.

2.3 There has been significant impact on projected resources due to sickness and the resignation of one Internal Auditor. A Counter Fraud Officer has moved to the Internal Audit team for the remainder of the financial year to try and fill some of the resource gap. As a consequence, we are currently projecting a loss of approximately 33 days from the projected 385 available at the start of the year and this has been addressed as part of the planning process for Q3-Q4.

3. Independence

3.1 The Internal Audit Charter was approved by the Finance & Audit Committee in February 2024 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 Principal Internal Auditor, five Internal Auditors (4.59FTE) and one Trainee Internal Auditor.

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 time the Internal Audit plan for 2023-24 was prepared, was forecasted to provide a total of 1,070 days available for internal audit work (net of allowances for leave, training, management, administration etc.) with the share for Gravesham being 385 days, along with a further 41 days for management of internal audit activity.

4.3 Net chargeable days available for Gravesham for the period 1 April to 31 July 2024 amounted to 84.3 days. This represents 22% of the 385 days originally estimated to be available at the start of 2024-25. Of this chargeable time, 82.5 days (98%) was spent on audit assurance work and 1.8 days (2%) 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 There has been a significant impact on available resource due to sickness within the team and the resignation of an Internal Auditor. A Counter Fraud Officer has moved to the Internal Audit team for the remainder of the financial year to help fill some of this resource gap.

4.5 Based on our most recent assessment, we are currently projecting a loss of approximately 53 days from the projected internal audit resource available at the start of the year.

5. Results of planned Internal Audit work

5.1 The Internal Audit Plan Q1-Q2 2024-25 for Gravesham was approved by the Finance & Audit Committee in March 2024. The Plan is 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 first six months of the financial year.

5.2 The tables below provide details of the work from 2023-24 that has been finalised in 2024-25 (excluding those detailed in the annual report for 2023-24) and the progress of work undertaken as part of the Q1-Q2 2024-25 plan during the period.

2023-24 Internal Audit assurance work finalised in 2024-25 (since the last Audit Committee meeting)

Ref	Activity	Day budget	Days used	Current status	Opinion, summary of findings & recommendations made
1	Tenancy Management	15	N/A	Fieldwork complete, in quality control	The review considered the following Risk Management Objective: **RMO1 - There are arrangements in place to manage council tenancies, including mutual exchanges, successions, and terminations.**
14	Planning Enforcement	15	N/A	Fieldwork complete, in quality control	The review considered the following Risk Management Objective: **RMO1 - Arrangements are in place to ensure that Planning Enforcement is carried out effectively.**
15	Asset Management	15	N/A	Fieldwork complete, in quality control	The review considered the following Risk Management Objective: **RMO1 - Arrangements are in place to manage and account for the council's land and property assets.**
16	IT Asset Management	15	24.6	Final report issued	The review considered the following Risk Management Objective: **RMO1 - Arrangements are in place to monitor distribution and relocation of IT equipment.** The review found that arrangements are in place for IT equipment to be requested and approved, and for the equipment to be procured appropriately. However, it would be beneficial for guidance to be made available to staff to support this process and for a central audit trail of all requests/purchases to be maintained. Asset registers are in place, although testing identified some gaps in records and there were no periodic checks to confirm accuracy. Arrangements exist for IT equipment to be returned and disposed of in accordance with an ICT Disposals Policy and ICT Device Buy-Back Guidance Document. **Opinion: Amber.** **Overall Opinion: Amber. Actions: One high, one medium and four low priority. Actions relate to guidance being made available to staff on the process for requesting / purchasing IT equipment; a central audit trail being maintained for all IT equipment requests / purchases; the Mobile Phone Policy being reviewed; arrangements being made to cross reference information held on the IT Asset Register(s); and, introducing periodic sample checking of the IT Asset Register(s).**

2024-25 Internal Audit assurance work

Ref	Activity	Day budget	Days used	Current status	Opinion, summary of findings & recommendations made
1	Homelessness - GBC	20	N/A	Terms of Reference being prepared	
2	Repairs & Supplies Management - GBC	15	N/A	Fieldwork underway	The review will consider the following Risk Management Objectives: **RMO1 - Arrangements are in place to deliver the councils responsive repairs service.** **RMO2 - Arrangements are in place to manage supplies for repairs.**
3	Housing Rent Administration & Collection, inc Service Charges - GBC	15	N/A	Terms of Reference being prepared	
4	Rough Sleeping Service - GBC	15	N/A	Fieldwork underway	The review will consider the following Risk Management Objective: **RMO1 - Appropriate measures are in place to operationally manage the service and to effectively deliver the Rough Sleeping Strategy.**
5	Community Grants - GBC	10	N/A	Fieldwork complete, in quality control	The review considered the following Risk Management Objective: **RMO1 - Arrangements are in place to facilitate and monitor the payment of community grants.**
6	Council Tax Discounts, Disregards & Exemptions - GBC	10	N/A	Terms of Reference being prepared	
7	Street Cleansing - GBC	15	N/A	Fieldwork underway	The review will consider the following Risk Management Objectives: **RMO1 - There are arrangements in place to effectively manage scheduled street cleansing services.** **RMO2 - There are arrangements in place to effectively manage reactive street cleansing services.**
8	Policy Framework - GBC	10	N/A	Terms of Reference being prepared	
9	Corporate Debt Recovery - GBC	15	N/A	Terms of Reference being prepared	
10	Parking - Income Collection - GBC	15	N/A	Terms of Reference being prepared	

Other assurance activity

Ref	Activity	Day budget	Days used	Current status	Opinion, summary of findings & recommendations made
	Finalisation of 2023-24 Planned Work	35	N/A	Underway	Three reviews remain outstanding, but it is anticipated that all will be finalised by the end of September.

Responsive assurance activity

Activity	Opinion, summary of findings & recommendations made
Election Spreadsheet Verification	The team carried out detailed checks to ensure the accuracy of spreadsheets used to verify the ballots issued and calculate the results of the PCC Election held in May and the General Election held in July 2024.

Other consultancy services including advice & information

Activity	Opinion, summary of findings & recommendations made
Town Twinning Accounts	The team carried out an audit of the Gravesham Town Twinning Association's accounts.

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 March 2024.

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 13 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 six of the 13 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	N/A	Annual outturn only
IA2	Proportion of non-qualified staff undertaking professional qualification training	N/A	0%
IA3	Time spent on professional qualification training:	N/A	84.8 days
IA4	Time spent on CPD/non-professional qualification training, learning & development (including corporate training)	40 days	8.5 days
IA5	Compliance with PSIAS	100%	Annual outturn only
LA Specific Performance Measurements			
IA6	Average cost per agreed assurance review	<£5,000	Annual outturn only
IA7	Proportion of estimated resources delivered	N/A	22%
IA8	Proportion of chargeable time spent on: a) Assurance work b) Consultancy work	N/A	 98% 2%
IA9	Proportion of agreed assurance reviews: a) Delivered b) Underway	95%	 5% 9%
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%	Annual outturn only
IA11	Number of agreed actions that are: a) Not yet due b) Implemented c) Outstanding	N/A	 22 19 8
IA12	Proportion of actions implemented by agreed date	N/A	70.4%
IA13	Client, Management and Member satisfaction with	90%	Annual outturn only

Ref	Indicator	Target	Outturn for period
	internal audit services		

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 noted in paragraph 4.5, we are projecting a loss of approximately 53 days from the estimated resource. However, this has been addressed as part of the planning process for Q3-Q4 and there are no changes to the Q1-Q2 plan being proposed. We will continue to monitor available resources as the year progresses and update the Committee on any changes that become necessary.

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 is established: *to monitor and ensure that management actions have been effectively implemented or that senior management has accepted the risk of not taking action*. As with all audit work, resources should be prioritised based on risk.

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 or have failed to meet a revised 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

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
Leaseholder Management	Opinion: **Amber.** Four actions agreed: One high and three medium priority.	Three actions due, two completed. One medium priority outstanding.
Planning Applications	Opinion: **Amber**. Five actions agreed: Two high, two medium and one low priority.	All actions completed.
Procurement Compliance	Opinion: **Amber**. Five medium priority actions agreed.	Four actions due, two completed. Two medium priority outstanding.
Homelessness	Opinion: **Red**. 13 actions agreed: Four high, five medium, and four low priority.	13 actions due, 12 completed. One high priority outstanding.
Climate Change Action Plan	Opinion: **Green**. Four actions agreed: One medium and three low priority.	One action completed before report finalised. Two actions due, two completed.
Write Offs	Opinion: **Amber**. Four actions agreed: Three medium and one low priority.	No actions due in reporting period.
Code of Conduct	Opinion: **Amber**. Ten actions agreed: One high, seven medium and two low priority.	Ten actions due, nine completed. One medium priority outstanding.
Trade Waste Collections	Opinion: **Green**. One medium and two low priority actions agreed.	All actions completed.
Corporate Credit Cards	Opinion: **Amber**. Two high priority actions agreed.	Two actions due, one completed. One high priority outstanding.
Staff Travel & Subsistence	Opinion: **Amber**. Three high, one medium and one low priority actions agreed.	None action due, none completed. One high priority outstanding.
Risk Management Framework	Opinion: **Amber**. Two high, two medium and one low priority actions agreed.	One action completed before report finalised. One action due, one completed.
Information Requests	Opinion: **Green**. One medium priority action agreed.	No actions due in in reporting period.
Taxi & Private Hire Vehicle Licencing & Enforcement	Opinion: **Green**. One medium and four low priority actions agreed.	Two actions implemented before report finalised. Three actions due, two completed.
Staff Flexible Working Arrangements	Opinion: **Amber**. Five medium priority actions agreed.	No actions due in in reporting period.
IT Asset Management	Opinion: **Amber**. One high, one medium and four low priority actions agreed.	Two actions implemented before report finalised. No actions due in in reporting period.

Actions outstanding more than six months after scheduled implementation date

Directorate	Audit title	Action	Priority	Planned implementation date	Management update
Housing	Leaseholder Management	Review the arrangements in place to raise interim service charges, with an appropriate policy explaining how interim charges are calculated.	Medium	~~31 March 2022~~ Revised ~~31 October 2023~~ Revised 30 June 2024	A Leasehold Service Charge Calculation Policy has been drafted and is currently with the new Assistant Director for review before being presented to Management Team for approval. It is anticipated that this will all be complete, and the policy published, by the end of October 2024.
Corporate Services	Procurement Compliance	Effective monitoring will be put in place to ensure contracts are established where required for spend that meets the required thresholds.	Medium	31 December 2023	Although outstanding as of 31 July, this action has been completed.

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.