

**GOVERNANCE AND AUDIT COMMITTEE**

**Tuesday, 19th May, 2026**

**10.00 am**

**Council Chamber, Sessions House, County Hall,  
Maidstone**







## AGENDA

### GOVERNANCE AND AUDIT COMMITTEE

**Tuesday, 19th May, 2026, at 10.00 am**  
**Council Chamber, Sessions House, County**  
**Hall, Maidstone**

Ask for: **Ruth Emberley**  
Telephone:

#### **Membership (14)**

Reform (7):	Mr M Brown (Chairman), Mr A Cecil, Mr R Palmer, Mr M Paul (Vice-Chair), Mr A Kibble, Mr J Finch and Mr T Mallon
Liberal Democrat (2):	Mr M Munday and Mr G R Samme
Conservative (1):	Mr H Rayner
Green (1):	Mr M A J Hood
Labour (1):	Mr A Brady
Restore Britain (1)	Mr O Bradshaw
Independent Member (1):	Ms C Black

#### **UNRESTRICTED ITEMS**

*(During these items the meeting is likely to be open to the public)*

1. Introduction/Webcasting
2. Apologies and Substitutes
3. Declarations of Interest in items on the agenda for this meeting

4. Minutes of the meeting held on 25 March 2026 (Pages 1 - 12)
5. Verbal Updates on Committee Business (Pages 13 - 20)
6. Update on the Performance of Corporate Complaints (Pages 21 - 36)
7. External Audit Progress Report for Kent County Council (Inclusive of Kent Pension Fund) - To Follow
8. Internal Audit External Quality Assessment Outcomes (Pages 37 - 58)
9. Internal Audit Progress Report (Pages 59 - 92)

### **EXEMPT ITEMS**

10. Oracle Cloud Progress Update Presentation

Benjamin Watts  
Deputy Chief Executive  
03000 416814

**Monday, 11 May 2026**

*Please note that any background documents referred to in the accompanying papers maybe inspected by arrangement with the officer responsible for preparing the relevant report.*

## KENT COUNTY COUNCIL

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### GOVERNANCE AND AUDIT COMMITTEE

MINUTES of a meeting of the Governance and Audit Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Wednesday, 25 March 2026.

PRESENT: Mr M Brown, Mr M Paul, Mr A Cecil, Mr T Mallon, Mr A Kibble, Mr J Finch, Ms B Porter, Mr M Munday, Mr G Samme, Mr H Rayner, Mr M Hood, Mr A Brady, Mr M Brown (Chairman), Mr A Cecil, Mr M Paul (Vice-Chair), Mr M Munday, Mr G R Samme, Mr H Rayner, Mr M A J Hood, Mr A Kibble, Mr J Finch, Mr A Brady, Mr T Mallon, Mrs B Porter and Mr O Bradshaw

ALSO PRESENT: Mr B Collins

IN ATTENDANCE: Ben Watts (Deputy Chief Executive), Amanda Beer (Chief Executive), Brendan Arnold (Corporate Director of Finance), David Adams (Interim Deputy Director Effectiveness, Sufficiency and Skills), Michael Thomas-Sam (Interim Adult Social Care Director), Joe McKay (Acting Chief Accountant), Cath Head (Head of Finance), Hayley Breathwick (Budgeting and Technical Accounting Manager), Sangeeta Surana (Pension Fund and Treasury Investments Manager), Mark Scrivener (Head of Risk and Delivery Assurance), James Flannery (Interim Head of Counter Fraud), Kevin Holyoake (Deputy Counter Fraud Manager (Proactive) ), Tristan Godfrey (Senior Governance Manager)

IN VIRTUAL ATTENDANCE: Dr D Horne, Ms C Black and Katy Reynolds (Governance Advisor)

### UNRESTRICTED ITEMS

#### **364. Apologies and Substitutes**

*(Item 2)*

Apologies were received from Mr Palmer, with Ms Porter in attendance as his substitute, Dr Horne and Ms Black, who were both in virtual attendance.

#### **365. Declarations of Interest in items on the agenda for this meeting**

*(Item 3)*

RESOLVED there were no Member declarations of interest in items on the agenda.

#### **366. Minutes of the meeting held on 28 January 2026**

*(Item 4)*

It was highlighted that in relation to item 7, the Committee voted unanimously for a summary project tracker to be included for *all proposed tasks*, not just the Oracle Cloud Programme. The project tracker would be developed and brought to Committee and would include details of time, cost and quality. The details of the format and reporting expectation for the tracker would be agreed an agenda setting meeting.

RESOLVED the Committee agreed that the minutes of the meeting held on the 28 January 2026 were a correct and accurate record and a paper copy be signed by the Chair.

### **367. Verbal Update on Committee Business**

*(Item 5)*

1. The Verbal update was presented to the Committee by the Senior Governance Manager, Tristan Godfrey. The key points were highlighted as follows:
  - a) The intention was to have the new Independent Member appointed ahead of the July Governance and Audit Committee meeting.
  - b) The committee effectiveness review survey had been circulated the previous day and Members were encouraged to respond.
  - c) The Clerk was working to review the existing Work Programme and the timings of the regular reports before further discussions were had with the Chair.
2. In response to points raised, Officers highlighted the following key points:
  - a) In relation to page 22 of the reports pack, the task highlighted in green relating to Commercial Services Group, being the purchase price of the WF Education Group, was commercially sensitive and would be provided to Members in May.
  - b) Members were drawn to other updates which included:
    - i) The Complaints and Continuous Improvement report date for May in relation to GA48.
    - ii) Initial enquiries had been made with the Project Manager to establish how a summary project tracker for the Oracle Cloud Programme, covering time, cost, and quality, be developed and brought to a future meeting, in relation to GA046.
3. RESOLVED Members noted the Verbal Updates

### **368. 2025/26 External Audit Plan for Kent County Council**

*(Item 6)*

1. The report was presented by Lucy Nutley from Grant Thornton. The key points were highlighted as follows:
  - a) Page 25 of the report set out the programme of work to be undertaken, while page 20 detailed the significant risks identified at the planning stage. These

included the presumed risk of management override of controls and the presumed low risk of fraud and error for KCC. They also highlighted the significant estimates relating to the valuation of land and buildings, noting that indexation would be introduced, and the valuation of pension liabilities and the Kent Pension Fund.

- b) A further significant risk related to the implementation of the Oracle programme, particularly the data migration from the legacy system. Additional risks had been identified, including the need for further work on financial sustainability. The auditors noted that the implications of Local Government Reorganisation (LGR) were still uncertain, and a placeholder had been included to reflect ongoing monitoring.
  - c) Page 37 summarised the group audit arrangements, including the work relating to the Wider Kent Group and education entities. Page 41 set out the materiality levels, which had been based on prior-year expenditure.
  - d) Pages 49–50 outlined the planned audit logistics, with the intention to report to Members in September, when the accounts were scheduled to be signed off in September 2026.
  - e) Page 51 confirmed the fee estimate, set at £475,000. The auditors also noted a potential significant risk relating to financial sustainability, particularly in the context of raising council tax. They additionally referenced a potential weakness in governance arrangements, clarifying that this did not indicate any identified failure but reflected the need to assess whether a significant risk existed
2. In answer to Member questions and comments, the following was said:
- a) The value-for-money work involved a series of interviews across the authority, supported by a desktop review of key meetings and documentation.
  - b) It was clarified to Members that the four-year valuation cycle was an accounting requirement. Valuations were undertaken by professional valuers and already incorporated assumptions about deterioration. It was emphasised that valuation and maintenance costs were separate matters and did not directly align.
  - c) Training for new Members and changes to Committee structures would be passed to the value-for-money team for consideration.
  - d) It was highlighted to Members that risks around data volumes and financial integrity were well publicised, but it was confirmed that no such issues had been identified to date.
3. RESOLVED Members NOTED the 2025/26 External Audit plan for Kent County Council.

**369. 2025/26 External Audit Plan for Kent Pension Fund**  
(Item 7)

1. The report was presented by Zargham Malik from Grant Thornton. The following key points were highlighted:
  - a) The risks associated with the implementation of Oracle Cloud were highlighted to Members. Both the Council and the Pension Fund used the same system and therefore the risk applied equally to both entities. IT specialists with appropriate professional qualifications and experience had been engaged to undertake testing, and their findings would be reported to the Committee in the final audit report.
  - b) Members were directed to the materiality levels set out on page 73, where separate thresholds had been established for investments and for contributions and benefits, reflecting the differing nature and scale of these balances. The fee section was also noted, with fees determined in accordance with PSAA guidance.
2. In answer to Member comments and questions the following was said:
  - a) A Member welcomed the management responses to previous audit recommendations and asked whether the actions taken were sufficient to address issues raised over several years. Mr Malik confirmed that specialist IT work was underway and that the auditors would assess the effectiveness of controls as part of their audit planning, reporting back on whether recommendations had been implemented.
  - b) It was explained that data migration work was ongoing and that the audit team would assess the outputs produced by the Pension Fund. While the auditors did not provide full assurance over the entire migration project, they would review the elements relevant to the financial statements.
  - c) Changes to pension administration arrangements were not expected to affect the current year's accounts but might influence next year's audit work. It was highlighted that the volatility of investment valuations around year-end and the need to consider updated information where valuations were, subject to time lags.
3. RESOLVED Members NOTED the 2025/26 External Audit Plan for Kent Pension Fund.

**370. Statement of Accounts 2025/26 Preparation and Accounting Policies Update**  
*(Item 8)*

1. The report was introduced by Acting Chief Accountant Joe McKay and presented by the Budgeting & Technical Accounting Manager, Hayley Breathwick. The key points were highlighted as follows:
  - a) The publication deadline for the draft accounts remains 30 June, consistent with the previous year. The intention is for the Governance and Audit Committee to approve the accounts in September, well ahead of the statutory audit deadline of 31 January 2027. It was acknowledged that the timetable placed pressure on both the Council and the auditors but emphasised the shared commitment to completing the process as efficiently as possible.

- b) The finance team had begun work earlier than in previous years. They had provided transactional data for months 1–9, enabling early sampling of operating expenditure, income, and payroll information. Additional business process documentation had also been supplied, covering both the legacy Oracle system and the new Oracle platform. This preparatory work was intended to strengthen readiness for the main audit phase in the summer.
  - c) The Committee received an update on changes to accounting policies. It was explained that the 2025–26 Code of Practice introduced indexation for property, plant and equipment valuations. Under the new approach, full revaluations of land and buildings would occur every five years, with indexation applied in the intervening years to ensure asset values remained materially up to date. It was explained that the indexation was an approximation technique rather than a full valuation.
2. In answer to Member comments and questions, the following was said:
- a) The Council had historically completed its accounts well ahead of the statutory deadline and had signed them off in October the previous year. It was explained that early audit work on transactional data mirrored the approach taken last year and should allow both teams to progress concurrently without compromising quality.
3. RESOLVED Members NOTED the timetable for the 2025/26 Statement of Accounts and external audit.

### **371. Treasury Management Strategy** *(Item 9)*

1. The item was presented by the Pension Fund and Treasury Investments Manager, Sangeeta Surana. The following key points were highlighted:
- a) It was explained that the annual refresh reviewed the Council’s use of required indicators and communicators, as outlined in the cover report. At a high level, there had been no changes to the Council’s investment strategy or its prudential indicators relating to security, liquidity, or borrowing. The Council continued to maintain its established approach to treasury management.
  - b) The Council’s Capital Financing Requirement showed a small increase in 2026/27, followed by a gradual decline in subsequent years. This indicated that no new borrowing was anticipated for future capital programmes, and that cash balances were expected to remain sufficient.
  - c) Reserve balances were projected to move slightly and would need to be monitored closely. The Council’s short-term cash balances continued to be invested across a mix of short- and medium-term instruments, with ongoing review to ensure efficient cash-flow management. The general decline in interest rates, despite recent rate-holding decisions by central banks was highlighted to Members.
2. In answer to Member comments and questions, the following was said:

- a) With respect to repayment of LOBO loans (Lender Option, Borrower Option) the Council would take opportunities to refinance where appropriate, although no immediate concerns regarding cash balances had been identified.
  - b) £75m represented the minimum operational level, acknowledging that liquidity fluctuated throughout the year. Reduced balances were always a possibility, but the revised minimum level was considered appropriate.
  - c) In relation to concerns raised about the performance of the money market and equity funds, with long-term returns were reported at 4.10% and recent returns had been closer to 2.5%, it was clarified that the funds in question were equity-based pooled funds and had originally been selected during a low-interest-rate environment. They had historically delivered strong returns, but the volatility was acknowledged and it was confirmed that the Council planned to reduce its exposure to these funds over the coming years, following advice from treasury advisors.
  - d) In answer to a question regarding the Council's unrealised loss position on funds once the IFRS 9 statutory override ended in 2029, it was explained that the funds' values fluctuated and that the most recent position (as of February) showed a small, unrealised gain. The situation would continue to be monitored and reflected in future reports.
  - e) A Member reiterated concerns previously raised at the meeting of the County Council regarding the investment strategy. Another Member wanted the Committee to note his suggestion for investing in oil futures, particularly in response to supply shortages for oil in Central Europe affecting certain markets and urged Member to remain alive to the risks.
3. RESOLVED Members NOTED the Treasury Management Strategy approved by the County Council on 12 February 2026.

### **POST MEETING NOTE**

***The following information was provided after the Committee meeting by the Pension Fund and Treasury Manager, in answer to a question asked by a Member at the Committee:***

*Rationale for change in the limit for minimum balance for 3-month liquidity in the Council's Treasury Management Strategy:*

*I can confirm that the Council has an overall minimum liquidity level assessed at £200M. This is the minimum cash balance that should be held at any time to maintain a sustainable level of liquidity. In addition, to help manage liquidity, there are limits on how much can be invested for greater than One year, and how much should be available in the shorter term (less than 3 months).*

*The minimum balance for liquidity within three months ensures that we have sufficient cash for immediate day to day requirements but if the limit is too high it also constrains the Council from investing in higher yielding instruments where appropriate. Hence the limit was reduced from £100m to £75m to provide that flexibility.*

## **372. Review of the Risk Management Strategy, Policy and Programme** (Item 10)

1. The report was presented by the Head of Risk and Delivery Assurance, Mark Scrivener. The following key points were highlighted:
  - a) Members' attention was drawn to the policy and strategy documents, which set out the Council's approach to risk management, and a summary of risk management activity undertaken throughout the year.
  - b) The policy had not undergone significant change since the previous year, but several updates had been made. The policy's lifespan had been shortened from three years to two, reflecting the anticipated timelines for local government reorganisation. Should those timelines shift, the Committee would be advised accordingly.
  - c) Following a question raised at the previous year's meeting, the policy had been subject to independent review by Internal Audit, whose work included an assessment of the risk management framework, including policy. Minor amendments had been made to section 4.3 to reference the *Reforming Kent* Strategic Statement, and to section 4.4 to incorporate higher-level references to local government reorganisation and associated monitoring requirements. More detailed updates would follow as the local government reorganisation process progressed.
  - d) Mr Scrivener emphasised that the effectiveness of risk management depended not only on the quality of the policy but on its active implementation across the organisation. He outlined the ongoing engagement, support, and targeted project work undertaken throughout the year to embed risk management practices
2. In answer to Member comments and questions, the following was said:
  - a) Members welcomed the Council's intention to explore the use of Artificial Intelligence (AI) to support risk management, noting the scale of the task with 627 open risks and thousands of associated controls. Mr Scrivener explained that work was underway to improve the clarity and taxonomy of controls, distinguishing between true controls and mitigating actions. The aim was to streamline control sets and focus attention on the most significant elements. He also described the use of risk management software to support analysis and guide officers, enabling more efficient second-line assurance activity.
  - b) In relation to third-party risk, it was confirmed that the policy now clearly defined control ownership, ensuring that external providers were not incorrectly listed as control owners. Accountability rested with the relevant directorates, supported by strengthened contract management arrangements. It was acknowledged that further work was ongoing and suggested that a broader update could be brought to the Committee in due course.
  - c) Mr Scrivener confirmed that the overarching risk appetite statement remained unchanged, though discussions about risk appetite continued to be embedded within regulations, policies, processes and procedures

3. RESOLVED Members APPROVED the Risk Management Policy and Strategy 2026-2028;

RESOLVED Members NOTED the report on the Risk Management Programme for assurance.

### **373. Schools Audit Annual Report**

*(Item 11)*

1. The report was presented by the Interim Deputy Director Effectiveness, Sufficiency and Skills, David Adams. The following key points were highlighted:
  - a) The audit work was carried out by Schools Financial Services on behalf of the Council, enabling the Section 151 Officer to confirm that schools were operating in accordance with the Council's financial regulations.
  - b) The structure of the audit process was outlined, noting that findings were categorised into critical (high-risk) issues and non-critical issues. The report summarised the outcomes of the previous year's audits and provided an update on schools with deficit budgets. It was highlighted that both the number of schools in deficit and the total value of deficits had reduced significantly, placing the Council in a strong position compared with national trends.
2. In answer to Member comments and questions, the following was said:
  - a) The ratings were broadly consistent year-on-year and that some schools did receive multiple findings. It was explained that deficits did not necessarily indicate poor management; in many cases, they were linked to demographic changes or structural factors. The Council's dedicated support team worked proactively with schools at risk of deficit, which contributed to the low number of schools in formal deficit positions.
  - b) Staffing levels were now where they needed to be and follow-up work had taken place with the schools audited in that cycle. However, the programme operated on a four-year rotation, and it was noted that similar issues tended to reappear in different schools each year due to staff turnover and the need for ongoing reminders about required processes.
  - c) A Member expressed concern that such a high proportion of schools had weaknesses in this area; this was recognised and noted by the Chair.
  - d) It was confirmed that the intention was to bring the next report to the September meeting, which would address the timing issue. He explained that Schools Financial Services had the specialist expertise required to audit school budgets and compliance with the financial scheme.
  - e) On procurement, it was clarified that only a small proportion of schools audited had procurement issues, and that most school expenditure related to staffing. While some corporate frameworks existed (e.g., for energy), schools generally operated their own procurement processes.

- f) The Interim Head of Counter Fraud, James Flannery, added that Internal Audit reviewed the effectiveness of Schools Financial Services as part of its assurance role.
  - g) Schools were reviewed within a four-year cycle, and persistent issues would be escalated through the Council's school intervention processes. In extreme cases, the Council could withdraw a school's delegated budget. Of the schools currently in deficit, two were new to the list, while one had appeared the previous year and was already subject to a financial warning notice
3. RESOLVED Members NOTED the Schools Audit Annual Report for assurance.

### **374. Counter Fraud Update (Quarter 3)**

*(Item 12)*

1. The report was introduced by the Interim Head of Counter Fraud, James Flannery and presented by Kevin Holyoake (Deputy Counter Fraud Manager (Proactive)). The following key points were highlighted:
- a) The final data-matching exercise with Adult Social Care had been completed, providing positive assurance regarding case accuracy and existing controls.
  - b) The ASCH Personal Budget data set had been matched for the first time in ten years due to previous data-ownership constraints and had now been incorporated into the routine data-matching programme.
  - c) The Counter Fraud function continued to generate significant value for the Council through both direct recoveries and preventative activity, delivering a return on investment close to 3:1 for the year.
  - d) The team had strengthened the Council's anti-fraud culture through expanded training, improved tools, increased work in high-risk expenditure areas, and external review to confirm compliance with professional standards.
  - e) Increased awareness and reporting had supported earlier identification of issues and improved governance.
  - f) A Member referred to the enforcement data presented on page 173 and noted significant variation between district authorities. He observed that, following Local Government Reorganisation (LGR), cooperation between tier-1 and tier-2 authorities had improved. It suggested that this goodwill could be used to strengthen joint working on enforcement, particularly in relation to blue badge misuse and parking enforcement. It was proposed that KCC's senior management engage with districts showing high enforcement activity and encourage wider collaboration across all districts to improve consistency. Chief Executive Amanda Beer confirmed she would raise this matter at the next Corporate Directors' meeting.
  - g) A Member queried whether there was a correlation between districts that had received recent training, such as the programme delivered to Maidstone Borough Council, and the higher detection rates shown in the report. He

highlighted stark differences between districts, with some reporting very high levels of detected misuse and others reporting very low levels, particularly in West Kent.

- h) Concern was expressed that low detection rates likely masked higher levels of undetected misuse. The positive developments within the West Kent Partnership were noted and further collaboration were encouraged.
  - i) Mr Holyoake explained that some district enforcement teams operated through private contractors, which influenced their financial and operational models. This could affect the extent to which they prioritised blue badge enforcement.
  - j) Increased engagement from KCC's Counter Fraud team could help raise awareness and referrals however it was emphasised that local management decisions within districts also played a significant role. Commercial arrangements and contractor priorities would need to be considered when seeking greater consistency.
  - k) Mr Flannery noted that approximately three years earlier, the Chief Executive had led work to improve district engagement, which had resulted in some positive changes. He suggested revisiting this work to reinforce expectations and strengthen the "tone from the top," which could drive more consistent behaviours and outcomes across districts.
  - l) Referring to Appendix A, a Member noted a year-on-year increase in financial irregularities and queried the reasons behind this. He also asked for an update on the progress of work referenced in Appendix B, particularly in relation to resource capacity.
  - m) Mr Holyoake explained that some of the increase related to asset checks, including laptop losses, which had been identified through ongoing review work.
  - n) Mr Flannery confirmed that some cases involved theft or unauthorised sale of Council assets. The team continued to pursue the return of assets from former staff where appropriate and ensured that cases were correctly classified.
  - o) Mr Flannery provided an update on exploratory work relating to the use of Artificial Intelligence (AI). He advised that the team was in the early stages of market testing and considering AI both as a defensive tool and as a response to emerging fraud risks involving AI-enabled attacks. He noted that further detail would be more appropriately shared in a future briefing outside the public session due to the sensitivity of operational approaches.
- 2) RESOLVED Members NOTED the Counter Fraud progress report including reported irregularities from 1 April 2025 to 31 December 2025

RESOLVED Members NOTED the progress of the Counter Fraud Action Plan for 2025/26

### **375. Governance Arrangements for Wholly Owned Companies**

*(Item 13)*

1. The presented was delivered by the Deputy Chief Executive, Ben Watts.
2. Mr Watts reminded Members that, at the last meeting, it had been agreed that an update would be brought to this session. He explained that the purpose of this item was to provide interim assurance and outline the work underway, with a more detailed report scheduled for the next Governance and Audit Committee. It was explained that a slide intended for the previous meeting was now being presented, as it set out the core principles of the governance framework for the Council's companies.
3. The following key points were highlighted:
  - a) The Council's companies were legally separate entities and not part of the County Council, although wholly owned.
  - b) Each company operated its own Annual Governance Statement (AGS) process, which fed into the Council's wider governance arrangements.
  - c) Board membership did not include elected Members, maintaining separation of powers and avoiding consolidation issues.
  - d) The Council's relationship with its companies was structured on an investment-based model, with the Council holding between 12–15% of business activity.
  - e) Companies had their own external audit arrangements, supplemented by internal audit and Council oversight.
  - f) Reserved matters ensured that the Council, as shareholder, retained appropriate control and assurance.
  - g) A programme of continuous improvement was in place across the companies.
4. Mr Watts outlined several developments arising from Member feedback at the previous meeting:
  - a) Annual reporting on company performance would be incorporated into the Governance and Audit Committee cycle, aligned with the AGS.
  - b) Grant Thornton had agreed to support the preparation of this reporting.
  - c) The new Section 151 Officer would review the governance arrangements to ensure full confidence in the framework.
  - d) Future agenda items relating to the Commercial Services Group would include attendance by the Group's Chief Executive to support technical questioning.
  - e) A mechanism had been established for Members to receive financial update meetings, enabling earlier visibility of financial performance without

encroaching on executive functions. These updates would be available to any Member of the Committee who requested them.

5. In relation to Member comments, the following was said:
  - a) The proposals were welcomed and the importance of early visibility of financial information, particularly given the challenging economic environment was emphasised
  - b) It was stressed that the Committee must have sufficient access to information (under Part 2 conditions where necessary) and the role of the Committee was not to duplicate executive functions but to act as an early warning mechanism.
  - c) Transparency was essential to avoid repeating mistakes seen elsewhere.
  - d) The journey toward improved transparency had been lengthy and at times frustrating. The progress was welcomed however it was highlighted that the Committee was not yet at the final destination.
  - e) Quarterly updates would provide valuable assurance to Members.
  - f) The opportunity for Members to attend financial update meetings and supported the enhanced oversight arrangements was welcomed
6. RESOLVED Members noted the presentation.

**Governance and Audit Committee Action Tracker**

<b>G&amp;A Reference Number</b>	<b>Meeting Date</b>	<b>Minute No.</b>	<b>Agenda Item/Subject</b>	<b>Action</b>	<b>Responsible Officer/Area</b>	<b>Status</b>
GA029	3 July 2025	319.3	Treasury Update Report	In answer to a Member's question, Mr Betts confirmed that he would be content to bring to Committee a review of the strategy for Money Market Funds and Investment Funds.	Corporate Director Finance	In progress: this has been added to the Work Programme as a future item and will be considered as part of the agenda setting process.  It is expected that a summary of the actions will be taken to the November 2026 Committee meeting. A brief summary of the plan is to be provided to the Committee in July.
GA032	24 September 2025	327.5	Verbal Update on Committee Business	It was agreed that arrangements for checking the value of matters covered by earmarked reserves would be	Corporate Director Finance/Ruth Emberly	This was covered by the Budget papers. However, it is suggested that further detail and discussion on this

				included in the Work Programme so the item could feature in future committee meetings		could be covered by this year's annual statement of accounts training.
GA033	24 September 2025	327.6	Verbal Update on Committee Business	In relation to a question regarding peppercorn rents, contact would be made with the relevant Corporate Director and the Deputy Leader to ensure all relevant questions were covered. It was commented that a list of properties that held a peppercorn rent would be helpful to Members and Mr Watts confirmed that he would reflect with the relevant senior officers to examine how best to present this information to the committee.	Ben Watts	This is currently in progress.
GA035	24 September 2025	330.3	External Auditor's Progress Report	Members unanimously agreed to ask the relevant officers to	Katy Reynolds	In progress: This information was provided in part to

				review and answer the model questions set out in the Grant Thornton report (pages 102 onwards) and if answers were not available, officers would provide these at the next Committee meeting		the Committee ahead of the meeting on 30 October 2025. The remaining answers will be provided to the Committee when available.
GA036	24 September 2025	331.6.i	2024/2025 Kent County Council Auditor's Annual Report	Members unanimously agreed that a midterm review covering the effectiveness of the committee would be helpful. Mr Watts confirmed that one would be added to the Governance Recommendations Improvement Plan (GRIP) and presented to the Committee in January 2026.	Ben Watts/Katy Reynolds	In progress: As part of the agenda setting process, it was agreed that this item be added to the Work Programme for the July 2026 meeting, to ensure that a full and thorough review could take place.
GA041	26 November 2025	352.2.m	Customer Feedback Annual Report	A Member commented that the culture of continuous improvement and making a difference was yet to be embedded and therefore it would	Pascale Blackburn-Clarke	In progress: An update on the performance of complaints will be brought to the Committee in May

				assist the Committee if efforts of continuous improvement could be shared with Members for review and comment. Mr Watts commented that a report containing the requested information could be brought to the Committee for future review and discussion.		2026. This will include a section on continuous improvement.
GA042	26 November 2025	353.2.b	Counter Fraud Report	Mr Watts confirmed that a Cyber Security update was being prepared for the Policy and Resources Cabinet Committee for March 2026. A discussion would be held in see if a single core briefing could be provided.	Ben Watts	Completed: Members discussed the potential to attend the item at the January meeting of the Committee.
GA043	28 January 2026	358.2.a	Verbal Update on Committee Business	A discussion would take place with the Chair to explore how the Work Programme could be incorporated into future agendas.	Ruth Emberly	In progress: As part of a Work Programme review, relevant report authors are being contacted to ensure that the timescales

						for regular reports are accurately captured. Once this has been completed, further discussions will take place with the Chair.
GA046	28 January 2026	360.2.h	Corporate Risk Register	It was proposed and seconded that a summary project tracker for the Oracle Cloud Programme, covering time, cost, and quality, be developed and brought to the Committee, and that the detailed format and reporting expectations for this tracker be agreed at the next agenda-setting meeting. The Committee voted accordingly and the motion was passed.	Ruth Emberly/Katy Reynolds	<p>In progress: initial enquiries have been made to establish how this action may be delivered. This includes an Oracle Cloud Programme update to the May 2026 meeting of the Governance and Audit Committee.</p> <p>It was clarified at the March Governance and Audit Committee that this request referred to all major projects. The relevant teams will be contacted.</p>
GA047	28 January 2026	360.2.i	Corporate Risk Register	In relation to Climate Change Risk CRR052,	Mark Scrivener	Completed: Concern regarding risk rating

				Mr Scrivener agreed to raise this with the responsible risk owner for further consideration.		and adequate coverage of water shortages discussed at GET Cabinet Committee on 10th March. Mr Smyth agreed to consider Mr Hood's points when next reviewing the risk.
GA049	25 March 2026	373.2.d.	Schools Audit Annual Report	It was confirmed that the intention was to bring the next report to the September meeting, which would address the timing issue. He explained that Schools Financial Services had the specialist expertise required to audit school budgets and compliance with the financial scheme.	David Adams	This is been added to the Work Programme for November.
GA050	25 March 2026	374.1.f	Counter Fraud Update (Quarter 3)	It was proposed that KCC's senior management engage with districts showing high enforcement	Amanda Beer	

				activity and encourage wider collaboration across all districts to improve consistency. Chief Executive Amanda Beer confirmed she would raise this matter at the next Corporate Directors' meeting.		
GA051	25 March 2026	375.4.a	Governance Arrangements for Wholly Owned Companies	Annual reporting on company performance would be incorporated into the Governance and Audit Committee cycle, aligned with the AGS.	Ben Watts	In progress: The "Annual Report on Wholly Owned Companies" and the "Company Governance Review" were added to the May 2026 agenda at the agenda setting meeting.

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## KCC Interim Customer Feedback Report

**By:** Ben Watts – Deputy Chief Executive  
**To:** Governance and Audit Committee  
**Date:** 19 May 2026  
**Subject:** KCC Interim Customer Feedback Report  
**Classification:** Unrestricted

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**Summary:** This report provides update following the presentation of the Annual Customer Feedback Report to Members.

**Recommendation:** The Committee is asked to note the contents of this report for assurance.

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### **Purpose of the report**

- 1) When considering the Annual Customer Feedback Report in November 2025, Members requested that a further paper be brought back within six months to:
  - a) Provide assurance on progress
  - b) Provide further detail in relation to the issues raised by Members
- 2) This report is intended to be a snapshot and does not repeat the full annual data set, which will be reported again as part of the next Annual Customer Feedback Report.
- 3) Further to the previous conversation, key services have been invited to Governance and Audit Committee so that Members can ask direct questions to them.
- 4) The paper provides further information to support oversight and allows the Committee to determine next steps, including any reference to Cabinet Committees for further review.

### **Introduction and Context**

Because this paper picks up on a wide range of issues raised by the Committee at the November meeting and seeks to provide the information and data requested in a number of ways, it is drafted around those headings which are marked in bold and underlined rather than in the usual numbered format.

Overall customer feedback volumes remain high, reflecting ongoing pressures across a number of services. Demand continues to be sustained in areas that are nationally and statutorily complex, which in turn affects response times and the likelihood of complaints escalating.

In addition to the general increase, there is also a greater complexity in those cases, including a rise in requests generated or expanded through AI tools.

While many services continue to manage volumes effectively, the nature and complexity of some cases means they take longer to investigate and resolve, this is

particularly true where AI has generated responses, making them longer and more complicated to unpick.

Despite this, learning from complaints remains a key focus. Themes around communication, timeliness and managing expectations are being used to inform service improvements, with actions underway to strengthen responses, support earlier resolution and improve consistency where pressures are greatest.

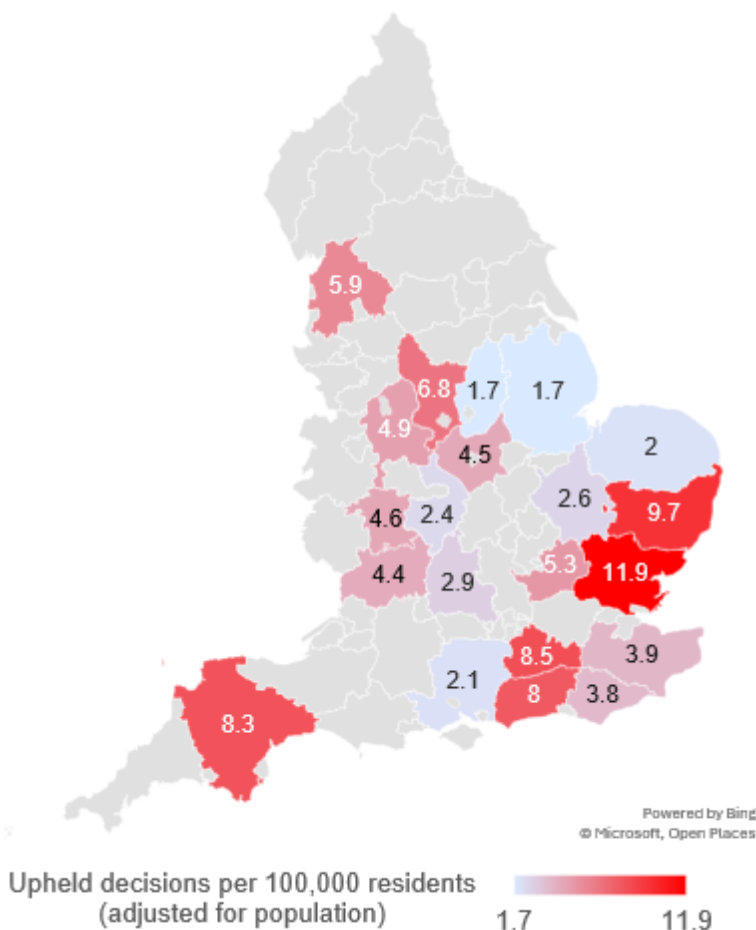
### **Benchmarking (for 2024/2025 financial year)**

In November, Members asked for greater information regarding benchmarking, to help understand the relative performance of the Council in relation to complaints.

The below stats are currently only available for the financial year of 2024/2025. Updated figures will be available later on this year, when the LGSCO releases its figures.

Comparisons with our nearest statistical neighbours is challenging, as the makeup of each County Council is vastly different in terms of population and services provided.

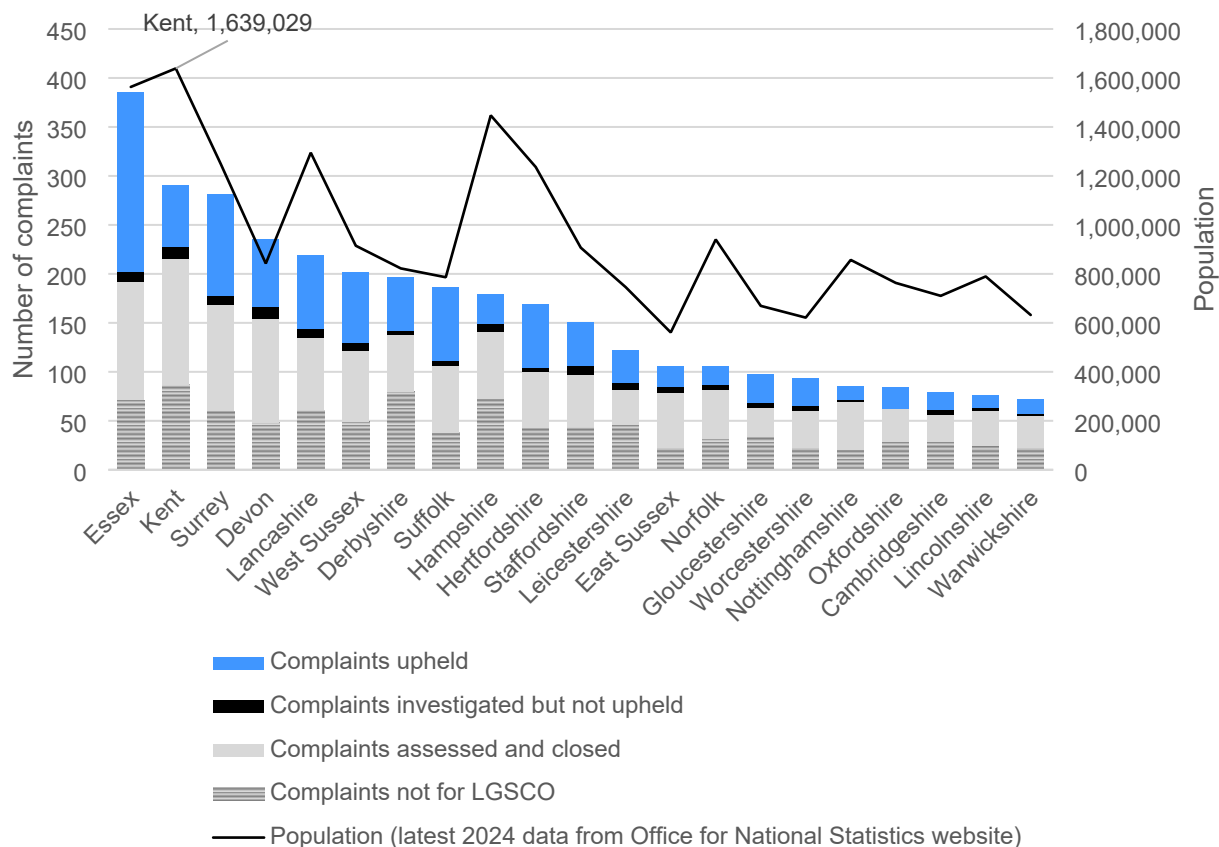
In numeric terms, Kent has one of the highest overall LGSCO complaints in comparison to other county councils across the country, second only to Essex. However, when adjusted for population, Kent's upheld decisions rate is just 3.9 per 100,000 residents. This indicates that, despite scale, our upheld LGSCO outcomes compare favourably on a population-adjusted basis. In contrast, Essex shows a markedly higher upheld rate of 11.9 per 100,000, alongside a much higher proportion of cases progressing to investigation.



The map above shows that we continue to perform comparatively well when looking at upheld LGSCO decisions per 100,000 residents, adjusted for population. While there is some variation across the country, Kent sits at the lower end of the scale compared with many other county councils, indicating fewer upheld decisions relative to population size.

Despite ongoing service pressures and high volumes of customer feedback, our complaint handling and decision-making processes are generally effective, with a lower proportion of cases resulting in upheld LGSCO findings.

### Comparison of county council complaint data published on LGSCO website for 2024/2025 financial year



The above chart shows that, when set against population size, our overall LGSCO complaint volumes remain proportionate and compare relatively well with other county councils. Although Kent has one of the largest populations, the number of complaints investigated and upheld sits in the mid-range nationally rather than at the higher end.

A significant proportion of cases are either assessed and closed or not upheld, indicating that many concerns are being resolved appropriately without adverse findings. Overall, this reinforces that our approach to complaint handling is effective and that decision-making is generally robust when viewed in the context of scale and demand.

## KCC Interim Customer Feedback Report

### Comparison of county councils complaint data published on LGSCO website (Population over 1 million) for 2024/2025 financial year

County Council	Complaints dealt with	Complaints not for LGSCO	Complaints assessed and closed	Complaints investigated	Complaints upheld	% of investigated complaints upheld	Upheld decisions per 100,000 residents	Population
Essex	385	71	121	193	183	95%	11.9	1.56m
Kent	291	87	128	76	63	83%	3.9	1.64m
Surrey	281	60	108	113	104	92%	8.5	1.25m
Lancashire	219	61	74	84	75	89%	5.9	1.3m
Hampshire	179	72	69	38	30	79%	2.1	1.45m
Hertfordshire	169	43	57	69	65	94%	5.3	1.24m

\* Complaint data from LGSCO website and population data from Office for National Statistics website.

\* Upheld decisions per 100,000 residents (adjusted for population).

\* Population Rounded to nearest 10,000.

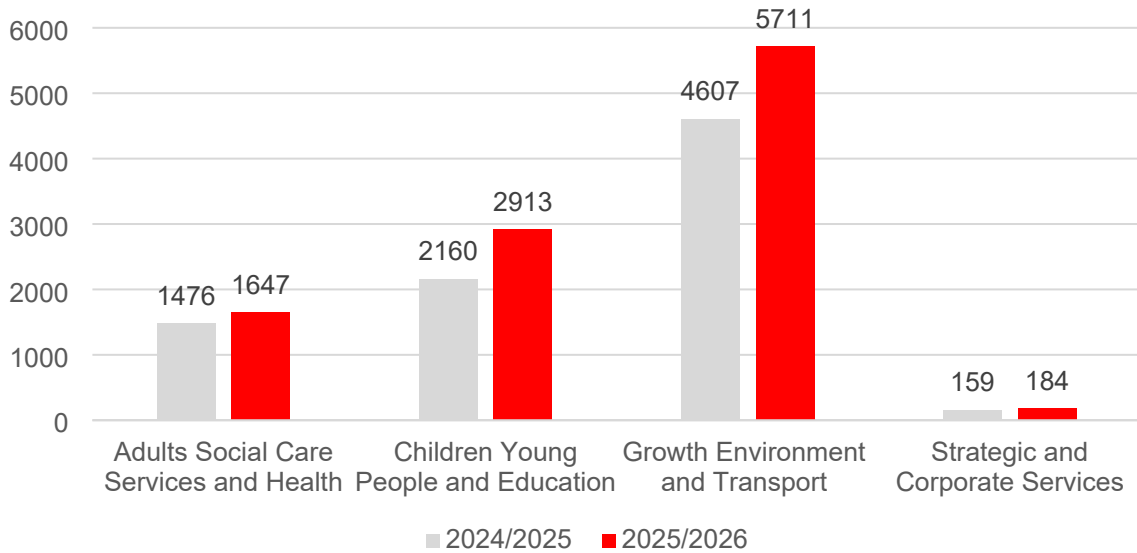
### Volume of all feedback received

Type of feedback	2024/2025	2025/2026	% difference from previous year
Comment	565	292	-48%
Compliment	1,610	1,675	4%
Coroners Enquiry	35	43	23%
Enquiry	1,505	2,662	77%
Informal Concern	174	75	-57%
Member enquiry	2,301	3,515	53%
Stage one complaint	5,386	5,985	11%
Stage two complaint	680	912	34%
LGSCO complaint	291	309	6%
<b>Total</b>	<b>12,547</b>	<b>15,468</b>	<b>23%</b>

The total volume of feedback increased by 23% from 2024/2025 to 2025/2026. Complaints (stage one and stage two combined) increased by 14% and Member enquiries by 53%. There has been a significant increase in the amount of feedback that requires a formal response from the Council.

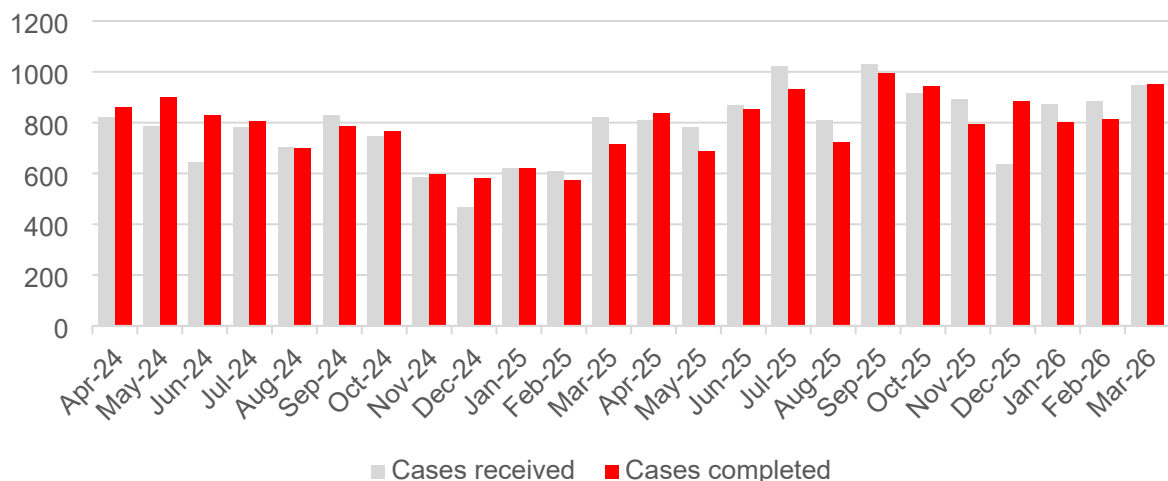
The above figures do not include Library comments, this is due to the Ask a Kent Librarian service which falls outside the normal scope of 'comments'. In addition, Waste comments have also been removed from both years as there has been a change in process which does not allow for like for like reporting. We will be reviewing the figures for the annual report.

**Volume of stage one and stage two complaints and Member enquiries received by Directorate**



The increase in feedback is significant particularly within GET and CYPE, the recent realignment in the feedback team has directed resource in the appropriate teams to ensure that these services are supported in responding to complaints.

**Monthly trend of stage one and stage two complaints and Member enquiries received and closed**



Overall, the volume of closed cases broadly tracks the volumes received over time despite sustained and fluctuating demand, this provides assurance that customer feedback continues to be actively managed. While there are periods of increased pressure, particularly during 2025, these tend to be short-lived and are followed by

recovery in closure activity, indicating effective prioritisation and workload management rather than the build-up of long-term backlogs.

Stage two complaints remain low in volume and controlled, suggesting that escalation is being limited through a continued focus on earlier resolution. Member enquiries are more volatile but are responded to promptly, with closures rising shortly after peaks in demand.

### **Volume of complaints in comparison to service delivery**

**0.4%**

The total number of complaints we received for Adults Social Care Services and Health in the last year represent less than 1% of the amount of people that we provide essential services for during that time...

...for example, we completed **19,891** occupational therapy assessments and received just **36** complaints...

and we received only **193** complaints about blue badges, despite having **39,755** active blue badge parking permits.



**137,000**



Our Children, Young People and Education Directorate supported over **137,000** people during the 2024/2025 period...

and the complaints we received for that period represent less than **1%** of that number.

**2,268,522**

**2,268,522** bookings were made at Household Waste Recycling Centres across the county, but we received just **323** complaints for the service.



## Reasons for closed stage one complaints

	2024/2025		2025/2026	
	Total	%	Total	%
Policy and Procedure	884	15%	1,990	30%
Quality of service	2,848	49%	1,821	27%
Communications	828	14%	1,021	15%
Service not provided	634	11%	944	14%
Equalities and Regulatory	207	4%	394	6%
Staff Conduct	313	5%	366	5%
Issues with service	0	0%	43	1%
Not for KCC	41	1%	42	1%
Blank	4	0%	28	0%
Comment/Enquiry use only	16	0%	25	0%
Value for money	13	0%	14	0%
<b>Total</b>	<b>5,788</b>		<b>6,688</b>	

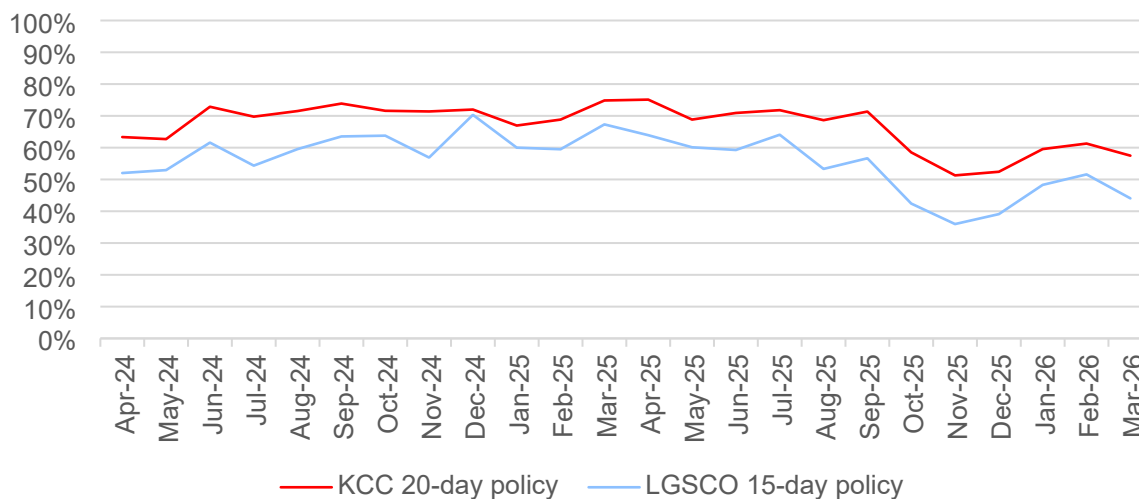
\* The total reasons will not match the number of complaints as some cases will have more than one reason recorded for the complaint.

There has been a shift in the reasons for complaints over the past year. Complaints recorded under the Policy and Procedure category include those concerning disagreements with decision making, policy, or with charges received (for example for care).

### Timeliness of responses

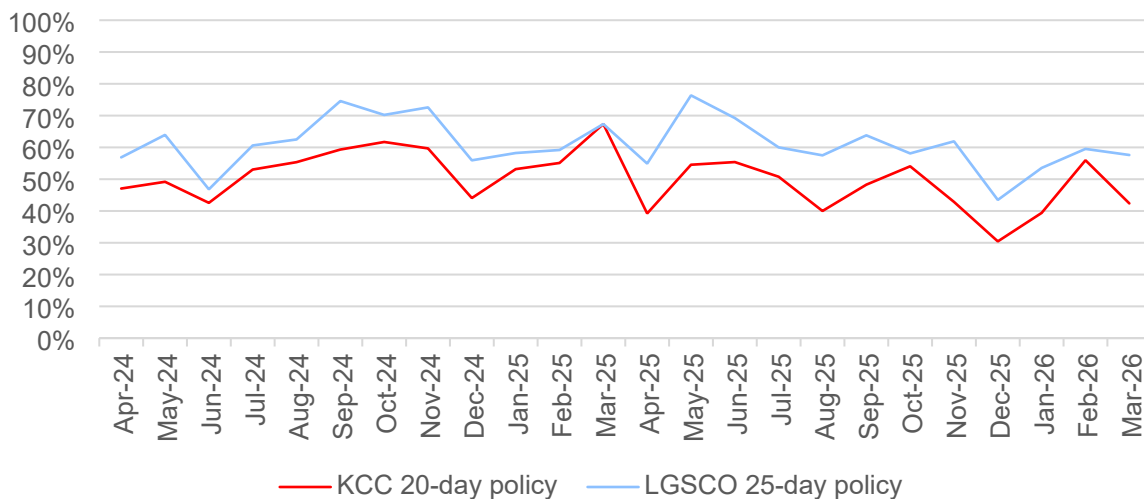
Members expressed concern about delays in responding to complaints and the impact this has on customer confidence. The following information tracks the volume of complaints and performance against the 20 day timescale.

### Timeliness of stage one complaints



<b>Percentage of stage one complaints responded to within timescale</b>	<b>2024/2025</b>	<b>2025/2026</b>
Stage one complaint within KCC policy of 20 days	70%	64%
Stage one complaint within KCC policy of 20 days (excluding SEN Services)	78%	72%
Stage one complaint within LGSCO timescale of 15 days (this figure excludes ASCH and Children Act complaints as the LGSCO policy does not apply)	60%	52%
Stage one complaint within LGSCO timescale of 15 days (this figure excludes ASCH and Children Act complaints as the LGSCO policy does not apply) (excluding SEN Services)	70%	60%

### Timeliness of stage two complaints



<b>Percentage of stage two complaints responded to within timescale</b>	<b>2024/2025</b>	<b>2025/2026</b>
Stage two complaint within KCC policy of 20 days	54%	46%
Stage two complaint within KCC policy of 20 days (excluding SEN Services)	68%	57%
Stage two complaint within LGSCO timescale of 25 days (this figure excludes ASCH and Children Act complaints as the LGSCO policy does not apply)	62%	59%
Stage two complaint within LGSCO timescale of 25 days (this figure excludes ASCH and Children Act complaints as the LGSCO policy does not apply) (excluding SEN Services)	77%	71%

## Percentage of complaints responded to within 20-day timescale by Directorate

	Stage one complaint		Stage two complaint	
	2024/2025	2025/2026	2024/2025	2025/2026
<b>Adults Social Care Services and Health</b>	61%	49%	33%	35%
<b>Children Young People and Education</b>	37%	28%	29%	26%
<b>Children Young People and Education (excluding SEN Services)</b>	64%	47%	51%	42%
<b>Growth Environment and Transport</b>	88%	85%	81%	68%
<b>Strategic and Corporate Services</b>	78%	85%	92%	70%

Performance dipped in quarter 3 which was particularly impacted by resourcing pressures, vacancies were filled but training and embedding into the service takes time. This exacerbated backlogs already present within CYPE.

Within Adults Social Care Services and Health, the dip in performance reflects pressures in a small number of services where complaint backlogs had developed. In response, additional support was put in place to help services work through outstanding cases and strengthen responses. While this action was necessary to address the backlog and improve the quality of handling, it had a short-term impact on timeliness, which is reflected in the performance figures for this period.

Children, Young People and Education also saw a reduction in timeliness compared to the previous year. During this period there was a concerted effort to reduce existing backlogs, particularly from late summer into the autumn. This focus on clearing older cases affected the ability to respond within timescales for newer complaints, resulting in a temporary dip in performance. Work is ongoing to stabilise performance, reduce the time taken to respond, and minimise delays caused by waiting for information, with the aim of improving timeliness while continuing to address underlying pressures.

### Average response time for complaints (in days)

	2024/2025	2025/2026
<b>Stage one complaint (all services)</b>	<b>29.6</b>	<b>27.8</b>
<b>Stage one (excluding SEN Services)</b>	<b>16.9</b>	<b>19.3</b>
Average response time in days for complaints responded to in 20 days or less	8.6	10.1
Average response time in days for complaints responded to in 20 days or less (excluding SEN Services)	8.6	10.0
Average response time in days for complaints responded	78.1	59.3

	2024/2025	2025/2026
to after 20 days		
Average response time in days for complaints responded to after 20 days (excluding SEN Services)	46.9	42.8
<b>Stage two complaint (all services)</b>	<b>40.2</b>	<b>35.7</b>
<b>Stage two (excluding SEN Services)</b>	<b>24.1</b>	<b>26.5</b>
Average response time in days for complaints responded to in 20 days or less	10.4	10.4
Average response time in days for complaints responded to in 20 days or less (excluding SEN Services)	10.3	10.2
Average response time in days for complaints responded to after 20 days	75.0	57.5
Average response time in days for complaints responded to after 20 days (excluding SEN Services)	53.5	47.8

Whilst more needs be to done to improve timeliness, the above table demonstrates that the time to respond in those overdue cases at stage one is reducing and for those answered in timescale the average is around 10 days.

### **High-volume and high-risk services**

Members highlighted concerns about sustained complaint volumes in specific services, particularly those under wider national and statutory pressures. Targeted support has continued in these areas, including management oversight, revised processes and additional guidance for officers. Progress has been made in some services, as demonstrated in the reduction of response times, although others continue to face ongoing pressures that limit the pace of improvement.

### **Compliance with complaint timescales in the LGSCO Code**

The Local Government and Social Care Ombudsman (LGSCO) has issued a Complaint Handling Code (“the Code”) as advice and guidance for all local councils in England under section 23(12A) of the Local Government Act 1974. The Code is not mandatory and applies only where no statutory complaints process is in place.

As a result, some complaints relating to children’s services, adult social care and public health fall outside the scope of the Code. This has been taken into account in the data and analysis presented within this report.

The Code recommends that:

- **Stage one complaints** are acknowledged within five working days and responded to within ten working days of acknowledgement, resulting in a total response timeframe of 15 working days.
- **Stage two complaints** are acknowledged within five working days and responded to within 20 working days of acknowledgement, resulting in a total response timeframe of 25 working days.

As part of its self-assessment against the Code, the Council has confirmed compliance with all aspects of the Code except for the recommended response timescales.

Rather than adopting the Code's timescales, the Council continues to operate its existing policy of a **20 working day response timeframe for both stage one and stage two complaints**.

For **stage one complaints**, the 20-day timeframe is intended to support a more thorough investigation and a more robust, well-evidenced response at the earliest stage. This approach is designed to maximise the likelihood that complaints are resolved satisfactorily first time, reducing the need for escalation.

At present, the Council is not consistently meeting its own 20-day service standard. In this context, adopting the shorter 15-day response timeframe recommended by the Code would risk setting expectations that cannot be reliably met and could undermine transparency and customer confidence.

For **stage two complaints**, the Council's 20-day response timeframe remains five working days shorter than that recommended by the Code. Maintaining a consistent response timeframe across both stages also supports clarity for customers by providing a single, easily understood expectation for when a response will be issued.

### **Training and Continuous Improvement within Directorates**

At the previous meeting, Members sought assurance that complaints are used to drive service improvement rather than treated as isolated issues. Across the organisation, all directorates use learning from complaints, alongside wider quality assurance activity, to support continuous improvement.

#### **Directorate-level learning and training**

Training is delivered through a mix of regular programmes and targeted learning activities. Many services use short, focused sessions to address emerging issues and reinforce good practice. Each Directorate organises training specific to its own services, aimed at enhancing service delivery.

- Children, Young People and Education (CYPE) runs a weekly *Workshop Wednesday*, providing mandatory and topic-focused sessions. Recent Special Educational Needs (SEN) sessions have included the Annual Review process and updates on social care procedures.
- Growth, Environment and Transport (GET) supports staff development through directorate-wide learning sessions, specialist and technical training, and shared resources that promote consistent practice and professional development.
- Adult Social Care and Health (ASCH) uses learning from audits, complaints, safeguarding reviews and lived experience to drive improvement. The directorate runs regular reflective learning sessions where staff explore real case themes, share good practice and learn collectively, including sessions

co-designed or co-hosted with people with lived experience of adult social care. Where patterns or concerns are identified, action is taken through targeted training, staff briefings, updates to practice guidance or policy changes.

In addition, all directorates provide ad-hoc training where specific issues or risks are identified, supporting continuous improvement as needs arise.

### **Training on complaints handling**

Complaints handling training is delivered in-house by experienced complaint professionals. This has been less frequent during the past year due to the need to prioritise backlog clearance and service pressures. However, training has already recommenced in some areas, and during 2026/27 a refreshed programme will be reviewed and delivered across the organisation.

Targeted training and guidance will be provided to services with higher complaint volumes, focusing on:

- clear and well-explained responses;
- evidence-based investigations; and
- learning from complaint outcomes.

### **Quality and consistency of responses**

The Customer Feedback function was established to bring together ASCH and the Corporate Complaints Team at a time when ASCH was experiencing a significant complaints backlog and difficulty meeting statutory timescales. Over a two-year period, the combined team worked with the service to improve processes, clarify roles and strengthen oversight. This resulted in improved timeliness, more consistent handling and greater capacity to manage demand.

As confidence and capability increased, the team was able to provide more proactive support to services, including earlier intervention and clearer advice on complaint responses.

The learning from this integration has informed subsequent transfers of resources from GET and CYPE into the Customer Feedback Team.

In GET, existing backlogs were reduced within around six months and performance has remained broadly stable since, demonstrating the effectiveness of the approach in a relatively stable service context.

In CYPE, the position is more complex. Integration coincided with major transformation in SEN services. As a result, the focus has been on supporting wider service improvement to reduce the root causes and severity of complaints over time, rather than solely reducing backlog volumes. Progress is therefore expected to take longer.

Quality assurance activity has identified improvements in the structure and tone of complaint responses, while also highlighting areas where greater consistency is still

required. This work has initially focused on services without active backlogs, allowing good practice to be embedded and then applied more widely.

Within SEN, an officer is embedded in the service to support investigations and the drafting of clear, well-evidenced responses. A dedicated role within the Customer Feedback Team also continues to provide specialist advice and short-term drafting support to improve timeliness, while longer-term capability is developed within the service.

### **Organisational Learning Panel**

The Organisational Learning Panel is a cross-organisation forum established to share learning from complaints and wider customer feedback, including cases investigated by the Local Government and Social Care Ombudsman.

The Panel identifies common themes, lessons learned and opportunities for improvement, promoting consistency and improving customer experience across services. It reviews case studies and agrees actions to support service improvement and organisational learning.

The next meeting is scheduled for 3 June 2026.

### **Ombudsman activity: update**

Closed figures as per KCC records. The LGSCO will be providing updated figures later this year.

<b>Outcome</b>	<b>2025/2026</b>
Closed after initial enquiries	161
Not upheld	9
Referred back for local resolution	85
Upheld	54
	<b>309</b>

The above are our current figures, however these will not exactly tally with the LGSCO's numbers, these will be released shortly for 2025/2026. The below table outlines last year's LGSCO figures as reported by the LGSCO.

<b>Outcome</b>	<b>2024/2025</b>
Closed after initial enquiries	128
Not upheld	13
Referred back for local resolution	75
Upheld	63
Incomplete/Invalid	9
Advice given	3
	<b>291</b>

Encouragingly 4 cases were reported upheld – remedy already provided. This is where the Council has already identified fault and provided a remedy in line with LGSCO guidance. Services are encouraged to identify fault as early as possible and offer appropriate remedies. In addition, there were fewer cases escalating to full investigations, with more cases closed after initial enquiries.

### **Risks, Issues and Mitigations**

Key risks during the period relate to sustained demand in high-volume services, increasing case complexity, and ongoing capacity pressures that continue to affect response times. These risks are inter-related and reflect wider pressures across services, particularly those delivering statutory functions and dealing with complex individual circumstances.

While the Customer Feedback Team is currently fully staffed, resourcing remains a challenge. The time required to manage complex complaints, provide effective support to services and maintain the quality of responses continues to place pressure on capacity, particularly during periods of increased demand and the use of AI tools by the public to submit complaints.

These risks are being mitigated through routine performance monitoring and targeted support to services experiencing the greatest pressures. There remains a strong focus on:

- early resolution where appropriate;
- improving the quality, clarity and consistency of responses; and
- embedding learning from complaints to reduce repeat issues.

Collectively, these actions are intended to improve timeliness, manage demand more effectively and strengthen the overall customer experience.

### **Next Steps**

Over the coming year, activity will focus on consolidating the improvements already achieved and strengthening the overall resilience of the complaints process. Key priorities include:

- reducing avoidable escalation by improving consistency and quality at the earliest stage;
- embedding learning more systematically so that issues are addressed before they progress; and
- continuing to streamline processes to reduce delays, including those caused by waiting for information from services.

This work will support earlier resolution, improved compliance with timescales and a more sustainable approach to managing demand.

## **Recommendations**

**Members are asked to:**

- 1) Note the progress made since the Annual Customer Feedback Report.**
- 2) Note the ongoing challenges and planned actions set out in this report.**

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By: Russell Smith – Interim Head of Internal Audit

To: Governance and Audit Committee – 19 May 2026

Subject: **External Quality Assessment Outcome**

Classification: Unrestricted

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**Summary:**

This Report summaries the outcomes of the External Quality Assessment (EQA) and the conformance of the Internal Audit Service against the new Global Internal Audit Standards (GIAS).

**Recommendation:**

**The Governance and Audit Committee note the outcomes of the External Quality Assessment (EQA) of the Internal Audit Function, and the action plan developed against suggested opportunities for future development.**

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**1. Introduction and background.**

- 1.1 The Global Internal Audit Standards (GIAS) came into effect from January 2025. In December 2024 a UK Public Sector Application Note was issued by the institute of Internal Auditors (IIA), which sets out interpretations and requirements which need to be applied to the GIAS requirements, in order that these form a suitable basis for internal audit practice in the UK public sector.
- 1.2 The standards require an Internal Audit function to be subject to regular internal and external assessments. The purpose of these assessments is to confirm compliance with the standards and to provide assurance to all stakeholders that the Internal Audit function is operating efficiently and effectively. An Internal assessment must be completed at least annually, and External Quality Assessment (EQA) must be completed at least every five years.
- 1.3 The standards require the Chief Audit Executive (Head of Internal Audit) to develop a plan for the EQA and discuss the plan with the governance and audit committee which was undertaken in March 2025 by the previous Head of Internal Audit. It was agreed that for the EQA a **self-assessment validation**, using an independent and

experienced assessor would be the option used. This report outlines the outcomes of the EQA.

- 1.4 The Assessment was undertaken by John Chesshire of JC Training Limited who met all the necessary requirements of enhanced qualification and experience required of an external assessor in the public sector. They are also the current Chairman of the Internal Audit Standards and Advisory Board whose role includes oversight of the development and periodic revision of GIAS.

## 2. External Quality Assessment Outcome

- 2.1 A full copy of the External Quality Assessment – Final Report is provided (Appendix A), in concluding their conformance opinion, the External Assessor states:

*“I am very pleased to report that the Internal Audit Service generally achieves the GIAS, which represents the global benchmark for internal audit quality. The IIA use the term ‘general achievement’ or ‘general conformance’ to indicate that “internal audit activities were performed in general conformance with the Global Standards.”*

*“This is an **excellent result**, particularly given the recent launch of the GIAS and the team’s complex nature as both an in-house and external provider of internal audit services. Some internal audit functions are struggling to conform with aspects of the GIAS, and others are not as well advanced in their implementation and maturity. Congratulations to all involved on this outcome.”*

*“I am satisfied that the Internal Audit Service appropriately achieves each of the fifteen GIAS Principles. I am very pleased to report that the Internal Audit Service also fully or generally achieves each of the fifty-two Standards. There are no partial conformances, or areas where the team do not conform with any Standards. Some of my conclusions differ marginally to those of the team in their own IQA. This is to be expected. I am also satisfied that the team achieves the expectations of the associated Application Note.”*

Summary of IIA Conformance	Standards	Does not Conform	Partially Achieves	Generally Achieves	Fully Achieves	Total
Purpose of Internal Auditing	N/A					N/A
Ethics and Professionalism	13	0	0	1	12	13
Governing the Internal Audit Function	9	0	0	6	3	9

Managing the Internal Audit Function	16	0	0	9	7	16
Performing Internal Audit Services	14	0	0	3	11	14
52	0	0	19	33	52	

2.2 Within **Appendix A** (Paragraph 33) the External Assessor references the key achievements of the service. Some of the areas highlighted by the service have been identified as best practice in which in discussions with the assessor is a term in which they do not use lightly and encouraged sharing of these areas across the Internal audit Profession.

2.3 It is important to note that the External Assessor has made no formal recommendations as part of their assessment, however, the External assessor has made a few suggestions for improvement. The suggestions made by the External assessor have been incorporated into the Action Plan which contains internally identified actions for improvement as a result of the EQA (**Appendix B**). The Action Plan is proactively being taken forward as a platform for continuous improvement of the service.

**2. Recommendation**

**The Governance and Audit Committee note the outcomes of the External Quality Assessment (EQA) of the Internal Audit Function, and the action plan developed against suggested opportunities for future development.**

**3. Background Documents**

Appendix A – External Quality Assessment – Assessor Report

Appendix B – External Quality Assessment – Action Plan

**Russell Smith, Interim Head of Internal Audit**

E: [russell.smith@kent.gov.uk](mailto:russell.smith@kent.gov.uk)

T: 03000 416707

**Appendix A – External Quality Assessment – Assessor Report**



# External Quality Assessment

## INDEPENDENT REVIEW FINAL REPORT

<p><b>GENERAL ACHIEVEMENT</b></p>	<p><b>KENT COUNTY COUNCIL'S INTERNAL AUDIT SERVICE GENERALLY ACHIEVES THE GLOBAL INTERNAL AUDIT STANDARDS AND THE WIDER INTERNATIONAL PROFESSIONAL PRACTICES FRAMEWORK</b></p>
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John Chesshire CFIIA CRMA CIA CISA  
JC Audit Training Ltd

23 March 2026

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## Executive Summary

1. The Institute of Internal Auditors (IIA) launched their new Global Internal Audit Standards (GIAS) in January 2024, providing organisations, and their internal audit functions, twelve months to adapt their governance and operational practices to meet the updated benchmark. The UK public sector delayed formal implementation to align with reporting years, and the GIAS became formally effective across this sector from April 2025.
2. The GIAS comprises five Domains, fifteen Principles, and fifty-two Standards. They replaced the IIA's earlier 2016 version of the International Standards and the associated Public Sector Internal Audit Standards (PSIAS).
3. Kent County Council commissioned this external quality assessment (EQA) in 2025 to assess their Internal Audit Service against the new GIAS, as the very latest, international internal audit practice. The GIAS requires an EQA at least once every five years. The Internal Audit service last had an EQA in 2021.
4. I am an experienced EQA reviewer, a former Head of Internal Audit and Chief Assurance Officer, and current Audit Committee Chair. I have delivered approximately 60 EQA reviews over the last eight years to a variety of clients of all sectors and sizes, across the UK and overseas. I have already undertaken many of these using the new GIAS.
5. I delivered this EQA by undertaking a formal validation of the Internal Audit Service's own internal quality assessment (IQA) over Q4 2025 and Q1 2026. This included examining the team's approach, ways of working, methodologies, document review and analysis, performing a selection of remote team member and stakeholder interviews from across the client base, reviewing a targeted selection of recent internal audit engagement files, evaluation, and the drafting and communication of this report.
5. I am very pleased to report that the Internal Audit Service **generally achieves** the GIAS, which represents the global benchmark for internal audit quality. The IIA use the term 'general achievement' or 'general conformance' to indicate that "internal audit activities were performed in general conformance with the Global Standards."
6. This is an **excellent result**, particularly given the recent launch of the GIAS and the team's complex nature as both an in-house and external provider of internal audit services. Some internal audit functions are struggling to conform with aspects of the GIAS, and others are not as well advanced in their implementation and maturity. Congratulations to all involved on this outcome.
7. In summary, the Internal Audit Service, and their key stakeholders, have established an effective governance and management framework over their activity that includes:
  - Well-established Governance and Audit Committee oversight, appropriate functional and administrative reporting lines, documented in a recently updated and approved Internal Audit Charter. This aligns to the expectations within the GIAS.

- A respected Interim Head of Internal Audit leads the Internal Audit Service and is growing into the role. They are supported by three Audit Managers, two Deputy Audit Managers, and fourteen team members, including a small IT audit cohort. A separate counter fraud team reports to the Interim Head of Counter Fraud.
  - Key stakeholders are very positive about the Internal Audit Service, and the team's delivery approach and model are working well in practice. The team are trusted, valued and respected for their professionalism and have a diverse range of experience and skills to meet stakeholder expectations and assurance needs.
  - The Internal Audit Service's strategic and operational priorities are guided by regular and constructive engagement with key stakeholders, rolling risk-based internal audit plans, and increasingly effective use of supporting technology.
  - Revised Internal Audit Service working practices, templates, tools, and an updated internal audit methodology aligned with the GIAS, seeks to deliver effective assurance and advisory services to its key stakeholders.
8. From the EQA results, **I am satisfied that the Internal Audit Service appropriately achieves each of the fifteen GIAS Principles. I am very pleased to report that the Internal Audit Service also fully or generally achieves each of the fifty-two Standards.**
9. I am also very happy to report that there are no Standards that the Internal Audit Service 'partially achieves' or 'does not achieve'. Once again, this is very positive and represents an excellent level of performance against a challenging - and new - set of demanding benchmarks.
10. Given the Internal Audit Service's high level of performance and achievement with the GIAS, I do not make any formal recommendations in this report. To aid continuous improvement, however, I do make several suggestions for further development, some of which the team themselves identified in their IQA.
11. I would like to thank everyone who assisted me in this review, most obviously the Interim Head of Internal Audit, their Business Support Officer, for organising everything, the wider Internal Audit Service, their colleagues, and the key stakeholders I interviewed as part of this EQA process. Thank you all for helping to make the process smooth, straightforward and easy to undertake.

## Introduction and approach

12. Kent County Council commissioned this External Quality Assessment (EQA) against the Institute of Internal Auditors (IIA) Global Internal Audit Standards (GIAS). The GIAS forms the key part of the broader IIA International Professional Practices Framework (IPPF) alongside the new Topical Requirements<sup>1</sup>.
13. The Chartered IIA state that the GIAS, “guide the worldwide professional practice of internal auditing and serve as a basis for evaluating and elevating the quality of the internal audit function. At the heart of the Standards are fifteen guiding principles that enable effective internal auditing. Each principle is supported by standards that contain requirements, considerations for implementation, and examples of evidence of conformance. Together, these elements help internal auditors achieve the principles and fulfill the Purpose of Internal Auditing”. The GIAS comprises five Domains, fifteen Principles and fifty-two Standards.
14. The GIAS build upon the previous International Standards and the previous UK Public Sector Internal Audit Standards (PSIAS). For the UK public sector, the GIAS are also supplemented by the Global Internal Audit Standards in the UK Public Sector Application Note (Application Note).
15. In local government, the CIPFA Code of Practice for the Governance Internal Audit in UK Local Government (CIPFA Code) also applies to address the ‘essential conditions’ for the governance of internal audit set out in Domain III of the GIAS. The Code concerns the roles of senior management and the audit committee regarding internal audit. EQAs must also consider the governance of internal audit, which for local government is set out in this CIPFA Code.
16. Where an internal audit function applies a common approach to its working practices for all its clients (e.g. engagement planning and conduct of audits), like the Internal Audit Service, then the EQA assessor may sample across the client base to verify those aspects of the Standards.
17. Where the internal audit provider has a large client base, this may mean the conduct of internal audit engagements at an authority may not be selected for sample testing. If the EQA assessor is satisfied that the provider adopts a common approach across the clients, then the authority can still be satisfied with the assessor’s conclusion. I have sampled and considered the Internal Audit Service’s work from across its client base and am satisfied that the team adopts a common approach across its clients.
18. The Internal Audit Service comprises an Interim Head of Internal Audit (Chief Audit Executive (CAE)), three Audit Managers, two Deputy Audit Managers, and fourteen team members. The team includes an expanding IT audit capability. A separate counter fraud team reports to the Interim Head of Counter Fraud.

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<sup>1</sup> The IIA states that the Topical Requirements “enhance the consistency and quality of internal audit services, increasing the professionalism of internal auditors’ performance. They help strengthen the relevance of internal auditing to address pervasive and evolving risks.” The first Topical Requirement on Cybersecurity became properly effective on February 5, 2026. Other Topical Requirements will follow.

19. The Interim Head of Internal Audit and the team report functionally to the Governance and Audit Committee at Kent County Council (and to equivalent bodies in each of its clients) and administratively to the Corporate Director of Finance.
20. The Internal Audit Service last had an EQA in 2021, undertaken by Business Risk Solutions. The GIAS, and the previous International Standards, mandate these EQAs at least once every five years.
21. Like many internal audit functions, the Internal Audit Service has reviewed its governance, management and operational practices because of the update and implementation of the GIAS. The team undertook their latest internal quality assessment (IQA) against the GIAS in November 2025, and I have validated this through my review.
22. This EQA examined the Internal Audit Service's overall approach, methodology, processes, remote document review and analysis, in-person and remote interviews with the team and stakeholders, a targeted review of a selection of their recent internal audit assurance engagement files, evaluation and the drafting and communication of this report. I include a list of stakeholder interviewees in appendix one, internal audit interviewees at appendix two, and a sample of stakeholder feedback at appendix three.
23. The EQA primarily involved comparison of working practices against the GIAS. The tried and tested process I followed involved:
  - Examining and reflecting upon the requirements of the Purpose of Internal Auditing, the five Domains, the fifteen Principles and the fifty-two Standards. I have also employed the 'Considerations for Implementation' and the 'Examples of Evidence of Conformance'.
  - Assessing the key criteria needed to demonstrate appropriate compliance.
  - Reviewing the team's IQA, corroborating and recording the necessary evidence to demonstrate the Internal Audit Service's conformance status with each Standard. I have undertaken this through documentation review, thorough validation of the Internal Audit Service's self-assessment, a targeted examination of working papers, discussions with team members and selected interviews (et al), as noted above.
  - Comparing the evidence to the key conformance criteria and assessing the degree of conformance. I have employed the standard IIA definitions for this and have provided these in appendix four.

## Conformance opinion

24. As noted above, I undertook this EQA review to provide an independent, objective, examination of the Internal Audit Service using the GIAS, as well as considering the team's effectiveness and delivery compared with other internal audit functions, current and emerging good practice(s).

25. The Internal Audit Service has achieved a very good result of ‘generally achieves’ in this EQA in relation to the GIAS. The IIA use the term ‘general achievement’ or ‘general conformance’ to indicate that “internal audit activities were performed in general conformance with the Global Standards.”

26. I include a summary of the Internal Audit Service’s conformance to the GIAS, in table one below. Overall, I believe that the team has achieved an excellent result given the breadth and depth of the benchmark established by the new GIAS.

27. I am satisfied that the Internal Audit Service appropriately achieves each of the fifteen GIAS Principles. I am very pleased to report that the Internal Audit Service also fully or generally achieves each of the fifty-two Standards. There are no partial conformances, or areas where the team do not conform with any Standards. Some of my conclusions differ marginally to those of the team in their own IQA. This is to be expected. I am also satisfied that the team achieves the expectations of the associated Application Note.

Summary of IIA Conformance	Standards	Does not Conform	Partially Achieves	Generally Achieves	Fully Achieves	Total
Purpose of Internal Auditing	N/A					N/A
Ethics and Professionalism	13	0	0	1	12	13
Governing the Internal Audit Function	9	0	0	6	3	9
Managing the Internal Audit Function	16	0	0	9	7	16
Performing Internal Audit Services	14	0	0	3	11	14
52		0	0	19	33	52

**Table One: Summary of the Internal Audit service ’s conformance to the GIAS**

28. Given that the GIAS remains ‘comply or explain’ in nature, any internal audit function can reasonably decide that some elements are not necessary to fully achieve, given the team’s nature, size, sector, cost/benefit, value for money considerations, or target maturity level. I summarise the results further with light green showing the ‘generally achieves’ results and dark green colour-coding indicating ‘fully achieves’ outcomes covering each of the 15 Principles:

**Principles**

1	Demonstrate Integrity
2	
3	Maintain Objectivity
4	
5	Demonstrate Competence
6	
7	Exercise Due Professional Care
8	
9	Maintain Confidentiality
10	
11	Authorised by the Board
12	
13	Positioned Independently
14	
15	Overseen by the Board
16	
17	Plan Strategically
18	
19	Manage Resources
20	
21	Communicate Effectively
22	
23	Enhance Quality
24	
25	Plan Engagements Effectively
26	
27	Conduct Engagement Work
28	
29	Communicate Engagement Conclusions and Monitor Action Plans
30	

29. For the Internal Audit Service’s conformance with the fifty-two Standards, the summary results are:

Standards							
1.1		6.1		9.5		13.2	
1.2		6.2		10.1		13.3	
1.3		6.3		10.2		13.4	
2.1		7.1		10.3		13.5	
2.2		7.2		11.1		13.6	
2.3		8.1		11.2		14.1	
3.1		8.2		11.3		14.2	
3.2		8.3		11.4		14.3	
4.1		8.4		11.5		14.4	
4.2		9.1		12.1		14.5	
4.3		9.2		12.2		14.6	
5.1		9.3		12.3		15.1	
5.2		9.4		13.1		15.2	

## Deliverables

30. In addition to this report, I have provided the Internal Audit Service with a briefly annotated version of their own Internal Quality Assessment (IQA) which I have validated through this EQA. This helps succinctly evidence my view and validation of the team’s own IQA.

31. I make several suggestions to help further promote the Internal Audit Service’s ongoing development and continuous improvement. I have included these on pages 10-14 below. I aim these suggestions at Standards that the team already achieve, and some repeat the team’s own

identified actions resulting from their IQA. As these are suggestions rather than formal recommendations relating to areas of non- or partial achievement in respect of particular Standards, I do not seek or expect a formal response to these.

## Key achievements

1. I believe that the Internal Audit Service performs effectively in much of its own governance, risk management and internal audit practices. I was particularly impressed with the following:
  - The Internal Audit Service delivers an effective, independent, and objective assurance and advisory service, covering Kent County Council and its other clients' diverse, complex, public sector and commercial business activities.
  - The team's own governance framework is mature, with active Governance and Audit Committee (or equivalent) and senior management engagement, oversight, reporting and regular communications. Regular communication and dialogue add value and enable a more focused service in respect of key priorities.
  - The Internal Audit Service's recently updated and approved Internal Audit Charters align with the good practice detailed in the GIAS. They appropriately detail the team's mandate, purpose, authority, and accountability.
  - A respected Interim Head of Internal Audit leads the team, supported by able colleagues with a wide range of knowledge, skills and experience. The team has clear knowledge of Kent County Council, its sector and context, and has diverse expertise, backgrounds, and capabilities. The team's expertise, awareness and understanding in respect of its diverse clients is expanding.
  - The Internal Audit Service are trusted and respected for their professionalism by key stakeholders. Key Governance and Audit Committee, and senior management value the service, its approach and how it operates in practice. Feedback throughout this review was positive. Quality is primarily about meeting customer needs, and the team achieve this.
  - The team has put considerable effort into developing an overarching skills matrix, supported by individual competency assessments and a service-wide review to identify and address gaps. This represents best practice. Internal Audit Service members undertake an appropriate range of professional learning and continuing professional development (CPD) activities to gain, maintain and enhance knowledge, skills, and experience. Professional certifications, such as the CIA and CISA, have been obtained, are being obtained, and are planned to commence.
  - An Internal Audit Strategy has been drafted for each client and rolling Internal Audit Plans include a diverse range of engagements, These include future engagements based upon key risks, client priorities, other sources of assurance and the team's own views and judgement. The plan template is clear and professional. The Governance and Audit Committee (or equivalent), senior management and other key stakeholders are appropriately involved in the planning and approval process.

- The team have introduced a suite of new Key Performance Indicators (KPIs) for their work with Kent County Council. These are clear, modern and focused on the delivery of outcomes. This represents best practice.
- Other assurance providers are engaged, and the team have developed another best practice methodology for coordination and reliance that will be properly embedded in the year ahead. The team also maintains a broader Relationship Management Strategy that is effective and adds value.
- The Internal Audit Service employ K10 as their Audit Management Software application and are seeking to further develop its functionality to further underpin service delivery. Use of other technology tools, AI and data analytics to enhance efficiency and effectiveness is expanding. The team has a small, but growing IT Audit capability and contingent to assist in delivering assurance over the challenging technology and cyber risk landscape.
- The Internal Audit Service have updated aspects of their own methodology, procedures, templates and working practices in line with the GIAS. Quality assurance is supported by K10, and the team are formalising a more systematic approach to the periodic internal quality assessments.
- The team's report template and engagement reporting also warrant particular mention. The template has been updated, is effective, fresh and clearly structured. Engagement reports are clearly written and relatively concise.
- It is clear from the EQA that the Internal Audit Service is trusted and valued by key stakeholders. Feedback was positive about the service, its evolution, the quality of work and its overall delivery, both at Kent County Council and for its clients.

## Suggestions for further improvement

32. As highlighted above, I make several suggestions to help further promote the Internal Audit Service's ongoing development, performance and continuous improvement, linking these to the relevant elements of the GIAS.
33. These relate to areas that appropriately meet the expectations of the GIAS, and me as the EQA assessor. They **do not** represent shortcomings or failures in respect of conformance with the GIAS. Several have been identified by the team themselves through their recent IQA. These observations and suggestions do not require a formal response.

- The Internal Audit Service fully achieves Standard 1.1 Honesty and Professional Courage, Standard 1.2 Organisation's Ethical Expectations and Standard 4.3 Professional Skepticism.

The Internal Audit Service intends to embed Honesty and Professional courage in 2026/27 Performance Objectives and Evaluations. I support this. Going forward, the team could usefully consider including further practical ethical dilemmas, ethics scenarios or case studies, common challenges and how to deal with them, in future learning and ongoing CPD activity in these areas. This could usefully build upon the session held at the Kent Audit Conference.

- The Internal Audit Service generally achieves Standard 3.1, Competency, and fully achieves Standard 3.2, Continuing Professional Development, and Standard 10.2 Human Resource Management.

While many of the team are highly skilled, knowledgeable and experienced, other team members continue to gain competence and confidence. The team does not always have deep, specialist expertise in everything they may be asked to deliver assurance over, such as AI as a topical example. Staying up to date with IT and cyber security changes and associated developments are a real, but common challenge for any internal audit function.

The Internal Audit Service actively supports team members as they gain experience, has identified overall learning priorities, and has commenced implementing solutions to address these learning needs. I support these initiatives.

The Internal Audit Service's leadership and their stakeholders recognise that additional emphasis on advisory, rather than assurance engagements, may well be needed over the medium term as Local Government Reorganisation and Devolution proceeds. Additional advisory skills and learning across the team may be necessary to help add value, insight and foresight in respect of the likely, associated change and transformation.

- The Internal Audit Service generally achieves Standard 6.2, Internal Audit Charter, and 7.1, Organisational Independence.

The Internal Audit Charter could usefully be updated to more explicitly reference the Interim Head of Internal Audit's counter fraud responsibilities and cover more clearly how assurance may be provided over these. The recent peer review is a good example of how this will be provided.

- The Internal Audit Service generally achieves Standard 6.3, Board and Senior Management Support, and 8.1, Board Interaction.

The team intends to introduce a consistent approach for meeting Governance and Audit Committee members before formal Committee meetings in 2026 to support open communication and reinforce the Committee's role in championing the internal audit

function. I support this. The team could usefully consider implementing similar arrangements with their other clients.

- The Internal Audit Service generally achieves Standard 8.3, Quality.

The team intends to embed the revised Quality Assurance and Improvement Programme (QAIP) and ensure internal quality assessments and reviews are carried out consistently, with the results reported to the Governance and Audit Committee periodically. I support this. The team could usefully consider implementing similar arrangements with their other clients.

- The Internal Audit Service generally achieves Standard 9.2, Internal Audit Strategy and Standard 12.2 Performance Measurement.

The team has agreed a succinct three-year Internal Audit Strategy with each of its main clients, These include a Vision, four or five key priorities, and supporting narrative. The team has also developed an interesting and innovative set of Key Performance Indicators for reporting to the G&A Committee (or equivalent) and senior management,

Going forward, the Internal Audit Service are upgrading these Internal Audit Strategies using the requirements detailed in Standard 9.2. SMART Objectives are defined and appropriate implementation plans developed for each objective. Progress tracking, ideally using relevant KPIs, and reporting on the implementation of improvements to the G&A Committee (or equivalent) and senior management should also occur for each client.

Revisiting the links between the Internal Audit Strategy, priorities, supporting actions, KPIs and stakeholder reporting should add value and demonstrate a clear internal audit golden thread. I am pleased to see this in train and understand the updated Internal Audit Strategy will be presented at the May 2026 Governance and Audit Committee meeting.

- The Internal Audit Service generally achieves Standard 9.4, Internal Audit Plan.

Future Internal Audit Plans must include additional detail – ideally bespoke for each client – on the rationale for not including an assurance engagement in a high-risk area or activity. It is clear in the current plan when a key risk is not being examined by the team, but the rationale for this is less explicit.

- The Internal Audit Service generally achieves Standard 9.5, Coordination and Reliance.

The team are embedding and operationalising their (very well-designed) methodology for coordinating assurance provision across client organisations to improve alignment, reduce duplication, and enhance governance assurance. I support this initiative.

- The Internal Audit Service generally achieves Standard 10.3, Technological Resources.

The team should consider updating their useful Data Analytics Strategy, by developing SMART objectives, and relevant SMART supporting actions. This Strategy could be extended to also encompass use of AI and be linked more explicitly to the Innovative Approaches to Auditing section of the Internal Audit Strategy.

- The Internal Audit Service generally achieves Standard 11.3, Communicating Results and Standard 14.3, Evaluation of Findings

The team are seeking to implement a more systematic approach to identifying and communicating root causes in their internal audit reports. K10 is being used to facilitate this with the inclusion of root cause analysis categories. From the sample of earlier internal audit reports I reviewed, there was a mixed approach undertaken, with some identifying root causes clearly and others not explicitly including them.

In addition, there are further opportunities for the Internal Audit Service to deliver insights into common root cause categories and themes across the assurance and advisory work that they undertake. The results will subsequently support further coverage of common themes in the Interim Head of Internal Audit's Annual Report and related communications. I support this.

- The Internal Audit Service generally achieves Standard 13.2, Engagement Risk Assessment, and Standard 13.6 Work Program

The team have now designed and are implementing a standardised Risk and Control Evaluation Template to enhance consistency and rigor in assessing control design. There are no 'standard' Templates for this promoted by the IIA or other professional bodies for this, so an approach that best suits the team, aligns with the methodology and integrates with K10 feels like the best way forward. This action will be complete once use of the standardised template is properly embedded following additional team training in May 2026.

- The Internal Audit Service generally achieves Standard 13.4, Evaluation Criteria. The Application Note states that Auditors must also be aware of the importance of value for money, alongside other key considerations, when determining appropriate evaluation criteria under GIAS 13.4 (Evaluation Criteria).

The team intends to deliver a targeted training session to reinforce the importance of incorporating value for money considerations into audit scoping and planning, ensuring auditors consistently apply this principle across all engagements. I support this initiative.

## Appendix One - Interviewees

Interviewee	Position
Amanda Beer	KCC, Chief Executive
John Betts	KCC, S151
Michael Brown	KCC, Chair of Governance and Audit Committee
Sally Richards	GCSG, Director of Assurance and Quality
Nick Hunter	GCSG, Audit Lead
Ceri Richards	GCSG, Chair of Audit and Risk Committee
Ann Millington	KFRS, Chief Executive
Barrie Fullbrook	KFRS, S151
Vince Maple	KRFS, Chair of Audit Committee
Kathryn Beldon	Canterbury Cathedral, Receiver General
Julie Wood	Canterbury Cathedral, Director of Finance and Planning
Helen Wiseman	Canterbury Cathedral, Chair of Audit Committee
Damian Roberts	TMBC, Chief Executive
Paul Worden	TMBC, S151
Robert Cannon	TMBC, Chair of Audit Committee

## Appendix Two – Internal Audit Interviewees

Khailam Anup	Trainee IT Auditor
Hannah Barton	Principal Auditor
Debbie Chisman	Audit Manager
Karen Herbert	Deputy Audit Manager
Lee Jones	Audit Manager
Ewelie Lifanje	Auditor
Daniel Mees	Auditor
Amanda Palmer	Interim Audit Manager
Andy Shade	Principal IT Auditor

## Appendix Three - Selected Interview Feedback

“We picked Kent County Council Internal Audit for their sensitivity. They have gained our trust, they are here to help, and I haven’t heard a single complaint about them.”

“The Head of Internal Audit comes across very well at Committee. He has experience and knowledge of our organisation, and we are really happy with the service that we get from them.”

“The internal audit documentation that the Committee receives is very well received and everything is well written and produced.”

“I have found them to be objective, candid and open.”

“They are always well-prepared for the Committee’s questions. They are open, honest and always very willing to engage with members.”

“I am certainly getting sufficient assurance from the internal audit team at the present time.”

“The quality of what we have seen as the Committee is consistently high.”

“Internal audit are pretty well engaged with us and have a good understanding of the nature of our organisation.”

“They always attend our audit committee and are well-prepared. Members are satisfied with the answers they give and the internal audit service as a whole.”

“Internal audit have been very flexible. We have built new audits into the plan and have delayed others, and they coped well with this.”

“The internal audit team are great value for money. They are trying their hardest to present themselves very well and are succeeding.”

“There have been a small number of delayed audits this year, but the team are working to resolve these.”

“They work really well with us now. They are sensible, pragmatic and understand our organisation is different to the County Council. They have worked really hard to learn about us and they add value.”

“They are very professional and very good at showing us what best practice looks like. We are keen to learn from them and to improve.”

“We take internal audit very seriously and internal audit help us survey the whole governance and risk landscape.”

“They are very thorough and always handle themselves very professionally.”

“I have a slight concern about their resourcing and how they keep up with new and evolving areas of risk, particularly around technology.”

“Overall, they are very good and one of the best partnerships we have.”

“Our internal audit contact has a good understanding of the organisation, and we have regular catch ups to keep on top of progress and any changes.”

“The quality of the internal audit reports are very high. We are extremely positive about these, and they have improved considerably over the last three and a half years.”

“The team’s approach is good and helps set a positive culture about internal audit. They are seen as constructive and very much a partner.”

“We have an excellent relationship with internal audit and are able to use internal audit effectively for assurance. They help us look at the things we are really worried about.”

“Internal audit tends to stay fairly quiet in the audit committee meetings. Sometimes we have to ask them for their opinion.”

“Internal audit now is much better than it was when we first brought them onboard. I can definitely say that we get a good service from internal audit and they are very collaborative.”

“They are learning to be more agile and are flexible when we do want to change things.”

“Pre-engagement meetings help ensure that the scopes are properly shaped and achievable.”

“They have listened to feedback, definitely improved and are very collaborative – I’d strongly recommend them.”

“Overall, I am extremely satisfied with the internal audit service that we get.”

“There has been turnover within their team, but today I’m very happy. The level of engagement is very positive. They have a good mix of skills given the capacity of being a larger team.”

“They push back when it is right to do so and their service compares very well compared to my experiences elsewhere.”

“I like the fact that the internal auditors are enthusiastic and like to make a positive difference.”

“The advisory help is always welcome and encourages a high degree of openness and trust.”

“The quality of information they provide is good and the quality of audit work is good too.”

“When it comes to delivering the programme of work, they have always been clear and transparent about the reason for any delays.”

“They are really good and have developed an excellent rapport with officers and members. I have nothing bad to say about them!”

## Appendix Four - External Quality Assessment Ratings

Quality Rating	Total Opinion	Principle Opinion	Standard Opinion
<b>Full achievement</b> The HIA can state that all internal audit activities were performed in full conformance with the Global Standards.	The internal audit function is fully achieving all 15 principles and the Purpose of Internal Auditing.	The internal audit function is fully achieving all the Standards related to the Principle and the Principle's intent.	The internal audit function is fully conforming with all requirements of the Standard and the Standard's intent.
<b>General achievement</b> The HIA can state that internal audit activities were performed in general conformance with the Global Standards.	The internal audit function is achieving the Purpose of Internal Auditing however it is not fully achieving at least one Principle or aspect of Domain I.	The internal audit function is achieving the Principle's intent. However, it is not fully achieving at least one Standard.	The internal audit function is achieving the intent of the Standard but not fully conforming with at least one requirement of the Standard.
<b>Partial achievement</b> The HOIA may not state that all internal audit activities were performed in conformance with the Standards but may be able to depending on the activity.	The internal audit function achieves some Principles. However, it is not fully achieving at least one Principle and one aspect of Domain I and the impact is significant enough to rate the function's overall achievement as partially achieving.	The internal audit function achieves some Standards. However, it is not fully conforming with at least one Standard, and the impact is significant enough to rate the function as Partially achieving the principle.	The internal audit function achieves some requirements of the Standard. However, it is not fully conforming with at least one requirement, and the impact is significant enough to rate conformance with the Standard as partially conforming.
<b>Nonachievement</b> The HIA may not state that internal audit activities were performed in conformance with the Standards.	The internal audit function fully achieves some Principles; however, it is not fully achieving more than one aspect of Domain I and the impact is significant enough to rate the function's overall achievement as not achieving.	The internal audit function is not fully conforming with more than one Standard, and the impact is significant enough to rate the function as not achieving the Principle's intent.	The internal audit function is not fully conforming with more than one requirement, and the impact is significant enough to rate conformance with the standard as not achieving the Standard's intent.

Appendix B – EQA Action Plan Summary

Title	Actions	Estimated Date	Status
Improve Audit Charter	EQA2, EQA3, EQA4, EQA21	30/06/2026	3 Complete 1 in Progress
Reporting Improvements	EQA1, EQA31, EQA32, EQA35, EQA36, EQA37	30/09/2026	1 Complete 4 in Progress 1 Not Started
Stakeholder Engagement	EQA9, EQA10, EQA16, EQA19, EQA33, EQA34	30/09/2026	1 Complete 4 in Progress 1 Not Started
Auditor Objectives, Competencies & Training	EQA7, EQA12, EQA17, EQA23, EQA25, EQA26	30/06/2026	5 in Progress 1 Not Started
Audit Methodology	EQA5, EQA8, EQA11, EQA20,	30/09/2026	2 Complete 2 in Progress
System & IT	EQA6, EQA22, EQA27, EQA28	30/06/2026	1 Complete 3 in Progress
Risk Assessments / Assurance Mapping	EQA13, EQA14, EQA15	30/06/2026	3 in Progress
Strategy	EQA24, EQA30	30/06/2026	2 in Progress
Quality Assurance	EQA18, EQA2	30/09/2026	1 in progress 1 Not Started

By: Russell Smith – Interim Head of Internal Audit  
To: Governance and Audit Committee – 19 May 2026  
Subject: **INTERNAL AUDIT PROGRESS REPORT**  
Classification: Unrestricted

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**Summary:**

This Progress Report details summaries of completed Audit reports for the period January – May 2026.

**Recommendation:**

**The Governance and Audit Committee note the Internal Audit Progress Report for the period January to May 2026.**

**FOR ASSURANCE**

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**1. Introduction**

- 1.1 Professional Internal Audit standards require that periodic reports on the work of Internal Audit should be prepared and submitted to those charged with governance.
- 1.2 This Progress Report provides the Governance and Audit Committee with an accumulative summary view of the work undertaken by Internal Audit for the period January to May 2026 together with the resulting conclusions, where appropriate.

**2. Recommendation**

- 2.1 Members are requested to note the Internal Audit Progress Report for the period January to May 2026.

**3. Background Documents**

Internal Audit Progress Report.

**Russell Smith, Interim Head of Internal Audit**

E: [russell.smith@kent.gov.uk](mailto:russell.smith@kent.gov.uk)

T: 03000 416707

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# **INTERNAL AUDIT PROGRESS REPORT**

## **GOVERNANCE AND AUDIT COMMITTEE**

### **19<sup>th</sup> May 2026**

The engagements included were conducted in conformance with the Global Internal Audit Standards and UK Public Sector Application Note

# 1. Introduction

The role of the Internal Audit function is to provide Members and Management with independent assurance that the control, risk and governance framework in place within the Council is effective and supports the Council in the achievement of its objectives. The work of the Internal Audit team should be targeted towards those areas within the Council that are most at risk of impacting on the Council's ability to achieve its objectives.

Upon completion of an audit, an assurance opinion is given on the effectiveness of the controls in place. The results of the entire programme of work are then summarised in an opinion in the Annual Internal Audit Report on the effectiveness of internal control within the organisation.

This activity report provides Members of the Governance and Audit Committee and Management with 10 summaries of work undertaken between January 2026 and May 2026.

# 2. Key Messages

- 10 audit summaries are included from ongoing and finalised work in the period reported. **Appendix A**
- 27 audits from the 2025-26 rolling Audit Plan are either in fieldwork, ongoing embedded assurance or reporting stage. **Appendix B**
- 8 audits either in not started or on hold. **Appendix B**
- **Section 4** of the report details the amendments to the Rolling Internal Audit Plan with the inclusion of 2 new audits.
- The Team has to date, audited and certified **15** government grants. **Appendix C**.

## 3. Resources

In accordance with the Global Internal Audit Standards (GIAS), Members need to be appraised of relevant matters relating to the resourcing of the Internal Audit function. The key updates are as follows:

- Interim arrangements for the Head of Internal Audit and the Head of Counter Fraud have been extended to September 2026. It is anticipated that an external recruitment exercise will be undertaken in the coming months.
- Following the resignation of a Principal Auditor, there is one vacancy within the Internal Audit Team. Recruitment to fill this vacancy is currently in progress. One contractor with previous experience within the team has been brought into the service temporarily to support delivery of current Audit Plans.
- Audit Management software development and enhancements to Internal Audit processes are ongoing and gathering momentum.
- Technology available to support the completion of the Rolling Internal Audit Plan is being utilised. This includes data analytics tools such as Power Bi and data-driven assurance (continuous auditing).
- The use of Artificial Intelligence is actively being explored and is already generating efficiencies and enhancing delivery.

## 4. 2025-26 Internal Audit Plan

The Rolling Internal Audit Plan is slightly behind with delivery as reported to January Governance and Audit Committee. However, this is broadly comparable, if not slightly ahead, to this point last year. Sufficient audit coverage will be undertaken to provide an annual audit opinion.

The Interim Head of Internal Audit has reviewed the current coverage of the Internal Audit Plan and identified additional revisions to the plan to support the organisation with its assurance needs relating to phase 2 of the Oracle Cloud Programme.

Discussions highlighted the following additional audits for inclusion within the current Rolling Internal Audit Plan:

- Oracle Cloud Programme – Lessons Learned
- Clarity System - Management Assurance Checks and Data Quality

Status	No	%
Not Started	6	11%
In Progress	27	53%
Completed	16	32%
On Hold	2	4%
Total	51	100%

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# Table 1 – Summary of Audits by Committee Meeting

Governance & Audit Committee – 19 <sup>th</sup> May 2026			
No	Audit	Opinion	Prospects for Improvement
13	ICT04-2026 - Laptops – Asset Management ( <i>EXEMPT</i> )	Substantial	Good
14	RB10-2026 - ASCH Saving Delivery Plan Governance	Limited	Good
15	RB22-2026 - Invicta Law & Integrated Children’s Service - Personal Data ( <i>EXEMPT</i> )	Substantial	Good
16	RB38-2026 - Emissions Trading Scheme – Financial Modelling & Assumptions	Adequate	Good
17	RB31-2026 - Elective Home Education	High	Very Good
18	RB13-2026 - Direct Payments Follow-up	N/A – Follow-up	N/A – Follow-up
19	RB01-2027 – Clarity - Management Assurance Checks and Data Quality – Interim Update	TBC	TBC
Embedded Assurance Updates			
No	Audit	Opinion	Prospects for Improvement
10	RB05-2026 – Oracle Cloud Programme – Embedded Assurance	Embedded Assurance	N/A
11	RB40-2026 – Highways Term Maintenance Contract – Embedded Assurance	Embedded Assurance	N/A
20	RB24-2026 – No Purchase Order No Pay – Interim Update	Embedded Assurance	N/A

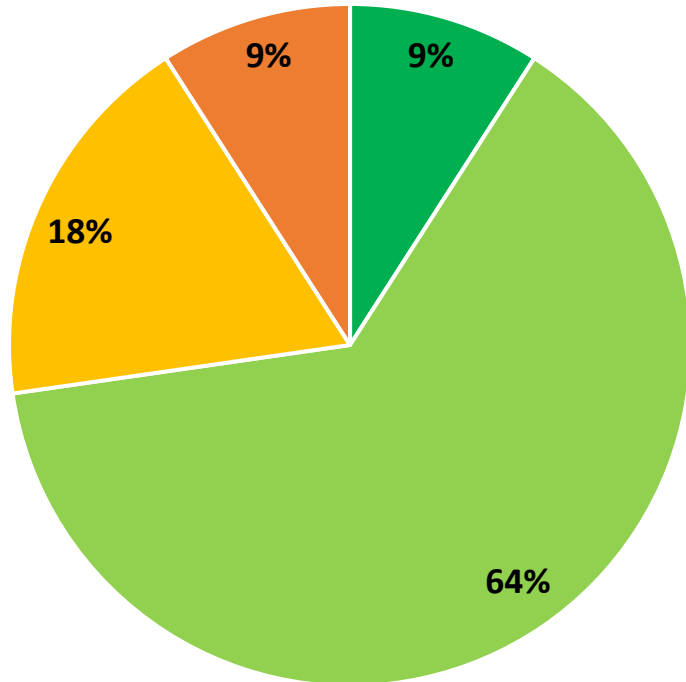
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With each Progress report, Internal Audit turns the spotlight on the audit reviews, providing the Governance and Audit Committee with a summary of the objectives of the review, the key findings, conclusions and issues; thereby giving the Committee the opportunity to explore the areas further, should it wish to do so. This report also provides an update on the work completed between January 2026 and May 2026, 10 audit summaries are provided at [Appendix A](#) covering completed work and updates on ongoing embedded assurance activity.

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# 2025-26 Audit Assurance Levels and Prospects for Improvement of Audits

**Assurance Levels 2025-26**



Assurance Level	No	%
High	1	9%
Substantial	7	64%
Adequate	2	18%
Limited	1	9%
No	0	0%

Prospects for Improvement	No	%
Very Good	4	36%
Good	7	64%
Adequate	0	0%
Uncertain	0	0%

## 5. Grant Certification Work

Internal Audit’s work on grant certification provides an essential service for the Council. Although it is not audit opinion work, the Audit team’s schedule of grant certifications is an ongoing commitment of Internal Audit resources which requires adherence to strict timescales for the certification of claims submitted.

Grant work is also completed by the Internal Audit team in respect of validating expenditure of various UK Government Grants awarded for activities such as Public Health, Highways, Environment, Travel Demand Management and Bus Service Operators Grant. In 2025-26, the Team has, to date, audited and certified **15 government grants** with a value of **£118,007,178**.

Details of all certifications for 2025-26 can be seen at **Appendix C**.

## RB10-2026 – ASCH Saving Delivery Plan Governance

### Audit Objective

The aim of the audit is to provide assurance that lessons learnt from 2024/25 ASCH delivery plans have been identified and fed into the ASCH 2025/26 plans, and that the ASCH governance arrangements put into place were adequate to enable effective monitoring and reporting.

### Audit Scope and Scope Limitations

#### Areas Covered

Commissioning

Operations – Short-Term and Long-Term Support

Holistic ASCH Savings Oversight

Operations – Short-Term and Long-Term Support

#### Scope Limitations

None

### Audit Opinion

Limited

### Prospects for Improvement

Good

Actions	Number	Agreed	Risk Accepted
High	3	3	0
Medium	3	3	0
Low	1	1	0

### Key Strengths

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Commissioning

- ✓ A dedicated savings team has been established with resources drawn down from across commissioning and arranging support teams to strengthen oversight and support the achievement of delivery.
- ✓ There is evidence of ongoing refinement to governance structures. Enhancements include the introduction of daily huddles, Strategic Reset Programme (SRP) Team attendance at both daily and weekly meetings, finance engagement at weekly meetings, and Director attendance at the weekly assurance meetings. This reflects a positive culture of continuous learning. During the fieldwork further changes were introduced with two of the daily huddles now being specific to the Supported Living workstream to provide dedicated focus on a high-risk area of concern.
- ✓ The Terms of Reference for the Commissioning and Pricing Savings Group are comprehensive, with a clear purpose to ensure the delivery of savings targets across commissioning workstreams and the wider interdependent Adult Social Care and Health (ASCH) workstreams.
- ✓ Weekly highlight reports are produced from the Commissioning and Pricing Week Ahead meetings, the daily huddles and end of week meeting and include progress against the individual savings targets and the activities for the week and planned activities for the next week for each.
- ✓ A comprehensive actions log has been recently developed to capture actions arising from the week ahead, daily huddles and end of week meetings. Progress is monitored at the week ahead meeting strengthening accountability.
- ✓ Since PwC's (PricewaterhouseCoopers) departure Project Management Office (PMO) support is provided by the Transformation and Delivery Team to assist with the monitoring of the commissioning saving workstreams. A project plan with tasks and milestones has been developed and progress is reviewed at the week ahead meeting.

Operations – Short-Term and Long-Term Support

- ✓ Operations (covering both short-term recovery and long-term sustainability) follow a structured weekly meeting cycle, comprising Week Ahead meetings, Checkpoint (Recovery) meetings, and End-of-Week review meetings. The Terms of Reference (ToR) supporting the meetings have a purpose of setting weekly priorities, providing operational oversight to ensure effective delivery of ASCH services within each area and review the performance management and escalation of key risks to achieving actions set out in the Localised Recovery Plan 2025/26.
- ✓ ASCH Savings and Recovery Programme Highlight reports are produced from the minutes of the weekly meetings. Each report provides a RAG rating against baseline KPIs targets for all workstreams, along with achievements that week, future plans, slippage and reasons, blockers, high level risks and any escalations and interdependencies.
- ✓ Copilot is used to capture minutes from the weekly Savings and Recovery Director meeting in e-mail form and is issued to the attendees.
- ✓ Savings and Recovery – Sharing Best Practice Workshops are regularly run to promote consistency, drive innovation, and embed learning across all localities with high level minutes captured and circulated.

**Areas For Development**

<b>High</b>	<p><b>Issue 1 – Lack of Transparency over ‘Alternative Savings’ plans for undeliverable Savings</b></p> <ul style="list-style-type: none"> <li>For savings deemed no longer deliverable there is an expectation for an alternative savings amount and description to be provided to the Chief Accountants team for input into the savings and income monitoring spreadsheet they maintain. Review of the September 2025 spreadsheet identified that whilst the variance explanation provides the reason for non-delivery for red rated lines, several saving lines considered no longer deliverable have no indication on how the shortfall will be managed or an alternative savings to replace the initiative.</li> <li>Whilst the SRP Slide Dec 2025 Exception Report enables the SRPB effective oversight and scrutiny, mitigating actions or alternative savings are not fed into this report which may weaken accountability and transparency.</li> </ul>
<b>High</b>	<p><b>Issue 2 – Lack of Clarity over Red BRAG Differentiations in the ASCH portfolio Reports</b></p> <ul style="list-style-type: none"> <li>The Red rating for the Blue, Red, Amber, Green (BRAG) rating scale currently defines savings as “undeliverable in 2025/26” but does not differentiate between those deferred to future years and those deemed permanently unachievable in the ASCH Portfolio Reports.</li> </ul>
<b>Medium</b>	<p><b>Issue 3 – Commissioning and Pricing and Operations (short &amp; long-term support) – Lack of Risk Log to Track Risk Ownership and Actions</b></p> <ul style="list-style-type: none"> <li>Risks and barriers are identified and noted in the weekly highlight report that is produced for senior leadership from discussions held at the Week Ahead and End of Week meetings. However, this is very high level and there is no comprehensive risk log to monitor and review the risks effectively.</li> <li>Risks and barriers are noted in the weekly highlight report that is produced from discussions held at the Week Ahead and End of Week meetings. However, this is very high level and there is no comprehensive risk log to monitor and review the risks.</li> </ul>
<b>High</b>	<p><b>Issue 4 – Root Causes Analysis and Learning from Experience</b></p> <ul style="list-style-type: none"> <li>Given the significant proportion of Red-rated saving lines (£23.1m in the BRAG breakdown for ASCH portfolio activity in the October 2025 portfolio report), it would be beneficial to undertake a structured root cause analysis and learning from experience exercise at the earliest opportunity.</li> </ul>
<b>Medium</b>	<p><b>Issue 5 – Absence of Transparency within Operations (Short-Term &amp; Long-Term Support) Weekly Saving Target Review Meetings</b></p> <ul style="list-style-type: none"> <li>Whilst the Short Term and Long-Term Support highlight reports deriving from the Week Ahead, Checkpoint and End of week Director Assurance meetings provide the RAG ratings against KPIs they do not incorporate savings targets for each workstream or demonstrate how KPI outcomes impact saving delivery. There is also no evidence that the savings target progress and impact is discussed at the weekly meetings.</li> </ul>
<b>Medium</b>	<p><b>Issue 6 – Absence of Actions Log for Operations (Short-Term &amp; Long-Term Support) Meeting Actions</b></p> <ul style="list-style-type: none"> <li>There are no consolidated actions log to monitor progress across actions arising from the weekly meetings, although we were advised that progress is discussed.</li> </ul>
<b>Low</b>	<p><b>Issue 7 – Strengthen the DMT Draft Terms of Reference</b></p> <ul style="list-style-type: none"> <li>The ToR for the DMT is currently under revision following the re-shaping to streamline the senior leadership governance. Review of the draft found that whilst the document outlines a broad purpose, it lacks defined objectives and scope.</li> </ul>

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**Audit Objective**  
 As part of the 2025/26 Internal Audit Plan, Internal Audit reviewed KCC's early ETS financial modelling and assumptions to assess whether the approach taken is appropriate for this stage of financial planning, given the high level of national uncertainty. The review considered the governance, methodology and assumptions supporting the current internal estimates. It did not examine contractual arrangements or negotiations.

**Audit Scope and Scope Limitations**

**Areas Covered**

- Governance & Decision Making
- Training & Support
- Subject Access Requests
- Privacy Notices
- Provider Contracts
- Scope Limitations: None

Audit Opinion	Prospects for Improvement	Actions	Number	Agreed	Risk Accepted
Adequate	Good	High	0	0	0
		Medium	2	2	0
		Low	0	0	0

**Key Strengths**

Reliable underlying waste tonnage Data Processes	✓ Operational waste tonnage information used to support the early ETS modelling was based on established data collection processes. Weighbridge transactions were routinely captured and consolidated into wider waste reporting dataset, and standard monthly checks were carried out between sites to confirm that recorded tonnages aligned. Although further work will be required to integrate this data formally into future ETS modelling, the underlying operational data provided a reasonable starting point for the initial estimates.
Transparent and repeatable reporting via Power Bi	✓ Power Bi dashboards present consistently structured monthly and rolling 12-month Allington Tonnages, with clear filtering and year on year comparisons. Walkthroughs and screenshots demonstrate how figures flow directly from underlying database, enabling independent re performance-on-performance totals.
Availability of authoritative assumption sources	✓ Although ETS modelling controls require further development, several reliable data sources are already in place. These include recycling datasets, fossil content benchmarks, GOV.UK carbon price forecasts and Kent Analytics' housing led population and dwelling projections. Together, these provide a reliable basis for standardising future ETS assumptions.
Clear visibility of ETS entries within Financial Planning	✓ The Medium-Term Financial Planning (MTFP) spending template app provides transparent visibility of the ETS pressure submitted into financial plan. ETS entries include supporting attachments and evidence links.
Strong engagement and openness from officers	✓ Waste, insight and finance officers engaged constructively throughout the audit, providing walkthroughs, datasets, and background information promptly. Officers also demonstrated awareness of ETS uncertainties and a willingness to strengthen modelling and governance once national guidance is finalised.

Areas For Development

Medium

**Issue 1 – Insufficient timeliness of Subject Access Request (SAR) responses**

- Although SAR procedures were robust and extensions were documented, timeliness performance was low, with only 52% of SARs completed within statutory time limits, 29% completed late, and 6% still overdue. This increases the risk that compliance failures may persist and affect service users.

Medium

**Issue 2 - Insufficient ongoing assurance over third party provider compliance**

- Although provider contracts include Information Governance clauses and breach notification requirements, ongoing compliance monitoring was limited to annual self-assessment questionnaires and ad-hoc Data Protection Impact Assessment (DPIA) updates. There was no documented, structured process for periodic Information Governance compliance or assurance reviews within contract management, increasing the risk that non-compliance may go undetected.

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**Audit Objective**  
 The audit assessed the adequacy and effectiveness of controls within KCC's statutory remit. It did not evaluate areas outside the Council's legal powers, such as compulsory engagement or educational quality enforcement. The audit focused on how KCC supports, monitors, escalates, and plans where families choose to engage.

**Audit Scope and Scope Limitations**

**Areas Covered**

- Governance & Decision Making
- Access & Systematic Pressures
- Safeguarding & SEN
- Post-14 Progression
- Data Quality & Reporting
- Staff Capacity & Training

**Scope Limitations** None

Audit Opinion	Prospects for Improvement	Actions	Number	Agreed	Risk Accepted
High	Very Good	High	0	0	0
		Medium	0	0	0
		Low	1	1	0

**Key Strengths**

Governance & Decision Making	<ul style="list-style-type: none"> <li>✓ A single, county-wide procedural framework is in place.</li> <li>✓ Timeliness expectations for admin processing, officer contact and review cycles are explicitly defined and generally reflected in case activity and dataset evidence reviewed.</li> <li>✓ Escalation routes are clearly set out and were evidenced as being in operation in the relevant cases reviewed.</li> <li>✓ Review of the full EHE dataset showed a high level of recorded operational activity.</li> </ul>
Access & Systematic Pressures	<ul style="list-style-type: none"> <li>✓ Timely Initial contact was evident in the cases reviewed, with early engagement following notification.</li> <li>✓ Safeguarding-linked cases reviewed showed strong escalation and multi-agency working.</li> <li>✓ Standard EHE workflows, Children Missing Education (CME) escalation were consistently observed within the sample and data reviewed.</li> <li>✓ Strategic oversight of demand and risk is supported through Divisional Management Team (DivMT) reporting, regional meetings, and Continuous Improvement (CI) forums.</li> <li>✓ Multiple data sources are used to identify and monitor system pressures.</li> <li>✓ Evidence of active service adaptation to demand was identified, including workflow automation, backlog clearance, and triage changes.</li> <li>✓ Risk management arrangements are aligned with safeguarding and ICS thresholds.</li> </ul>
Safeguarding & SEN	<ul style="list-style-type: none"> <li>✓ Safeguarding concerns were identified through multiple routes in the cases reviewed, including schools, CME, Integrated Children's Services (ICS), and non-engagement.</li> <li>✓ Strong multi-agency working was evidenced between EHE, CME, schools and social care in safeguarding-related cases sampled.</li> <li>✓ The Access to Education (A2E) Safeguarding Tracker provides structured, service-wide oversight of safeguarding concerns and actions.</li> <li>✓ Staff safeguarding training and manager oversight of complex cases were evidenced through documentation and management confirmation.</li> <li>✓ EHE officers interviewed demonstrated a clear understanding of Education, Health, and Care Plan (EHCP) processes and responsibilities within cases reviewed involving EHCPs.</li> </ul>
Post 14 Progression	<ul style="list-style-type: none"> <li>✓ CME escalation was applied appropriately in post-14 cases reviewed where non-engagement or risk was identified.</li> <li>✓ Core EHE workflows (notification, Initial contact form (ICF) issue, review scheduling) were applied consistently across the post-14 cases sampled.</li> </ul>

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Key Strengths Continued

Post 14 Progression	<ul style="list-style-type: none"> <li>✓ CME escalation was applied appropriately in post-14 cases reviewed where non-engagement or risk was identified.</li> <li>✓ Core EHE workflows (notification, ICF issue, review scheduling) were applied consistently across the post-14 cases sampled.</li> </ul>
Data Quality & Reporting	<ul style="list-style-type: none"> <li>✓ Core dataset fields were complete and well-structured across the data reviewed.</li> <li>✓ The dataset is actively used for DivMT and Continuous Improvement (CI) reporting to monitor trends and pressure points.</li> <li>✓ Routine data quality checks were evidenced, including the use of Power BI dashboards, MI queries and admin review processes to identify missing, inconsistent or anomalous data and support corrective action checks.</li> <li>✓ Where SEN data was incomplete, EHE mitigated this in cases reviewed through direct parental enquiry via ICFs and review discussions.</li> </ul>
Staff Capacity & Training	<ul style="list-style-type: none"> <li>✓ Mandatory training is monitored centrally via DELTA and compliance was evidenced by management.</li> <li>✓ Extensive whole-team and role-specific training has been delivered, including Safeguarding, CME, Special education needs (SEN), and multi-agency learning.</li> <li>✓ A structured induction framework is in place, including onboarding and shadowing arrangements.</li> <li>✓ Officers demonstrated a clear understanding of roles, thresholds and escalation pathways through casework and interviews.</li> <li>✓ Evidence of active multi-agency engagement was identified in Safeguarding and complex cases reviewed.</li> <li>✓ Based on the evidence reviewed, staffing levels appear sufficient to meet statutory duties, despite high demand.</li> </ul>

Areas For Development

<p style="text-align: center; background-color: #00b050; color: white; padding: 10px; border-radius: 5px;"><b>Low</b></p>	<p><b>Issue 1 – Inconsistent recording of training information</b></p> <ul style="list-style-type: none"> <li>• Mandatory training for EHE staff (e.g. Safeguarding, Information Governance, Prevent) is monitored and evidenced through KCC’s corporate DELTA system, which EHE management uses to confirm compliance. However, the local EHE training log is not consistently maintained or aligned to DELTA. This means the local log cannot be relied upon as a complete record of staff training without reference to DELTA.</li> </ul>
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**Introduction**

The aim of the Oracle Cloud Programme (OCP) is to replace the Council's current Oracle E-Business Suite (EBS) Solution, which is a critical system that has been in use for more than 20 years.

- Phase 1 (Finance + Procurement) went live in August 2025
- Phase 2 (HR + Payroll) was due to go live on 7 April 2026, but in January 2026 it was concluded that this date was not achievable and a revised phase 2 go-live date has not yet been set.

The Strategic Reset Programme (SRP) Programme Board agreed in April 2026 to carry out a strategic review of the OCP to support and assure decision-making on the next phase of the programme, with advice and recommendations being to inform the purpose, governance, structures, and behaviours from this point forward.

Internal Audit have continued to undertake ongoing embedded assurance providing challenge at OCP and SRP Boards.

Progress on OCP Internal Audit engagements is outlined below:

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OCP Engagement	Progress
<b>RB43-2026 - Oracle Cloud Programme (OCP) Phase 2 – Resources</b>	<ul style="list-style-type: none"> <li>• Internal Audit is waiting for the strategic review to conclude before setting the audit scope, as it may lead to changes in resourcing arrangements and reduce the value of auditing this area sooner.</li> </ul>
<b>RB44-2026 - Oracle Cloud Programme (OCP) Phase 2 - Security of Data Migration</b>	<ul style="list-style-type: none"> <li>• The audit was able to proceed despite the absence of a confirmed go-live date because it focused on the adequacy of controls and arrangements in place.</li> <li>• This audit is in the process of being finalised.</li> </ul>
<b>RB45-2026 - Oracle Cloud Programme (OCP) Phase 2 - Communication and Training</b>	<ul style="list-style-type: none"> <li>• The scope of this audit has been agreed to evaluate the design of communication and training controls.</li> </ul>
<b>RB46-2026 - Oracle Cloud Programme (OCP) Phase 2 - HR Connects Readiness for the new Payroll system</b>	<ul style="list-style-type: none"> <li>• The timing of this audit will be agreed following the strategic review, once the revised go-live date is confirmed, ensuring it is undertaken at the point of greatest insight and value.</li> </ul>
<b>RB47-2026 - Oracle Cloud Programme (OCP) Lessons Learned Review</b>	<ul style="list-style-type: none"> <li>• The initial report has been issued to Statutory Officers for review.</li> <li>• Exit and closing meetings are to be undertaken with key stakeholders to discuss the findings in detail and to check factual accuracy.</li> </ul>

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**Audit Objective**

Internal Audit undertook a review of Kent Cards and Direct Payments Policy and Practice (RB06-2024). This audit, which was reported in October 2024, identified 2 high and 7 medium risk issues, and was allocated 'Limited assurance'.

**Key Findings from Follow-up**

The follow-up work has identified that of the nine previous issues being reviewed, that seven issues have been fully implemented. Internal Audit found that some progress had been made for the remaining two issues reviewed however, these remain in progress.

Improvements have been made during 2025/26 which include the following:

- The direct payment policy has been updated and outlines various support services and includes clear guidelines on what direct payments cannot be used for.
- The updated policy includes version control and review dates for policy updates.
- A sample of direct payments were reviewed to provide assurance that people are not in receipt of double funding.
- Plans are in place to prioritise communication to individuals who are high risk.
- Workforce planning sessions commenced in the autumn using the KCC workforce planning tool.
- The number of individuals receiving Direct Payments has remained stable over the past two years, and the service has confirmed that current workloads are being managed effectively within existing resources.
- The updated policy includes timelines for direct payments review, including how the risk of misuse can alter the frequency of review.
- The policy has not yet been fully updated to reflect all agreed management actions, as the co-production and re-imagining exercise is still ongoing.

As a result, Internal Audit will seek to provide additional coverage in 2026-27 utilising data driven assurance.

	Original Issues Raised	Implemented	Issues Outstanding	Risk Accepted
<b>High Risk</b>	2	1	1	0
<b>Medium Risk</b>	7	6	1	0
<b>Low Risk</b>	0	0	0	0

Issue	Risk Rating	Status
<b>Issue 1</b> – Areas of Policy are Vague or Ambiguous	Medium	Implemented
<b>Issue 2</b> - No written timeframe for identified amendments needed to Direct Payments	Medium	In Progress
<b>Issue 3</b> – No guidance on monitoring separate Bank Account	Medium	Implemented
<b>Issue 4</b> – Direct Payments Review Frequency	Medium	Implemented
<b>Issue 5</b> - Manual Reporting Procedures	Medium	In Progress
<b>Issue 6</b> - Insufficient Resources	High	Implemented
<b>Issue 7</b> - Ambiguity when offering Direct Payments	Medium	Implemented
<b>Issue 8</b> - Difficulties in evidencing Equitable Choice	Medium	Implemented
<b>Issue 9</b> - Inconsistencies with Service Users Management or Use of Direct Payments	High	In Progress

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**Audit Objective**

Internal Audit is engaged on a consultancy basis, acting as a critical friend to provide embedded assurance and advice on the ongoing development of the Delivery plan to embed the “No PO, No Pay” Policy.

This is an interim update. The management letter will be reported to a later Audit committee.

Audit Opinion	Prospects for Improvement	Actions	Number	Agreed	Risk Accepted
Advisory	N/A	High	An action plan will be developed for any outstanding areas for development at the end of the engagement.		
		Medium			
		Low			

**Audit Scope and Scope Limitations**

**Areas Covered**

- Post-Go-Live Issue & Root Cause Analysis
- Tracking Success to Shape Actions
- Building Clear, Achievable Actions
- Ensuring Adequate Resourcing
- Review Expectations and Defining Clear Exception Criteria
- Governance, Communication & Change Management

**Scope Limitations** None

**Key Strengths**

Post-Go-Live Issue & Root Cause Analysis	<ul style="list-style-type: none"> <li>✓ Issue logging is now underway, with Finance and Procurement building a consolidated list of issues.</li> <li>✓ Early categorisation is being added to support triage.</li> <li>✓ Workarounds/technical items are being identified and separated for technical discussion.</li> <li>✓ Risks and impacts are being captured against issues in the action plan.</li> </ul>
Tracking Success to Shape Actions	<ul style="list-style-type: none"> <li>✓ Compliance reporting is recognised as necessary and has actions underway.</li> </ul>
Building Clear, Achievable Actions	<ul style="list-style-type: none"> <li>✓ Progress tracking fields exist in the draft plan.</li> </ul>
Communication & Change Management	<ul style="list-style-type: none"> <li>✓ Training is acknowledged as a key dependency, with concrete training actions underway.</li> </ul>

**Area that are being progressed during the engagement**

- Root cause analysis and consistent issue categorisation are not yet fully evidenced.
  - Reporting of circumventions to Counter Fraud needs confirming and evidencing.
  - Implementation indicators and targets are not yet defined; for example, the retrospective PO rate target. These will need to feed into issue prioritisation decisions
  - Some outcomes are too vague to evidence whether their related actions have been completed
  - Exception criteria must be documented, agreed, and communicated, and a periodic review of exceptions (including Procurement Act 2023 exemptions) needs to be built into the plan.
- Note:** It has been acknowledged that monitoring and refresher training not yet completed due to the issues still arising with Oracle Cloud will be included in the action plan.

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**Audit Objective**

This audit on the Clarity System is the first data-driven assurance audit and sits within the Council’s wider approach to improving data quality, preventing fraud and strengthening financial controls. During the period February 2024 to March 2025 £516,734 of expenditure was processed using the Clarity System to purchase hotels and travel arrangements with over 90% of transactions being generated within social care. This audit will use advanced data analytics to assess risk which will lead to an assessment on whether key controls are functioning sufficiently.

**Audit Opinion**

TBC

**Prospects for Improvement**

TBC

Actions	Number	Agreed	Risk Accepted
High	An action plan will be developed. Data quality improvements will be tracked and reported as part of our ongoing data driven assurance programme of work		
Medium			
Low			

**Audit Scope and Scope Limitations**

**Areas to Cover**

- Assurance Checks
- Data Quality
- Accounting Controls

**Scope Limitations**

This audit will not provide an assessment of value for money in relation to the cost of purchasing direct verses the cost of purchasing from Clarity.

**Progress to Date**

Assurance Checks	<ul style="list-style-type: none"> <li>Potential weaknesses highlighted in the robustness of the management assurance checks.</li> </ul>
Data Quality	<ul style="list-style-type: none"> <li>Potential significant weaknesses in relation to data quality with the clarity system.</li> </ul>
Accounting Controls	<ul style="list-style-type: none"> <li>Still to be established.</li> </ul>

**Area that are being reviewed during the engagement**

- Assess the effectiveness of methodologies used to undertake management assurance checks across all directorates.
- Assess whether methodologies used to undertake management assurance checks represent good value for money.
- Use data analytics tools to identify data quality issues.
- Assess the design of data quality controls in place within the Clarity System.
- Assess the impact of any data quality issues raised through internal audit work and explore ongoing data led assurance options to track data quality progress.
- Use data analytics tools to identify poor or inconsistent accountancy coding controls.
- Assess the design of accountancy coding controls in place within the Clarity System.

The aim of the Highways Term Maintenance contract (HTMC) project was to ensure KCC procured a new HTMC which was fit for purpose, held the latest industry specifications, offered value for money and was innovative. The options analysis of delivery models helped to achieve this.

Internal Audit has provided ongoing embedded assurance over the past two years with the objective to provide an independent opinion on the adequacy and effectiveness of the governance and risk management over the project. A decision was taken in January 2026 for internal audit to continue supporting the project over the mobilisation phase which is due to end on 1st May 2026.

In line with our agile audit approach Internal Audit provided a timely update to senior management in November 2025 followed by the Governance and Audit Committee in January 2026. Since the last update in January 2026 Internal Audit has helped management refine the format of the mobilisation risk register to help support greater transparency and decision making and these changes have been implemented. Recently Internal Audit have also provided some informal procedural advice on how to align its WAMs financial and assurance checking procedure with KCC Financial Regulations ahead of the new contract go-live in May 2026.

Internal Audit will now cease supporting the project with the mobilisation phase coming to an end and this Management Letter marks the end of the embedded assurance and consultancy process.

Audit Opinion	Prospects for Improvement
Advisory	Advisory

Actions	Number	Agreed	Risk Accepted
High	0	0	0
Medium	1	1	0
Low	0	0	0

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**Internal Audit Findings and Observations – Governance and Risk Management**

- The Project Development Report contain all the details of the commissioning process over the last 2+ years and demonstrates due process through the whole commissioning cycle.
- There were suitable internal governance arrangements in place for the procurement phase of the HTMC and confidentiality was maintained throughout (delegated authority, declarations signed).
- There were clear programme roles and responsibilities and timely reporting arrangements in place to support decision making.
- Good engagement, support and challenge at Programme Board Meetings was observed. For example, in October 2025 good use of internal legal expertise to help navigate the communication and contract award phase was very positive and helped to mitigate emerging risks.
- Risk registers and governance logs were used effectively during the mobilisation phase however some improvements to the mobilisation risk register format were suggested and implemented prior to the mobilisation phase. **Issue 1 - closed.**

## Internal Audit Findings and Observations – Mobilisation Phase

- Since the decision to award the contract to Ringway the Programme Board has met monthly and is tracking progress and emerging risks through the mobilisation phase. Roles and responsibilities are well documented and the timelines are clear.
- Communication between teams leading work strands has been an area of focus for management during March 2026 which is helping to ensure successful co-ordination between teams during mobilisation.
- As at March 2026 mobilisation is progressing well and key issues and risks are being discussed and tracked at the Programme Board.

## Other Observations

- In March 2026 Internal Audit were asked to provide some informal advice on the design of the current WAMs financial and assurance checking procedure and as a result of that work, misalignments with the KCC Financial Regulations have been highlighted by Internal Audit to take forward.

## Financial Position

- In March 2026 Internal Audit were asked to provide some informal advice on the design of the current WAMs financial and assurance checking procedure and as a result of that work, misalignments with the KCC Financial Regulations have been highlighted by Internal Audit to take forward.
- Actual costs were covered by Highways budget across service areas (legal, procurement, infrastructure, depot leases).

## Conclusion

- In March 2026 Internal Audit were asked to provide some informal advice on the design of the current WAMs financial and assurance checking procedure and as a result of that work, misalignments with the KCC Financial Regulations have been highlighted by Internal Audit to take forward.

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# Appendix B – 2025-26 Rolling Internal Audit Plan Status

No	Ref	Audit	Status	Assurance	Prospects for Improvement	Committee
	RB01-2026	Fulfilling Best Value Statutory Duty	Planning			
	RB02-2026	Future Operating Environment – Local Government Reorganisation Implementation	Ongoing			
	RB03-2026	New Contact Centre Contract	Deferred			
	RB04-2026	Ongoing Review of Identified Actions	Ongoing	Follow-up	N/A	January 2026 GAC
10	RB05-2026	Oracle Cloud Programme - Embedded Assurance	Ongoing	Embedded Assurance	N/A	January 2026 GAC
1	RB06-2026	Oracle Cloud Programme - Programme Management – Follow up	Complete	Follow-up	N/A	September 2025 GAC
	RB07-2026	Payment Card Industry Data Security Standards (PCI DSS) Follow up	On Hold			
Page 80	RB08-2026	Annual Governance Statement – Directorate Action Plans	Not Started			
	RB09-2026	Contract Management & Monitoring	Not Started			
10	RB10-2026	ASCH Saving Delivery Plan Governance	Complete	Limited	Good	May 2026 GAC
	RB11-2026	Adult Social Care Debt Recovery	Draft Report			
	RB12-2026	Commissioning and Transformation – Embedded Assurance	Ongoing			
18	RB13-2026	Direct Payments including Follow up	Complete	Follow-up	N/A	May 2026 GAC
8	RB14-2026	Information Governance - ASCH	Complete	Substantial	Good	January 2026 GAC
	RB15-2026	ASCH Future Planning of Contracts	Planning			
	RB16-2026	MOSAIC Invoice Validation	Fieldwork			
	RB17-2026	Safeguarding – Protecting Adults at Risk	On Hold			
	RB18-2026	ASCH Provider Failure Risk	Fieldwork			
	RB19-2026	Public Substance Misuse Health Campaigns	Not Started			
	RB20-2026	Budget Management	Planning			
	RB21-2026	Post-Implementation Review of Commissioning	Not Started			
15	RB22-2026	Personal Data - Invicta Law (combined with GCSG)	Complete	Substantial	Good	May 2026 GAC

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No	Ref	Audit	Status	Assurance	Prospects for Improvement	Committee
	RB23-2026	Core Financial Controls	Planning			
20	RB24-2026	No Purchase Order No Pay	Ongoing			
	RB25-2026	Process review of SEND Payments	Fieldwork			
	RB26-2026	Recommissioning of TEP - Transition of Early years service back to KCC	Removed			
	RB27-2026	CYPE Assurance Map	Planning			
	RB28-2026	Education Health Care Plan (EHCP) Outcomes	Deferred			
	RB29-2026	All Pay (Replacement of Kent Card) - Card Payments	Planning			
	RB30-2026	Essential Living Allowances - Follow-up	Draft Report			
17	RB31-2026	Elective Home Education	Complete	High	Very Good	May 2026 GAC
	RB32-2026	Business Continuity Planning	Planning			
3	RB33-2026	Health and Safety	Complete	Substantial	Very Good	January 2026 GAC
Page 81	RB34-2026	Managers - People Management Responsibilities (Objective Setting and Performance Management)	Deferred			
	RB35-2026	Restructures	Planning			
6	RB36-2026	Property Disposals	Complete	Substantial	Good	January 2026 GAC
	RB37-2026	Economic Strategy	Deferred			
16	RB38-2026	Emissions Trading Scheme – Financial Modelling & Assumptions	Complete	Adequate	Good	May 2026 GAC
2	RB39-2026	Helping Hands Follow up	Complete	Follow-up	N/A	September 2025 GAC
11	RB40-2026	Highways Term Maintenance Contract – Embedded Assurance	Complete	Embedded Assurance	N/A	January 2026 GAC
7	RB41-2026	Utility Works on Kent Network – Process and Alignment of Utility Works	Complete	Adequate	Good	January 2026 GAC
	RB42-2026	Commercial & Procurement Oversight Board (CPOB)	Ongoing			
5	ICT01-2026	Backups	Complete	Substantial	Very Good	January 2026 GAC
	ICT02-2026	Legacy IT Works	Not Started			
	ICT03-2026	Cyber Security Topical Requirements	Planning			
14	ICT04-2026	Laptops – Asset Management	Complete	Substantial	Good	May 2026 GAC

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No	Ref	Audit	Status	Assurance	Prospects for Improvement	Committee
	RB43-2026	Oracle Cloud Programme – Resources	Not Started			
	RB44-2026	Oracle Cloud Programme – Security of Data Migration	Fieldwork			
	RB45-2026	Oracle Cloud Programme – Communication & Training	Planning			
	RB46-2026	Oracle Cloud Programme - Readiness for the New Payroll System	Planning			
	RB47-2026	Oracle Cloud Programme – Lessons Learned Review	Draft Report			
	RB48-2026	Local Mitigation Fund (LMF)	Draft Report			
	RB49-2026	Data Security and Protection Toolkit	Draft Report			
12	RB56-2025	Public Health Service Transformation Programme	Complete	Embedded Assurance	N/A	January 2026 GAC
4	RB31-2025	Unaccompanied Asylum-Seeking Children (UASC) Reception Centres and Registered Children's Homes	Complete	Substantial	Very Good	January 2026 GAC

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## Appendix C – Grant Certification

Government Department	Description	Amount	Current Status
Department of Transport	Bus Service Operators Grant (BSOG) – Annual grant to support local bus services (reported Previously)	£1,100,000	Complete
Department of Transport	Integrated Transport & Maintenance Block (Reported Previously)	£47,000,000	Complete
Department of Transport	Local Transport Block Funding – Pothole Fund (Previously Reported)	£4,300,000	Complete
Department of Transport	Bus Service Operator Grant for Walmer in Dover	£2,000,000	Complete
Department for Culture, Media & Sport	Sport England 2023-24	£900,000	Complete
Department for Health	Supplementary substance Misuse Treatment & Recovery (SSMTRG) 2024-25 (mid year & end of year review)	£2,200,000	Complete
Department for Health	SSMTR – Housing Support Fund 2024-25 (mid year & end of year review)	£809,000	Complete
Department for Health	Inpatient Detoxification Treatment (IPD) 2024-25 (mid year & end of year review)	£814,000	Complete
Department for Health	Individual Placement Support (IPS) 2024-25 (mid year & end of year review)	£257,000	Complete
Department for Health	Rough Sleeping Drug & Alcohol Treatment 2024-25 (mid year & end of year review)	£586,000	Complete
Department for Culture, Media & Sport	Sport England	£832,002	Complete
Department for Transport	Bus Services Improvement Grant (BSIP) 2023-24	£18,985,735	Complete
Department for Transport	Bus Services Improvement Grant (BSIP) 2024-25	£18,985,735	Complete
Department for Health	OHID Substance Misuse Grant (DATRIG & IPD)	£3,701,746	Complete
Department for Health	Individual Placement Support (IPS) 2025-26	£198,960	Complete
<b>Total</b>		<b>£118,007,178</b>	

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## Audit Opinion

<p><b>High</b></p>	<p>Internal control, Governance and the management of risk are at a high standard. The arrangements to secure governance, risk management and internal controls are extremely well designed and applied effectively.</p> <p>Processes are robust and well-established. There is a sound system of control operating effectively and consistently applied to achieve service/system objectives.</p> <p>There are examples of best practice. No significant weaknesses have been identified.</p>	<p><b>Limited</b></p>	<p>Internal Control, Governance and the management of risk are inadequate and result in an unacceptable level of residual risk. Effective controls are not in place to meet all the system/service objectives and/or controls are not being consistently applied.</p> <p>Certain weaknesses require immediate management attention as there is a high risk that objectives are not achieved.</p>
<p><b>Substantial</b></p>	<p>Internal Control, Governance and management of risk are sound overall. The arrangements to secure governance, risk management and internal controls are largely suitably designed and applied effectively.</p> <p>Whilst there is a largely sound system of controls there are few matters requiring attention. These do not have a significant impact on residual risk exposure but need to be addressed within a reasonable timescale.</p>	<p><b>No Assurance</b></p>	<p>Internal Control, Governance and management of risk is poor. For many risk areas there are significant gaps in the procedures and controls. Due to the absence of effective controls and procedures no reliance can be placed on their operation.</p> <p>Immediate action is required to address the whole control framework before serious issues are realised in this area with high impact on residual risk exposure until resolved</p>
<p><b>Adequate</b></p>	<p>Internal control, Governance and management of risk is adequate overall however, there were areas of concern identified where elements of residual risk or weakness with some of the controls may put some of the system objectives at risk.</p> <p>There are some significant matters that require management attention with moderate impact on residual risk exposure until resolved.</p>		

Prospects for Improvement		Issue Risk Ratings	
<b>Very Good</b>	There are strong building blocks in place for future improvement with clear leadership, direction of travel and capacity. External factors, where relevant, support achievement of objectives.	<b>High</b>	There is a gap in the control framework or a failure of existing internal controls that results in a significant risk that service or system objectives will not be achieved.
<b>Good</b>	There are satisfactory building blocks in place for future improvement with reasonable leadership, direction of travel and capacity in place. External factors, where relevant, do not impede achievement of objectives.	<b>Medium</b>	There are weaknesses in internal control arrangements which lead to a moderate risk of non-achievement of service or system objectives.
<b>Page 85 adequate</b>	Building blocks for future improvement could be enhanced, with areas for improvement identified in leadership, direction of travel and/or capacity. External factors, where relevant, may not support achievement of objectives	<b>Low</b>	There is scope to improve the quality and/or efficiency of the control framework, although the risk to overall service or system objectives is low.
<b>Uncertain</b>	Building blocks for future improvement are unclear, with concerns identified during the audit around leadership, direction of travel and/or capacity. External factors, where relevant, impede achievement of objectives.		

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By virtue of paragraph(s) 3 of Part 1 of Schedule 12A  
of the Local Government Act 1972.

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