IACF | Improving Outcomes Creating Value

INTERNAL AUDIT PROGRESS REPORT

GOVERNANCE AND AUDIT COMMITTEE

21st January 2021

1. Introduction

1.1 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.

1.2 Upon completion of an audit, an assurance opinion is given on the soundness 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.

1.3 This activity report provides Members of the Governance and Audit Committee and Management with 18 summaries of completed work since the previous Committee in October 2020.

1.4 The following areas, usually covered within a Progress Report, are detailed within the Internal Audit Annual Report in a separate agenda item:

- Analysis of Assurances issued;
- Plan Status and Delivery;
- Grant Certification
- Issue Implementation; and
- Internal Audit Resources, as required by the Public Sector Internal Audit Standards (PSIAS).

2. Key Messages

- Planned work remains below target at the end of quarter 3, however delivery pace has increased, and a substantial amount of work is in progress;
- 36 grants/ certifications have been certified to date;
- The analysis of issue implementation has been updated, highlighting a decline in implementation.
- A summary of matters arising for 18 of the completed audit assignments has been provided at Appendix B.

3. Updates

3.1 Internal Audit Plan Status:

Since the previous Committee, delivery has accelerated with 23 planned reviews completed to either draft or final reporting stage. A further 29 reviews are either in progress or at planning stage with 13 audits to commence. Although a substantial proportion of the Audit Plan remains to be completed, it is anticipated that coverage will be sufficient for the Annual Head of Internal Audit Opinion.

The Internal Audit service has undertaken a review of the factors that are impacting upon the delivery of its audit coverage prior to the end of 2020. The principal reasons for the delays across all stakeholders and clients to be drawn to the attention of the Committee are summarised below:

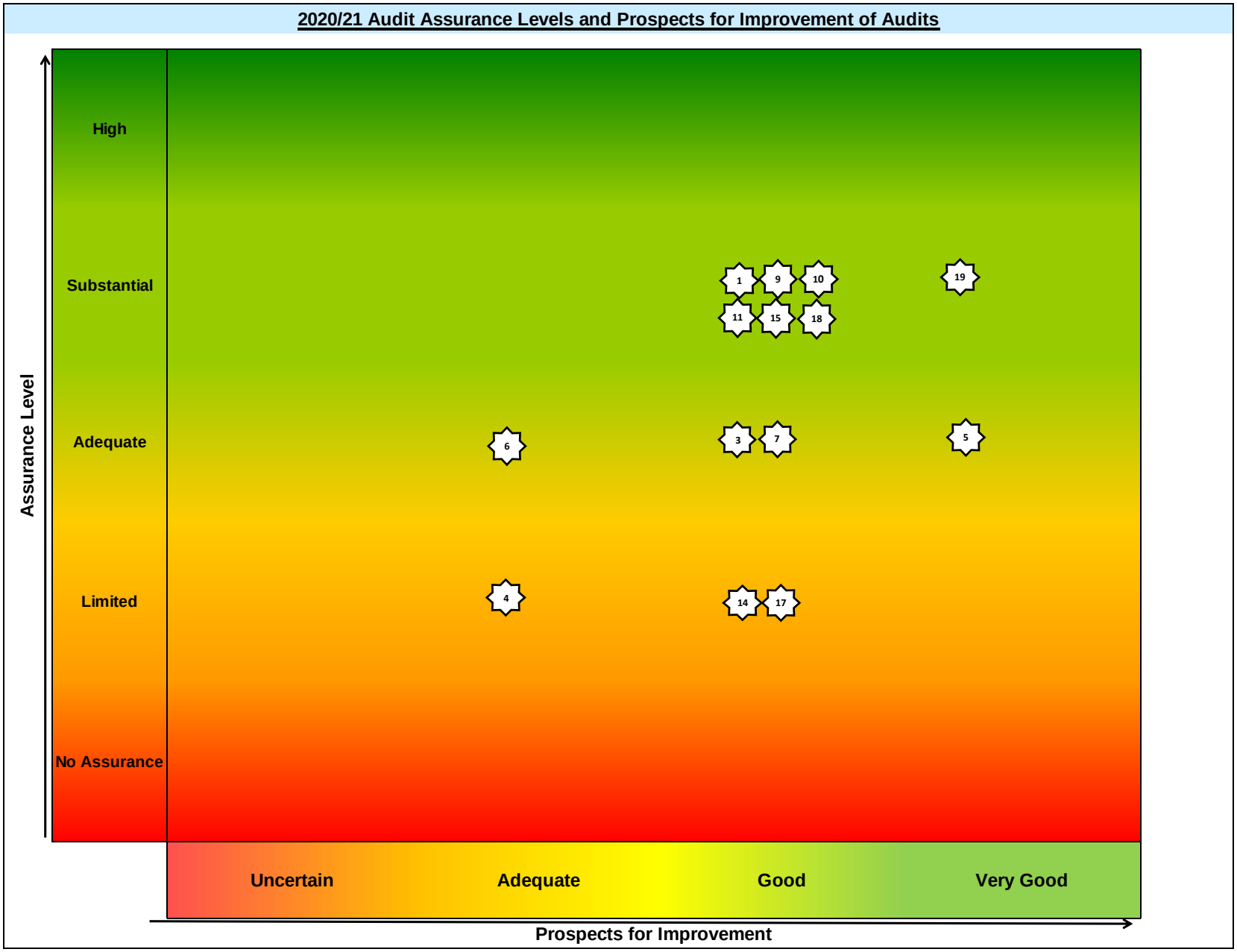
- Resistance from management to audit commencing.
- Delays in responses to information requests.
- Arranged meetings being cancelled.
- Audit closure meetings difficult to arrange.
- Delays in post audit meetings to discuss draft reports.
- Delays in management providing responses to final audit reports.

Additionally, several factors relating to Internal Audit processes have been identified to be undertaken in a more lean and effective manner. These factors are reflective of the many varied and significant challenges that all stakeholders and managers, with whom Internal Audit work with to undertake audit assignments, are facing. A series of actions to manage and monitor these factors has been initiated.

This period has again required significant resources to be assigned to Grant Certification (see 3.2) and, additionally, resources are now being directed towards preparations for the External Quality Assessment of the service. Audit an grant certification work for the remainder of 20-21 may be impacted dependent upon the period in which a member if the team is effectively seconded to support EU Transition and also the speed of seeking a replacement for a colleague who is leaving the service.

Full details of the status of planned work, for the period to 31st December 2020 are provided at Appendix A of this report. A summary of the completed reports is shown in Table 1 below:

Table 1: Summary of Assurance Levels to Date



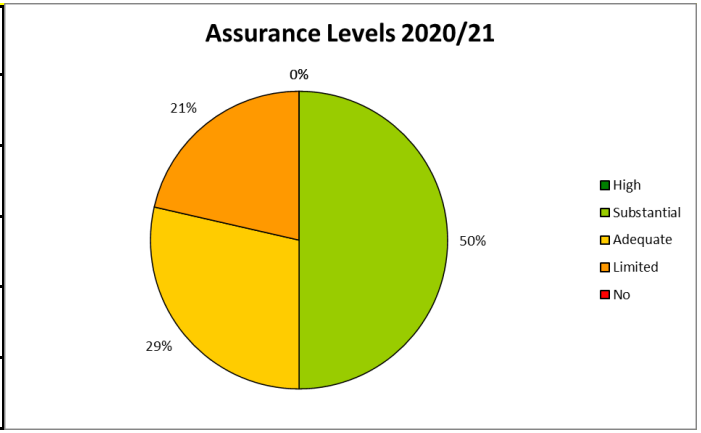
Audit Opinion October G&A Committee

No	Audit	Assurance	Prospects for Improvement
1	PPE	Substantial	Good
2	Supplier Relief Payments	N/A	N/A
3	Change for Kent Children	Adequate	Good
4	ICT Asset Control (COVID-19 IMPACT)	Limited	Adequate
5	AGS 2019/20	Adequate	Very Good

Audit Opinion January G&A Committee

No	Audit	Assurance	Prospects for Improvement
6	DoLS	Adequate	Adequate
7	ASCH Covid-19 Response Plan	Adequate	Good
8	Succession Planning (Mgt Letter)	N/A	N/A
9	Review of COVID-19 Expenditure	Substantial	Good
10	Purchase to Pay (P2P)	Substantial	Good
11	Charging Arrangements	Substantial	Good
12	CYPE Assurance Map - Safeguarding	N/A	N/A
13	Provider Data Protection Themed Report	N/A	N/A
14	Urgent CHAPS Payments	Limited	Good
15	Blue Badge Applciation Process	Substantial	Good
16	Kent Pension Fund Investment Governance Follow-Up	N/A	N/A
17	Adult Social Care Client Billing	Limited	Good
18	ICT Access Controls / User Accounts for DSPT Assurance	Substantial	Good
19	Respite Overpayment Follow-Up	Substantial	Very Good
20	Winter Pressures (Mgt Pressures)	N/A	N/A
21	Op Fennell (EU Transition) (Mgt Letter)	N/A	N/A
22	ASCH Assurance Map - Safeguarding	N/A	N/A
23	Highways (HTSCP)	N/A	N/A

Assurance Level	No	%
High	0	0%
Substantial	7	50%
Adequate	4	29%
Limited	3	21%
No	0	0%



3.2 Grant Certification Work:

To date in 2020-21, the team has audited and certified 36 grant claims and work is currently in progress for several other certifications. Details of all certifications can be seen at Appendix A. Internal Audit work on grant certification provides an essential service for the Council, although it is not audit opinion work. The Audit team's schedule to grant certification work is an increasing commitment of Internal Audit resources and it is apparent that one aspect of changed working arrangements has been the increasing challenges of completing such work, which requires adherence to strict timescales for the submission of grant certifications.

It is also highlighted that the service will be undertaking further new, complex and comparatively high-profile grant certifications in the next year, including the Test and Trace Support Grant, for which £6.3m has been allocated to the Council.

3.3 Internal Audit Resources:

In accordance with the Public Sector Internal Audit Standards, members of the Committee need to be appraised of relevant matters relating to the resourcing of the Internal Audit function.

As stated at previous Committees, the positive expansion in recent years of the provision of Internal Audit and Counter Fraud services to in excess of 20 external clients and bodies has not been accompanied by corresponding resources to deliver the very wide range of assurance and governance matters it is engaged in. Furthermore, the Internal Audit Plan for 2020-21, agreed at the July Governance and Audit Committee, noted a shortfall in resources to deliver the planned work.

With the appointment of the Head of Internal Audit in September 2020, the review of options to address the resource and skills requirements of the section has commenced albeit still at early stages. Consequently, short-term resource shortfalls will continue to be addressed by a combination of fixed-term and agency resource and other options are currently being considered. Any proposed changes to the resourcing of Internal Audit will initially be drawn to the attention of the Chair of the Committee and the s.151 Officer.

3.4 Revision of Audit Plan:

The Internal Audit Plan must be flexible to ensure that it remains relevant to risks facing the Council throughout the year. The Audit Plan, therefore, needs to be amended to reflect changing risk circumstances and requests from senior management. The following audit plan amendments are drawn to the attention of the Committee:

Additional work

- Operation Fennel (EU Transition - replaces planned audit work, plus additional resources provided)
- Data Analytics Development – Procurement Card Usage
- Strategic Reset Programme – Programme Governance

20-21 planned audits removed or deferred:

- Strategic Delivery Plan (CA08)
- Non-residential care payments through Finestra (CS03 - deferred to 21-22)
- Data Analytics Development – Payroll (RB06)
- Revised Equality Impact Assessment (EQIA) process (RB01 -deferred to 21-22)
- Capital Investment in Good Day Program (RB17)
- Establishments Themed Review (RB 31 - deferred to 21-22)
- Resilience and Emergency Planning Service (RB32 – resource utilise to support Operation Fennel)

During the course of 2020-21, Internal Audit has increased operating in an agile manner to assist the Council in significant areas and its coverage to deploy and/or redirect resources to the areas of high risk facing the Council. This has included specific audits related to risks highlighted by Covid-19 and also being a critical friend to advise within the Council. One of the most important examples of this is the current deployment of a Principal Auditor to provide critical friend support and advice in relation to the Council's role in EU Transition.

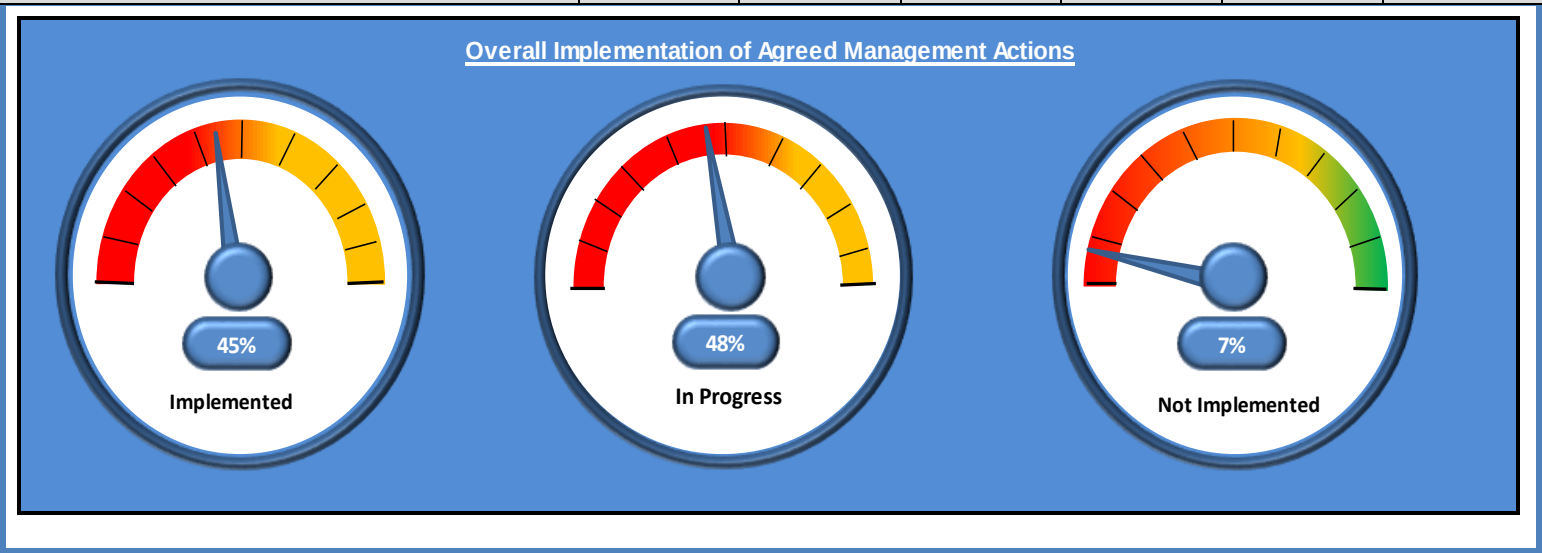
3.5 Issue Implementation

3.5.1 Details of the current position on the implementation of actions from Internal Audit reports is set out at Appendix C. This details the implementation status of 58 actions categorised by the assurance level assigned to the original report.

3.5.2 The status of implementation of implementation in Appendix C is summarised in Table 2:

Table 2 Summary of Action Implementation

	Total Number due for Implementation		Implemented		In Progress		Not Implemented	
	High	Medium	High	Medium	High	Medium	High	Medium
Total	12	46	3	23	8	20	1	3
		Total %	**25%**	**50%**	**67%**	**43%**	**8%**	**7%**



3.5.3 Table 2, therefore, highlights the following key points:

- 98% of high and medium ranked actions have either been implemented or are in progress;
- 92% of high ranked actions have either been implemented or are in progress;
- 93% of medium ranked actions have either been implemented or are in progress;
- 25% of high ranked actions had been implemented;
- 50% of medium ranked actions had been implemented;
- 75% of both high and medium ranked actions had been implemented;
- 67% of high ranked actions were in progress and not fully implemented;
- 43% of medium ranked actions were in progress and not fully implemented; and
- 38% of both high and medium ranked actions were in progress and not fully implemented.

3.5.4 This level of implementation is compared to 2019-20 and 2020-21 in Table 3:

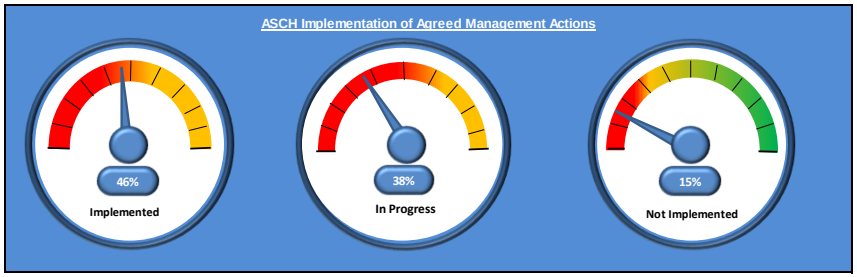
Table 3: Summary of Implementation of Actions 2019-20 to 2020-21

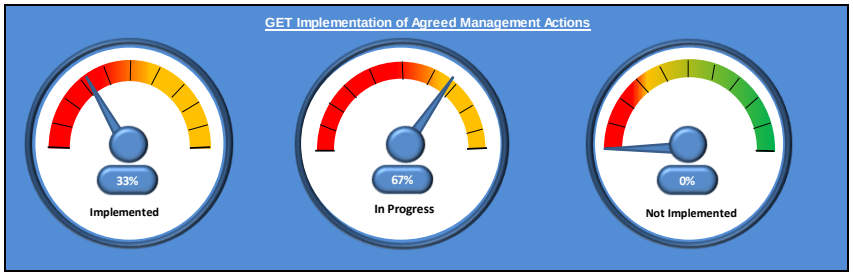
Indicator	20-21 to date	19-20	Change
High and medium ranked actions have either been implemented or are in progress	**98%**	**98%**	
High ranked actions have either been implemented or are in progress	**92%**	**100%**	
Medium ranked actions have either been implemented or are in progress	**93%**	**97%**	
High ranked actions had been implemented	**25%**	**62%**	
Medium ranked actions had been implemented	**50%**	**62%**	
High and medium ranked actions had been implemented	**75%**	**60%**	
High ranked actions were in progress and not fully implemented	**67%**	**38%**	
Medium ranked actions were in progress and not fully implemented	**43%**	**35%**	
High and medium ranked actions were in progress and not fully implemented	**38%**	**36%**	

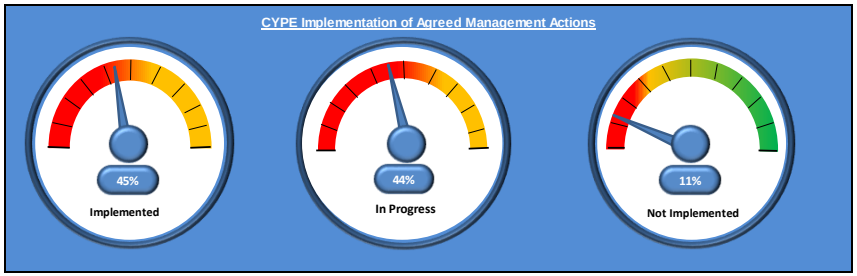
3.5.5 The analysis of the implementation of actions to address internal control and risk management actions following Internal Audit reports, therefore, highlights a decline in implementation indicators compared to 2019-20. Approximately 17% of actions cited as "In Progress" reported that delays had been caused due to Covid-19 pressures which in part accounts for the shift in position.

3.5.6 It is important that the implementation of agreed actions gains momentum to ensure that full implementation rates increase moving forward.

3.5.7 Internal Audit maintain analysis of outstanding recommendations to all Corporate Directorates and Directorate Management Teams and this is utilised in the monitoring and promotion of action implementation.


ASCH Implementation of Agreed Management Actions
46%
Implemented
38%
In Progress
15%
Not Implemented


GET Implementation of Agreed Management Actions
33%
Implemented
67%
In Progress
0%
Not Implemented


CYPE Implementation of Agreed Management Actions
45%
Implemented
44%
In Progress
11%
Not Implemented


ST Implementation of Agreed Management Actions
44%
Implemented
50%
In Progress
6%
Not Implemented

4. Under the Spotlight!

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 recommendations; thereby giving the Committee the opportunity to explore the areas further, should it wish to do so.

In this period, the following report summaries are provided at Appendix B, for the Committee's information and discussion.

A Cross Directorate:

1. Respite Overpayment Follow Up (CYPE / ST)
2. Covid-19 risk – Covid-19 Expenditure
3. Winter Pressures Commissioning (ASCH / ST and in Exempt Session)

B Adult Social Care and Health:

1. Deprivation of Liberties- Progressing with Addressing Backlog
2. Social Care Client Billing
3. Covid-19 risk - Charging Arrangements
4. Adults Safeguarding – Assurance Map
5. Blue Badge Application Process
6. Covid-19 risk - ASCH Covid-19 Response Plan

C Children, Young People and Education:

1. CYPE Assurance Map - Safeguarding

D **Strategic and Corporate Services**:

1. Strategic Commissioning – Purchase to Pay Process
2. Kent Pension Fund Investment Governance Follow Up
3. Finance - Urgent Payments Process (In Exempt Session)
4. Succession Planning
5. IT Access Controls / User Accounts
6. Provider Data Protection Compliance

E **Growth, Environment and Transport**:

1. EU Transition Planning Support
2. Highways Term Services Commissioning Project (HTSCP and in Exempt Session)

Appendix A – Internal Audit Plan 20120-21 – Status and Assurance Summary

Ref	Audit	Status as at 31.12.20	Assurance
CA01	Annual Governance Statement Assurance Statement Process 2019-20	Final report	Adequate – GAC Oct 20
CA02	Corporate Governance	Planning	
CA03	Records Management	In Progress	
CA04	Risk Management	In Progress	
CA05	Information Governance - DSP Toolkit Annual Audit	Planning	
CA06	Information Governance - Advisory/ Attendance at IG Steering Group.	Ongoing	
CA07	Information Governance – Remote working	In Progress	
CA08	Strategic Delivery Plan	Removed from Plan – replaced by Strategic Reset coverage	
CA09	Office Cleaning Arrangements	In Progress	
CS01	Imprest Accounts Follow-up	In Progress	
CS02	Social Care Client Billing	Final Report	Limited – GAC Jan 21
CS03	Non-residential care payments through Finestra	Deferred to 21-22	
CS04	Respite Overpayment - Follow up	Final Report	Substantial - GAC Jan 21
CS05	Schools Financial Services (TEP)	To Commence	
CS06	Capital Planning and Prioritisation	Planning	
CS07	Kent Pension Fund Investment Governance - Follow up audit	Final Report	N/A/ - Follow Up Report
CS08	ACCESS Pool	Planning	
CS09	Payment Project	Ongoing	
CS10	Finance - Urgent Payments Process	Final Report	Limited – GAC Jan 21
CS11	Covid-19 risk - Supplier Distress Payments - Part 1	Complete	N/A - Management Letter – GAC Oct 20
CS11(a)	Covid-19 risk - Supplier Distress Payments - Part 2	Planning	
CS12	Covid-19 expenditure	Final Report	Substantial - GAC Jan 21
RB01	Revised Equality Impact Assessment (EQIA) process	Deferred to 21-22	
RB02	Strategic Commissioning Follow-up	To Commence	
RB03	Replacement of Oracle (Enterprise Business Capabilities Project)	In Progress	
RB04	Health and Wellbeing Strategy	To Commence	

Ref	Audit	Status as at 31.12.20	Assurance
RB05	Succession Planning	Complete	N/A - Management Letter – GAC Jan 21
RB06	Data Analytics Development - Payroll	Removed from Plan	
RB07	Future of Sessions HQ (Project)	Planning	
RB08	Property Infrastructure - Functions and Processes Transferred to KCC from Gen2	To Commence	
RB09	Covid-19 risk - Asset Control of Laptops and Other Equipment	Final Report	Limited – GAC Oct 20
RB10	Covid-19 risk - Procurement and Contracts	Planning	
RB11	Adults Safeguarding - Assurance Map	Complete	N/A - Management Letter – GAC Jan 21
RB12	Shaping the Market	To Commence	
RB13	Quality Assurance Framework	To Commence	
RB14	Partnership Working – NHS	To Commence	
RB15	Mosaic - Post Implementation	To Commence	
RB16	Workforce – Recruitment & Retention of Staff	Planning	
RB17	Capital Investment in Good Day Program	Removed from Plan	
RB18	ASCH Covid-19 Response Plan	Final report	Adequate – GAC Jan 21
RB19	Covid-19 risk - PPE Distribution and Stock Control	Final Report	Substantial - GAC Oct 20
RB20	Project KARA - ASCH Digital Assistive Technology Project Board	Ongoing	
RB21	Charging Arrangements	Final Report	Substantial - GAC Jan 21
RB22	ASCH Contingency		
RB23	Accommodation for Young People/ Care Leavers	Planning	
RB24	Schools Themed Review (Cyber Security)	In Progress	
RB25	Children Missing Education	In Progress	
RB26	Delivery of Statutory Services – Contract Management - TEP	To Commence	
RB27	Adoption	To Commence	
RB28	Change for Kent Children (see also 19-20 c/fwd)	Ongoing	
RB29	CYPE Assurance Map - Safeguarding	Complete	N/A - Management Letter – GAC Jan 21
RB30	Provision of Laptops to service users	In Progress	
RB31	Establishments Themed Review	Deferred to 21-22	
RB32	Resilience and Emergency Planning Service	Removed from Plan & Resource combined with RB35	

Ref	Audit	Status as at 31.12.20	Assurance
RB33	Gypsy and Traveller Service - Pitch Allocation and Charging	Planning	
RB34	Kent Scientific Service	Planning	
RB35	Operation Fennel (EU Transition) - previously called EU Transition Planning	In Progress and Ongoing	N/A - Management Letter – GAC Jan 21
RB36	KCC support to Kent businesses - e.g., Kent and Medway Business Fund	To Commence	
RB37	Blue Badge Applications Process	Final Report	Substantial - GAC Jan 21
RB38	Highways Term Services Commissioning Project (HTSCP)	Final Report	N/A - Management Letter – GAC Jan 21
ICT01	IT Cloud Strategy, Security and Data migration	To Commence	
ICT02	IT Access Controls/ User Accounts – for DSP Toolkit	Final Report	Substantial - GAC Jan 21
ICT03	Cyber Security - Management of Backups for Applications, Data and active Network Devices.	Planning	
ICT04	Cyber Security - Management of Firewall rulesets/ Anti-virus and Anti-Malware Software	Planning	

B. Work Carried Forward From 2019-20:

Ref	Audit	Status as at 31.12.20	Assurance
1	Strategic Commissioning (Purchase to Pay Process)	Final Report	Substantial - GAC Jan 21
2	Deprivation of Liberties - Progress with Addressing Backlog	Final Report	Adequate - GAC Jan 21
3	ASCH – Winter Pressures	Complete	Management Letter – GAC Jan 21
4	Change for Kent Children	Final Report	Adequate – GAC Oct 20

C. Additions:

Ref	Audit	Status as at 31.12.2020	Assurance
1	Strategic Reset Programme – Programme Governance	Planning	
2	Data Analytics – Procurement Card Usage (In Counter Fraud Plan)	To Commence	
3	Operation Fennel (EU Transition)	Ongoing	

D. Grant Certifications completed since 1.4.2020:

No.	Grant	Description	Status as at 31.12.20
	EU Interreg - Aspire	A holistic approach to lowering obesity and unemployment rates in identified communities where the two issues are linked.	2 Claims Completed
	EU Interreg - BEGIN	An approach to climate resilience for cities that mimics nature's potential to deal with flooding.	2 Claims Completed
	EU Interreg - BHC21	To contribute to the development of more efficient and effective vocational training services for low-skilled people and develop a generic 21st century training model to reduce unemployment rates amongst low-skilled people.	1 Claim Completed
	EU Interreg – C5A	Aims to deliver a whole system approach to water and flood risk management in response to current and future risks from climate change.	1 Claim Completed
	EU Interreg – DWELL	Empowerment programme enabling patients with type 2 diabetes to access tailored support giving them mechanisms to control their condition and improve their wellbeing.	1 Claim Completed
	EU Interreg - Empower Care	To create resilient communities and reduce individual frailty and loneliness, addressing issues facing the care of our aging population	1 Claim Completed
	EU Interreg - Ensure	Making use of the community peer to peer support, which will allow societies to become proactive in addressing circumstances which create vulnerability across Kent.	1 Claim Completed
	EU Interreg - Experience	To provide the tools and infrastructure to capitalise on the emerging trend for personalised and local tourism experiences which provide reasons to visit at any time of the year.	2 Claims Completed
	EU Interreg - FRAMES	Assess the impact of and build resilience to flooding and climate change across the health and social care sector in Kent.	1 Claim Completed
	EU Interreg - H20	Overcoming barriers to integrated water and ecosystem management in lowland areas adapting to climate change.	1 Claim Completed
	EU Interreg - ICAReS	Developing a cross border innovation cluster to create the necessary conditions for innovation in the field of remote sensing & advanced data communication & processing	1 Claim Completed
	EU Interreg - Inn2Power	Supporting Kent based companies in the offshore wind sector with internationalisation & market entry in mainland Europe	2 Claims Completed
	EU Interreg - ISE	Supporting Kent business from several priority sectors innovate & internationalise through partnering & collaborating with new contacts in France, Belgium & the Netherlands	1 Claim Completed
	EU Interreg - PATH2	Enabling women, families and healthcare professionals to prevent, diagnose and successfully manage mild and moderate perinatal mental health issues.	1 Claim Completed
	EU Interreg - Prowater	Contributing to climate adaptation by restoring the water storage of the landscape via ecosystem-based adaptation measures.	1 Claim Completed
	EU Interreg - SCAPE	Developing landscape-led design solutions for water management that make costal landscapes better adapted and more resilient to climate change.	1 Claim Completed
	EU Interreg - SHIFT	Engaging with people over 45 years of age to develop a tailored sexual health and wellbeing model.	1 Claim Completed
	EU Interreg - SIE	Evaluating and improving business support services for SMEs specifically related to exporting and internationalisation.	1 Claim and On-the-Spot check Completed
	EU Interreg – STAR2Cs	Overcoming the implementation gap faced by local government adapting to climate change.	1 Claim Completed

	EU Interreg - TICC	Implementing an integrated community team at a pilot site to work with the principles of Buurtzorg (A Dutch home-care model known for innovative use of independent nursing teams in delivering relatively low-cost care).	1 Claim Completed
	EU Interreg - Triple A	Supporting homeowners to adopt different low-carbon technologies in their homes.	1 Claim Completed
	EU Interreg - Triple C	Implementing a set of cost-effective actions to reduce flooding and erosion.	1 Claim Completed
	EU Interreg - Upcycle your waste	The programme will run over three years and aims to support SMEs in reducing their running costs by handling and transforming their waste into new resources for the community.	1 Claim Completed
	Department for Transport - Capital Funding Grant	Capital Block Funding (Integrated Transport and Highway Maintenance)	Completed
	Department for Transport - Capital Funding Grant	Capital Block Funding (Integrated Transport and Highway Maintenance) (Live Lab Trials)	Completed
	Department for Transport - Capital Funding Grant	Local Transport Capital Block Funding (National Productivity Investment Fund)	Completed
	Connecting Europe Facility	A2-M2 works	Completed
	Department for Transport - Capital and Revenue Funding Grant	Kent Traffic Management System: (Operation Brock) grant	Completed
	Department for Transport - Capital Funding Grant	Network Requirements for Additional Work at Manston	Completed
	Department for Transport - Capital Funding Grant	Ashford Truck Stop Works and Ashford Borough Council	Completed
	Department for Transport – Bus Service Revenue Grant	Kent County Council Bus Service Operators Grant	Completed

Appendix B – Summaries of Completed Audit Reviews

A1 - Respite Overpayment Follow-Up

Audit Opinion	**Substantial**
Prospects for Improvement	**Very Good**

The follow-up audit highlighted that there has been significant progress since the original audit, including completion of all management action plans for the 2 high and 1 medium priority issues that were raised. As a result of the follow up audit 1 further low priority issue was raised.

Key Strengths

- Data Validation on the system is present and exception reports are now live and distributed to the Operational teams on a regular basis.
- Pre-payment checks have not been incorporated into the contract with Cantium and happen every 4 weeks prior to the payment run being actioned.
- Operational teams have sign off the payment run and the facility of a back- up run to process any amendments to services on the system.
- Creditors are checked regularly to ensure any overpayments or outstanding credits are reclaimed in a timely way.

Areas for Development

- There are no set timescales for the recommissioning of specific providers that have variable unit costs and therefore do not align with standard inputting procedures on the LAS/Controcc.

Prospects for Improvement

Our overall opinion of **Very Good** for Prospects for Improvement is based on the following factors:

- There is now clarity in the roles and responsibilities between KCC teams and Cantium, which will allow for better identification of issues and further process improvement.
- Tools and processes are now in place to identify erroneous payments before they are made.

Summary of Progress

Issue	Priority Level	Conclusion from testing
Exception Reporting	High	**Implemented**
Pre-Payment Checks	High	**Implemented**
Roles and Responsibilities (end to end process)	Medium	**Implemented**

A2 - Review of Covid-19 Expenditure

Audit Opinion	**Substantial**
Prospects for Improvement	**Good**

'Covid-19 logs' are maintained and continue to be developed by Finance and these provide an adequate mechanism to monitor and scrutinise the financial pressures attributed to Covid-19. Sample testing covering the period April 2020 to July 2020 and totalling £830k of expenditure, revealed that all transactions tested were related to the pandemic.

Guidance has been produced and circulated by email to support relevant Finance Officers and Budget Managers. However, 5 of the 19 (26%) Officers interviewed during the audit were not aware of the guidance available. The sample reviewed covered all four Directorates.

Key Strengths

- Guidance is available to support Budget Managers and relevant Finance Officers.
- Covid-19 logs have been developed and continue to evolve as new reporting requirements become evident.
- All transactions sampled totalling £830k were found to be linked to Covid-19.
- Internal Audit was were informed that costs associated with Covid-19 are under constant review and challenge.
- The financial impact of Covid-19 is closely monitored and is reported to various committees and MCHLG on a regular basis.
- A consistent approach has been developed and applied across each Directorate to provide oversight of Covid-19 financial pressures.
- Any potential gaps in the level of Covid-19 expenditure and income loss against the funding provided are monitored and understood.

Areas for Development

- Although, as detailed above, guidance is available and had been circulated to Budget Managers and relevant finance staff, it was not available on Knet and 6 out of 20 (30%) staff interviewed were not aware of the guidance.

Prospects for Improvement

Our overall opinion of **Good** for Prospects for Improvement is based on the following factors:

- There is a good understanding of financial pressures caused by Covid-19 whilst there is also robust monitoring in place with the ability to evidence spend where required.
- Management actions have been developed for all issues raised.

Summary of Management Responses

	Number of Issues Raised	Management Action Plan Developed	Risk Accepted and No Action Proposed
High Risk	0	0	NA
Medium Risk	0	0	NA
Low Risk	1	1	NA

B1 – Deprivation of Liberties – Progress with Addressing Backlog

Audit Opinion	**Adequate**
Prospects for Improvement	**Adequate**

Audit testing found that since the previous audit in 2017 there has been a marked improvement in the efficiency of the processing of Deprivation of Liberties (DoLS) applications and the caseload monitoring and review process. Internal Audit sample testing found the quality of assessments to be of a consistent high standard. However, capacity of the team is an ongoing challenge, resulting in delays in completing cases and the statutory deadlines not being consistently achieved.

The issues raised in the 2017-18 audit were followed up as part of this review. Of the two issues raised; the high-risk issue relating to inconsistent administration practices was no longer relevant following the implementation of Mosaic and the medium risk issue regarding risk management had been implemented.

Furthermore, since the previous review, new client pathways have been introduced in order to create efficiencies and models of sustainability, yet the team continues to see an increase in applications presented to them and demand continues to outstrip the available resource.

Areas for Development

- The backlog of cases highlighted in the 2017 audit persists despite management actions to improve efficiency and team capacity. In addition, a Supreme Court Decision in 2014 has led to a further increase in the number of assessments required to be carried out by local authorities. As a result, backlogs remain and statutory deadlines for completion of DoLS assessments are not consistently being achieved.

Key Strengths

- The assessment process was found to be effective and efficient.
- Applications reviewed were found to have been correctly assessed and prioritised using ADASS (triage). There was uniformity of approach and execution of forms.
- All assessments had been signed off and authorised.
- The introduction of the new service user pathways within the process (Equivalent Assessment - EQiA) has generated a cost saving for KCC of £430 per assessment. This represents an improvement in the DoLS process and a service improvement for the client. This also facilitates the management of the number of applications that go into the backlog.
- The Introduction of data validation by admin business support on a timetabled basis continues to make checks on pending applications and whether they are still necessary. This maintains the control on what was backlog, with cases building up and also ensures that if the client's circumstances have changed there is an opportunity for the case to be re-prioritised with the client being seen.
- Management are closely monitoring the available capacity of the existing team redirecting and allocating the resource as forecasting of demand necessitates.
- On a monthly basis the management team monitor all activity in order to ensure there is a clear position statement on the number of clients that have not been seen and take action accordingly.
- There are robust manual caseload monitoring and reporting arrangements in place covering both the progress of current cases and the volume of new applications.
- Any processing issues are escalated and management are proactive in investigating any peaks and troughs in demand.
- Feedback from service user's next of kin is routinely requested by the service. The analysis of feedback performed in August 2020 found that the vast majority of respondents were extremely satisified with the service received.

Prospects for Improvement

Our overall opinion of Adequate for Prospects for Improvement is based on the following factors:

- Reporting from Mosaic requires improvement. Dashboards are in development which will assist in the provision of monitoring information and facilitate trend analysis (currently a significant amount of management time is spent manually monitoring service provision).
- The team's capacity is a heightened issue because the volume of applications is increasing. This is an ongoing issue and there is heavy reliance on additional contracted staff which is costly and potentially unsustainable.
- In July 2018, the government published a Mental Capacity (Amendment) Bill, which passed into law in May 2019. It replaces the Deprivation of Liberty Safeguards (DoLS) with a scheme known as the Liberty Protection Safeguards. The original target date for implementation of October 2020 has been postponed until April 2022. Prior to then, a revised MCA Code of Practice will be published, which, the sector trusts will bring clarity to some outstanding questions about how Liberty Protection Safeguards will work in practice. KCC need to consider and plan to determine how this will be resourced.
- The service has experienced an increase in the number of safeguarding referrals following a coroner's inquest. These are currently being managed via paying staff overtime. The lack of existing capacity to manage this has been raised at DMT level.
- The REA (Returning Equivalent Assessment) Pathway is currently in development to facilitate the performance of non-practice tasks by administrators and to enable tasks to be delegated and to provide a training opportunity for student social workers.

Summary of Management Responses

	Number of Issues Raised	Management Action Plan Developed	Risk Accepted and No Action Proposed
High Risk	1	1	0
Medium Risk	0	0	0
Low Risk	0	0	0

B2 – Adult Social Care Client Billing

Audit Opinion	**Limited**
Prospects for Improvement	**Good**

The adult social care client billing processes are complex, the areas examined within this audit were well documented and included the use of checklists to ensure all tasks are completed prior to moving to the next stage of the process. There are also regular reconciliations and exception reports produced to highlight items which need attention/ investigation prior to the client invoices being generated.

One element of planned audit testing included with the audit scope could not be completed. Despite numerous requests to BetterGov (an agency supporting KCC with the implementation of Mosaic), Internal Audit were unable to obtain any reports of amendments made via the Mosaic Provider Portal (MPP). Therefore, Internal Audit have been unable to conclude on the adequacy of controls over amendments to care records through the MPP. However, Internal Audit were able to test the controls related to the weekly reconciliation between MPP to the expected provisions on Mosaic and the associated exception reporting of invoices above the 10% tolerance or where there is no provision on Mosaic.

A number of concerns have been raised regarding the lack of verification and reporting available within MPP to identify client's whose bills are within the tolerance level but could have variances which are significant to the client. This lack of information means that it is not possible to identify potential issues before a client receives their bill and Internal Audit are unable to quantify the extent and potential impact on clients and the reputation of the service of this issue.

Key Strengths

- Testing of a sample of residential and non-residential client invoices from billing runs in the period April to September 2020 found:
  - Client contributions are accurately calculated based on the financial assessment and did not exceed the cost of care.
  - Invoice values in Oracle were accurate.
  - Any payments made had been deducted prior to the next payment run.

- Oracle is aligned with Mosaic through a daily interface of amendments and new clients from Mosaic into Oracle.

- There are several processes in place to identify and investigate discrepancies in the billing run. Audit testing confirmed that all planned reports are run, and the exceptions highlighted are actioned prior to moving on to the next stage of the billing run.

- The total value and volumes of invoices from Mosaic is loaded into Oracle and validated. Testing confirmed that the Mosaic control report and validation from Oracle matched both in terms of values and volumes.

- Testing of a sample of billing runs found that timescales were met for each element of the billing run and evidence was available to support this.

- Invoices were produced and issued in line with agreed timescales and direct debits are taken on the date stated on the Kentcare invoice.

Areas for Development

- MPP links directly to client billing and where a provider invoices less than expected or within the 10% tolerance level this is automatically applied to client bills for those who pay the full cost of their care. However, there is no way to identify these amendments or to inform the client prior to them receiving their invoice.

- Providers may raise zero invoices in MPP in error resulting in the client not being charged for care at the time and when errors are rectified by the provider client invoices will fluctuate.

- Both providers and the KCC Purchasing Team within Adult Social Care & Health can apply suspensions to a provision. However, when this happens there is no link to the financial assessment and therefore the full cost of the care and the client contribution is refunded back to the client in error.

- There is no reconciliation carried out between the number of invoices expected to be printed and the number of invoices actually printed.

- There was no investigation into the differences highlighted by the reconciliation between invoice amounts and Oracle transactions. These have now been investigated and needs further action to resolve them.

- The process for setting up residential codes in Mosaic could be enhanced to reduce the number of coding errors to be investigated during the billing run.

Prospects for Improvement

Our overall opinion of **Good** for Prospects for Improvement is based on the following factors:

- At the time of the audit, checklists are used by several teams involved in the billing run process but there was no overarching checklist to monitor progress against timescales for the full billing and invoicing process. From November 2020, a new document was introduced which can be accessed by all relevant contributors so they can indicate the time & date their actions were completed to show progress at any point in time.

- The purchasing team now review any invoices showing zero and these are not paid until resolved. They are also asking providers not to submit zero invoices.

- The BDU systems team are looking into the variation recording process with the support of the purchasing team.

- It is proposed that MPP will be rolled out to additional providers which, without the necessary reporting, could increase the number of potential issues with client invoices. However, a task and finish subgroup has been established which includes representatives from various teams to examine the whole process including MPPs link with client billing.

Summary of Management Responses

	Number of Issues Raised	Management Action Plan Developed	Risk Accepted and No Action Proposed
High Risk	1	1	N/A
Medium Risk	2	2	N/A
Low Risk	1	1	N/A

B3 – Covid-19 Risk - Charging Arrangements

Audit Opinion	**Substantial**
Prospects for Improvement	**Good**

As part of the 2020/21 Audit Plan, it was agreed that Internal Audit would undertake a review of the Hospital Discharge arrangements put in place as a result of the Covid-19 pandemic. This specifically reviewed the charging of clients and reclaiming of cost against the government fund.

The aim of the audit was to provide assurance that systems have been implemented to deliver against the Hospital Discharge guidance, that Service Users have not being incorrectly charged and monitoring was in place to reclaim money and undertake financial assessments when services under the arrangements ended.

The delay in receiving and understanding the guidance for the Covid-19 Hospital arrangements meant that systems or processes were not in place to accurately determine eligible Service Users.

Reasonable manual work arounds were developed. Although some Service Users appear not to have been identified, the assumptions and method used meant that these were exceptions rather, than a systemic failing. The inception of a working group in May to tackle the implementation of the guidance and the capture of data, both manually and on the system, has improved the process.

Although further isolated errors have been identified through the audit, the introduction of a system solution to capture clients not to be charged would further improve these controls for any future repeat of these arrangements.

Monitoring of Service Users identified under the arrangements is good and there is a central source shared with all stakeholders. Information to support applying for money from the covid-19 fund is accurate, although claims have yet to be made.

Key Strengths

- The referral process remains unchanged although the timing means the referral is post discharge, and therefore obtaining the actual date of discharge has not been possible for all Service Users.
- Hospital Trackers have been in place since the start of the arrangements but were not easy to extract the desired data. These were refreshed, improved and standardised at the start of June.
- From June, data captured by the operational teams was effectively used to identify eligible Service Users.
- The process and assumptions used to retrospectively identify Service Users that were being charged incorrectly due to the late implementation were reasonable, although due to data quality, and lack thereof at the start of the arrangements, there are some that were not identified (see area for improvement)
- Once arrangements were known, a project group has ensured comprehensive operational guidance has been disseminated to cover eligibility for discharge and avoidance criteria and also for additional input to the Mosaic system, Including warning notices to flag cases eligible cases.
- The project group have been effective in coordinating tasks to ensure Adult Social Services comply with guidance released.
- Adequate manual processes have been implemented to identify hospital discharge and avoidance cases and these have reduced the number of Service User not identified.
- The record retained of clients under the arrangements is produced by the performance and information team and is distributed to relevant parties. There is recording of actual start and end dates, including the total cost for the period.
- The backlog of financial assessments was completed with remaining assessments for clients referred during August either completed or booked in.
- The master monitoring record is received monthly and calculation of funding to reclaim is accurate.

Areas for Development

- Although the current work for identifying service users that are included under the Covid19 discharge arrangements are reasonably robust, there were 2 Service Users that were not identified and had been charged. (these were prior to June 2020)
- Instances of poor data quality mean it is not possible to provide complete assurance that all Service User have been identified. Although these instances have reduced as process have become more embedded.
- Four from a sample of 20 identified Service Users, showed that they had, or potentially had, been incorrectly charged or their existing charge has not been capped.
- To date there is still no system solution to prevent clients being assessed and charged incorrectly although work is ongoing to develop one.
- To date no reclaim of funds have been made from the CCG.

Prospects for Improvement

Our overall opinion of **Good** for Prospects for Improvement is based on the following factors:

- Initial issues affecting the notification of the commencement of Covid-19 Hospital Arrangements have been addressed, ensuring a timely response to future arrangements.
- There is an established manual work around to ensure further arrangements could be met from their start date.
- There is continuing work to find a system solution, with a number of options being pursued.

Summary of Management Responses

	Number of Issues Raised	Management Action Plan Developed	Risk Accepted and No Action Proposed
High Risk	0	0	0
Medium Risk	1	1	0
Low Risk	0	0	0

B4 - ASCH Assurance Map – Safeguarding

Audit Opinion	**N/A**
Prospects for Improvement	**N/A**

Introduction

It was agreed that Internal Audit would undertake an assurance mapping exercise against the Council's significant risks, with this map focussed on Adult Safeguarding. Assessment was undertaken through interviews with key officers, and reviews of relevant documentation.

Key Findings

An assurance map was provided for Directorate Management and highlighted areas where assurance gaps exist and where future work should be directed. Below are the key potential scope areas in which gaps exists in assurance for ASCH Safeguarding:

- Management supervision
- ASCH Performance dashboard and Quarterly Safeguarding report
- Quality Assurance Framework

	1st Line Assessment	2nd Line Assessment	3rd Line Assessment	RAG
Management Supervision	• Supervision should be carried out every 4-6 weeks and this should in include professional supervision. • An audit report of supervision records should be presented to Senior Management		• Gaps in frequency and quality	
Adult Social Care performance dashboard and Quarterly Safeguarding report	• Current system just measures process and compliance of set indicators/measures. Safeguarding only considered once referral has been made. The danger is that safeguarding is not identified as safeguarding encompasses the whole service		• No Internal Audit Coverage	
Quality Assurance Framework	• Complete Quality Assurance Framework is not currently in place. There is a danger that safeguarding has not been identified. Current system just measures process and compliance once a referral has been made. Safeguarding of adults should be across the service.		• Consultancy work completed in 2019/20 with no outputs/implementation noted at that time	
Learning and Development	• Competency framework in place and has been refreshed. There is mandatory training and development specified dependent on role. Attendance is reported to the Organisational Development Group and the Safeguarding Group, however little analysis to demonstrate impact		• No Internal Audit coverage	
Countywide Safeguarding Unit/Leads	• Model of unit not Currently adopted by LD and MH and therefore is not Directorate Wide			
Directorate Management Team	• Meetings have not happened recently and reporting centres around issues identified and compliance with process not quality			

B5 - Blue Badge Application Process

Audit Opinion	**Substantial**
Prospects for Improvement	**Good**

The Blue Badge Service has procedures in place to process new applications, renewals and payments, as well as data maps which reflect national good practice guidance. A third-party service provider is engaged to review initial applications, which are then processed to completion by the KCC Blue Badge team. In recent months, there has been a substantial increase in applications not being reviewed within timescales by the third-party service provider. This is understood to be due to a significant period of change within that organisation, and the contract manager is actively engaged in addressing this.

Sample testing of Blue Badge applications found that all had appropriate supporting evidence, including proof of ID. Further assessments were used to clarify applicant conditions and the decisions reached were well documented and supported.

Key Strengths

- All applications reviewed were found to have been assessed in line with procedures.
- The assessment process was effective and efficient, using a scoring matrix to assist in decision making.
- The service maintains up to date procedure notes and guidance for staff.
- Data maps are used show the flow of work and these reflect national guidance.
- Where applicants have not provided sufficient information, they are contacted promptly.
- Access to Government systems (for example to verify claimed benefits and confirm ID) helps to reduce the risk of fraud.
- Only applicants who have been assessed as meeting the criteria are issued a badge.
- The appeals process allows the applicant/carer the opportunity to bring forward any further information to support their application.

Areas for Development

- The third-party service provider which carried out initial assessment of applications is not currently completing applications within contracted timescales.
- The Blue Badge service has not developed a risk register. There are service specific operational and fraud risks which are not formally assessed for mitigation.
- It is unclear whether the data maps are reviewed and updated regularly.

Prospects for Improvement

Our overall opinion of **Good** for Prospects for Improvement is based on the following factors:

- The service is planning to further enhance the guidance notes to include additional areas such as Blue Badges being lost in the post.
- There remains uncertainty regarding the performance of the third-party service, which is currently not meeting agreed timescales for the initial assessment of applications.

Summary of Management Responses

	Number of Issues Raised	Management Action Plan Developed	Risk Accepted and No Action Proposed
High Risk	0	NA	NA
Medium Risk	2	2	0
Low Risk	1	1	0

B6 - ASCH Covid-19 Response Plan

Audit Opinion	**Adequate**
Prospects for Improvement	**Good**

The Directorate's response to the Covid-19 emergency was split into two distinct periods. During the period leading up to 11 March, the Directorate's response to the pandemic was driven by guidance from Central Government and Public Health England. During this period, the Directorate neither updated its business risks, nor did it review its business continuity plans in view of Covid-19.

The Directorate actively participated in KCC's Cross-Directorate Resilience Forum. This, however, did not extend to pro-active engagement with Public Health colleagues in the Directorate's preparedness for the pandemic, including consideration of changes to pre-Covid-19 business practices to ensure appropriate protection of elderly and vulnerable adults.

Internal Audit found weaknesses in controls relating to the monitoring and recording of business continuity training. The Directorate, however, benefited from extensive business continuity planning that had taken place to prepare for anticipated disruption linked to Brexit.

The second period was after 11 March, when the Directorate decided to stand-up its Resilience Group, initiated daily situation reporting and ensured services had reviewed their business continuity plans.

At this stage, the Directorate's response was guided by the business continuity plans and the Directorate's Resilience Group provided an effective discussion and decision-making forum, with timely information on service pressures.

In late March, the Directorate Management Team (DMT) redeployed the Portfolio Management Team to project manage the Directorate's response. The team provided good discipline and control over the Directorate's identified response activities.

The Coronavirus Act 2020 included provisions for Care Act easements for Local Authorities. In responding to the emergency, the Directorate did not need to seek easements under the Coronavirus Act.

Key Strengths

- The Directorate's System Resilience Plan contributed to an effective response to the pandemic.
- Extensive preparation had been conducted in anticipation of a "No Deal" Brexit, which included having up-to-date business continuity plans.
- The Directorate's Resilience Group met twice weekly from 11 March.
- On 11 March, the Directorate initiated daily situation reporting for all services.
- The situation reports were collated to create a single operational picture across the Directorate. These situation reports were then able to identify issues within the Directorate e.g. PPE shortages.
- The Directorate's situation report evolved as needed, settling on a RAG rated dashboard of service provision.
- The Resilience Group's meetings included feedback from multi-agency meetings and the Council's Business Partners.
- The Directorate was represented at the daily Corporate Management Team meetings and information was cascaded down to the Directorate Management Team (DMT).
- Strategic Commissioning already attended DMT meetings and a representative from the Public Health Team attended these meetings from mid-March.
- The Directorate's response was well integrated into both the Kent Resilience Forum and KCC's response structures.
- Issues and concerns relating to the emergency response were appropriately categorised and reported to DMT.
- Redeployed resources from the Portfolio and Project Management Team project managed the actions identified by DMT, tracked progress and provided daily updates.

Areas for Development

- There were no corporate policies, procedures or guidance that promote, at a directorate level, active and structured horizon scanning of risks and potential emergencies.
- None of the reviewed emergency plans set out how the Director of Public Health and the Directorate's Resilience Group should co-ordinate preparations to address public health risks arising from the pandemic.
- There was no record confirming that all relevant staff members have received the appropriate resilience training.
- A schedule of business continuity training and testing exercises could not be located.
- The reviewed business continuity plans contained generic references to pandemic risk but did not cover how pandemic specific risks should be addressed.
- Officers had not specifically prepared themselves, or their teams in advance to be alert to, and to respond to potential frauds.
- Several corporate policies or procedures were out of date.
- There was no evidence that in preparing its Response Plan, the Directorate proactively included activities necessary to achieve all the service priorities listed in KCC's Coronavirus (COVID-19) Pandemic Contingency Plan.

Prospects for Improvement

Our overall opinion of **Good** for Prospects for Improvement is based on the following factors:

- The Directorate is ready to contribute to active and structured horizon scanning of risks and potential emergencies, when corporate policies, procedures or guidance are published, and will contribute to the development of these council wide policies.
- The Directorate's Resilience Group is aware that there are weaknesses in the resilience training programme and is considering ways of removing these.
- The Directorate's approach to training and exercising was signed-off by DMT on 7th October 2020.
- The Directorate has put forward nominations for multi-agency strategic command and control training as part of the induction programme for Assistant Directors appointed in September 2020.
- DMT agreed a schedule for Business Continuity Plan reviews on 7th October 2020. Plan reviews will seek to strengthen key areas of perceived weakness identified through this audit and operational lessons identified through the response to Covid-19.

Summary of Management Responses

	Number of Issues Raised	Management Action Plan Developed	Risk Accepted and No Action Proposed
High Risk	2	2	0
Medium Risk	5	5	0
Low Risk	1	1	0

C1 - CYPE Assurance Map – Safeguarding

Audit Opinion	**N/A**
Prospects for Improvement	**N/A**

Introduction

It was agreed that Internal Audit would undertake an assurance mapping exercise against the Council's significant risks, with this map focussed on CYPE Safeguarding. Assessment was undertaken through interviews with key officers, and by reviewing supporting documentation. Internal Audit sought to establish whether each component CYPE has in place to operate to the 3 lines of assurance were operational.

Findings

An assurance map was provided for Directorate Management and the high-level review found no operational gaps in the CYPE Safeguarding Governance at 1st, 2nd and 3rd lines of defence.

The beginning of the Financial Year had been disrupted due to the Pandemic and that some meetings governing CYPE Safeguarding, at the 3rd line, had been postponed. However, the subsequent use of technology to hold remote meetings had helped to stabilise the control framework. This had subsequently meant that some annual reports remained in draft longer, prior to them being issued to the relevant governing panel or board for review and formal issue.

At the time of the review, Internal Audit noted that:

- The Kent Safeguarding Children Multi-Agency Partnership (KSCMP) was in its first year since replacing the Kent Safeguarding Children Board. The last Annual Report available was for the year 2018/19, however Internal Audit were advised that the Independent Scrutineer was preparing a report for the KSCMP Executive Board, and that future annual reporting is likely to take place in July each year.
- The Corporate Parenting Panel (CPP) Draft report and Independent Reviewing Officer reports were awaiting approval prior to presenting to the CPP in December 2020.
- The Local Authority Designated Officer (LADO) report was awaiting sign off by the KSCMP Executive Board and publication on the KSCMP website.
- The latest Child Death Overview (CDOP) report was awaited.
- Pressures had also meant that there were instances where the Council's Intranet and other relevant websites had not been updated with reports and copies of meeting minutes.

D1 - Purchase to Pay (P2P)

Audit Opinion	**Substantial**
Prospects for Improvement	**Good**

The individual processes and controls within P2P were generally well controlled, with a few areas identified during our review that require improvement. Investment in the success of P2P has come from Strategic Commissioning and Finance, however there is no mandate for Directorates to use the catalogues set up on the iProc system. In addition, P2P lacks an end-to-end owner to ensure that improvements are driven through and service users are engaged.

The advances in Directorate core system technology have resulted in an increased use of interfaces between core systems and AP (rather than using the iProc system) with the evidence of approval of orders residing within those core systems. Internal Audit found that there was adequate control over setting up new suppliers within the Directorate core systems, supplier payments from those systems can only be made through the AP function and these were recorded in the General Ledger.

Data analysis has revealed that an average of 14% of all PO's raised were raised retrospectively, e.g., after the order was placed with the supplier, however Internal Audit note that this was not impacting adversely on payment of suppliers.

Key Strengths

- Policies and Procedures are up-to-date and available to staff.
- Analysis of elements of the P2P process is carried out by Strategic Commissioning in line with their Divisional Business Plan objectives.
- Strategic Commissioning are re-evaluating the receipting and new supplier set-up processes to identify improvements and efficiencies.
- Suppliers are paid promptly by CBS AP once an approved invoice has been received from KCC.
- All purchase and payment transactions are accurately recorded in the Council's Oracle financial systems.
- The CBS Control Team verifies changes to supplier bank details before changes are processed in Oracle AP.

Areas for Development

- The impact on financial control from purchases progressed outside iProc (and without a PO) has not been assessed and understood.
- The process for verification of a new supplier's bank details prior to set-up in Oracle AP does not include verification that the supplier bank details provided are correct.
- Both KCC Finance and CBS stated that delays in receipting of goods was the largest problem in processing invoices for payment promptly and leads to significant administrative burden.
- Suppliers are removed from the Oracle AP system after 12 months of inactivity, which is proving to be too soon in many instances.
- The Procurement Toolkit has not been published on KNet, and some of the and 'How to' guides issued by Procurement have broken links.
- There are no routine reviews of Flexfields to remove leavers, and the iProc user list to check if users have been set-up with dual 'requisitioner' and 'approver' roles.

Prospects for Improvement

Our overall opinion of Good for Prospects for Improvement is based on the following factors:

- A Finance Payment project has been set up with a remit to evaluate all methods of payment used by the Council;
- Strategic Commissioning have a project to improve the goods receipting workflow;
- Strategic Commissioning is working in conjunction with CBS to streamline new supplier set-up processes and reduce the error rate and lead time;
- Strategic Commissioning and Finance dashboards have been developed to monitor exceptions to the standard P2P process, e.g., late payments.

Summary of Management Responses

	Number of Issues Raised	Management Action Plan Developed	Risk Accepted and No Action Proposed
High Risk	0	0	0
Medium Risk	2	2	0
Low Risk	4	4	0

D2 - Kent Pension Fund Investment Governance – Follow-Up

SUMMARY OF IMPLEMENTATION OF MANAGEMENT ACTIONS

Total Issues	Implemented	In Progress	Not Implemented	Superseded
15	**1 (7%)**	**8 (53%)**	**6 (40%)**	**0 (0%)**

SCOPE SUMMARY

1) The audit included a review of relevant documentation and an interview with the Acting Business Partner to the Kent Pension Fund.

2) In order to provide assurance, Internal Audit reviewed the implementation and effectiveness of all management plans for the 15 Issues with a "High" or "Medium" risk rating in the report, AD01-2020 – Pension Fund Investment Governance, Lessons Learned Review.

KEY FINDINGS FROM FOLLOW UP

Key Findings:

- KCC's Finance Function considered that governance of the Kent Pension Fund (the Fund) would benefit from a more thorough review conducted by an external adviser. Implementing this meant that the target dates for completion of the management actions for all 15 "High" or "Medium" risk rated issues would be missed.
- Following a procurement competition, KCC's Finance Function appointed Barnett Waddingham to conduct two separate but linked reviews of:
  - The governance of the Fund, including the management and organisation of KCC's Finance Function's support to the Fund
  - The management and resources of KCC's Treasury and Investments team Finance Function's support to the Fund
- The external review commenced on 23 October 2020 and the final report is expected in Spring 2021.
- KCC's Finance Function implemented a number of changes including varying Mercer's contract to monitor the performance of investment fund managers and to provide the Superannuation Fund Committee (the Committee) with investment advice.

MANAGEMENT ACTIONS STATUS

Implemented

- Management action for 1 out of 9 Issues with a "High" risk rating

In Progress

- Management actions for 6 out of 9 Issues with a "High" risk rating
- Management actions for 2 out of 6 Issues with a "Medium" risk rating

Not Implemented

- Management actions for 2 out of 9 Issues with a "High" risk rating
- Management actions for 4 out of 6 Issues with a "Medium" risk rating

D4 – Succession Planning – Management Letter

Audit Opinion	**N/A**
Prospects for Improvement	**N/A**

As part of the Audit Plan, it was agreed that Internal Audit will undertake a review of Succession Planning. The objective of this review was to provide assurance that effective and robust succession planning has been established and embedded across the Council to mitigate the risks related to the continuity of services.

However, in September 2020, following discussions with officers from Human Resources & Organisation Development (HR & OD), Internal Audit were made aware of a programme of work currently underway as part of the accelerated People Strategy and Organisation Development reset which significantly impacted the agreed scope of the audit.

Using the findings from last year's workforce planning review, and in collaboration with the LGA, a new workforce planning approach, process and toolkit has been developed and is soon to be piloted before being rolled out. A key element of the workforce planning toolkit is to facilitate effective divisional succession planning.

As the project is now at an advanced stage, it was agreed that Internal Audit would refocus the audit as follows:

- Phase one - a Management Letter and initial observations on the Council's succession planning arrangements
- Phase two – Internal Audit will work proactively and collaboratively to identify critical success factors to support the achievement of project objectives.

This initial report does not provide a formal assurance opinion but is a management memorandum to highlight issues and advice provided by Internal Audit to ensure appropriate actions can be implemented as soon as possible.

Initial Observations

Succession planning is a recognised method to assure that competent staff are assigned to fill vacant positions. It incorporates hiring, training, performance evaluation, and retention practices. Directors, Heads of Service, managers and HR have important roles in succession planning and management. Internal Audit findings are summarised below.

- None of the Heads of Service interviewed had formal, written succession plans.
- There was some awareness of the current HR & OD succession planning tool (available on KNet), though none had utilised it.
- Current succession planning guidance / tools are better suited to a pyramid staffing structures.
- Some potential successors are being identified and informally aligned with specific roles. However, there are some statutory services (such as Planning in GET) where options are limited with a number of staff nearing retirement / voluntary early retirement. Many are likely to have considerable knowledge and experience and may hold roles that are critical to the service.
- There was a perception that support is needed to create development opportunities for potential successors so that they can compete with external candidates.
- Heads of Service interviewed perceived that there was a need for more specific tailoring of formal learning and development for those identified as potential successors.
- Where potential successors cannot be identified, mitigation has been considered but not documented.
- There was some consensus that recruiting to bring in fresh new thinking from outside the Council has merit and would be welcomed.
- Interviewees also believed that they needed more HR support and engagement to develop effective succession plans.
- Formal skills matrices have not been consistently developed or documented to identify skills gaps in their teams and drive wider development plans.

Conclusion

The current Covid-19 pandemic has highlighted how critical it is to devote time and attention to identifying future leaders for key operational roles, on which the Council's success depends.

For any succession planning to be effective in identifying, developing, nurturing, and retaining future talent across services to mitigate future risk, it is imperative that they have access to the best possible guidance, tools, and support. The new Workforce Planning Toolkit aims to deliver this.

The extent to which the new workforce planning approach, process and toolkit will deliver improvements in succession planning depend on the, new processes and procedures being fully embedded and consistently applied across the Council. It is, therefore, vital that all key stakeholders involved define what success will look like and how the effectiveness of the succession planning component of the new toolkit will be qualitatively evaluated, monitored, reported and adjusted as needed.

Accordingly, HR management should ensure there is sustained focus and support to ensure this project is kept on a sound basis. Internal Audit will continue to liaise with relevant officers involved with the project and work collaboratively to identify critical success factors to support the achievement of project objectives.

D5 – ICT Access Controls / User Accounts for DSPT Assurance

Audit Opinion	**Substantial**
Prospects for Improvement	**Good**

Overall, there is a balanced control framework in place over ICT access and the applications selected for testing were found to be generally well managed. Whilst Internal Audit have raised some specific findings relating to the status of specific users, or accounts, these findings are at a relatively low level when compared to the population of users.

Both the CYPE Management Information & Intelligence Unit (MIIU), assisted by the Cantium LA Applications team, and the ASCH Business Delivery Unit (BDU) utilise a variety of different controls between them to manage the users of their main client systems, the Mosaic and Liberi applications which contain the electronic caseworker records for ASCH and CYPE respectively.

Internal Audit also reviewed access to the Public Health England system, for which Kent Public Health has access restricted only to five users. There was evidence that the treatment of the sensitive personal data that the system contained was being continually considered and advice sought where appropriate.

At the time of the audit, KCC held a current certificate from the Public Services Network Authority (PSN A), and Cantium, who manage the security controls on behalf of KCC, were certificated to Information Security Management System: ISO27001:2017.

Key Strengths

- Policies and Procedures are up-to-date and available to staff.
- Information Governance and Data Protection Essentials training are mandated for all Council officers.
- All auditees interviewed were found to have a good understanding of Data Protection and how personal data should be treated.
- Specific application training is provided to users on the CYPE Liberi and ASCH Mosaic systems, and access is granted only after users have completed the relevant training.
- Allocation of system permissions on the Liberi and Mosaic applications is by role, and on a needs-only and least-privilege basis.
- New user applications are authorised by the user's line manager and there are established policies and processes to manage new users.
- The Liberi and Mosaic logon authentication criteria meet the KCC Policy.

Areas for Development

- There was no single mechanism for Public Health to manage information governance risks in response to the fluid Government's expectations of the Local Authority.
- One Liberi system administrator account has a generic name.
- There was no direct evidence that the activities of highly privileged users on the Liberi and Mosaic applications are monitored.
- Several leavers and one user that had transferred to a different role had not been notified or actioned on the Liberi system.
- The Liberi and Mosaic applications were not yet single-sign-on.
- Periodic reviews of all users, including highly privileged users, are not being carried out.
- Mosaic last logged on reports were not being routinely used as a detective control.
- A small number of leavers had not been notified or actioned on the Mosaic system.
- Four leaver's Active Directory accounts had not been removed from the KCC systems.

Prospects for Improvement

Our overall opinion of **Good** for Prospects for Improvement is based on the following factors:

- Adequate resources were in place for the management of system users.
- The CYPE MIIU for Liberi, and the ASCH BDU for Mosaic are working in conjunction with CBS to improve the joiner, leaver and user change processes.
- All staff interviewed were eager to further improve their internal processes and increase levels of information security and information governance.

Summary of Management Responses

	Number of Issues Raised	Management Action Plan Developed	Risk Accepted and No Action Proposed
High Risk	0	0	0
Medium Risk	3	3	0
Low Risk	6	6	0

D6 – Provider Data Protection Compliance

Audit Opinion	**N/A**
Prospects for Improvement	**N/A**

Internal Audit were commissioned by KCC Strategic Commissioning to undertake reviews of 16 key suppliers selected based on high-risk criteria determined by Commissioning to provide assurance on their compliance with the Data Protection Act (DPA) 2018.

In order to provide assurance, Internal Audit reviewed the adequacy of the controls in place against the DPA Principals. An assessment opinions for each supplier reviewed. And reported in a heatmap format.

Each provider was contacted via an MS Forms survey to obtain an understanding of their data protection arrangements and the related key documentation. This information was separately provided to Strategic Commissioning.

Key Strengths

- 69% of providers were assessed overall as Adequate or better in relation Data Protection.
- All providers had a Data Protection Policy in place, although these varied in quality - see Areas for Development.
- Each provider had a training programme for Data Protection in place.
- The providers which confirmed they had experienced Data Breaches appeared to have taken reasonable steps on the most part, with some good examples of organisational learning.
- Sub-contracting arrangements for those in our sample appeared robust.

Areas for Development

- Retention Schedules were in place for the vast majority of providers however, a large proportion of these require extra detail in order to operate effectively.
- Records of Processing activity (ROPA) which were only in place for a small number of providers and would provide an opportunity to understand why information is required and processed.
- Destruction of Data was not always sufficiently covered in procedures and often did not adequately cover both physical and electronic records.
- There is little reporting of the occurrence of data breaches which may suggest these are not being identified and escalated. This was a particular issue for the providers assessed as Adequate (56%) or Limited (31%) assurance.

E1 – Op Fennel (EU Transition) Management Letter

Background

This Internal Audit Memorandum describes the work of the Operation FENNEL Peer Review Team between 22 October and 11 December 2020. Operation FENNEL is a multi-agency response to adverse volumes of International freight and International tourist and light goods vehicles (LGV) traffic that are unable to leave the country via the Port of Dover and/or the Channel Tunnel in a timely way. The purpose of Op FENNEL is to collate Department for Transport, Highways England, Kent Police and Kent County Council plans together as a single plan.

In October 2020, ten weeks prior to the end of the EU transition period, the Kent Resilience Forum (KRF) initiated a review of the Op FENNEL plan. The Peer Review Team (PRT) was established comprising two Assistant Joint Regional Liaison Officers from the military and a member of KCC's Internal Audit Team. The Terms of Reference and a 5-Phase approach to reviewing the Op FENNEL Plan (Understand, Shape, Refine, Review, Reassure) were agreed on 27 October 2020. The Terms of Reference for the PRT were agreed as follows:

a. Review plans for issues and identify potential conflicts or inconsistencies.
b. Identify and highlight dependencies and interdependencies.
c. Identify potential planning gaps in plan, preparation & execution.
d. Assess whether there are capability and capacity gaps.
e. Review any planned assumptions of responsibilities/activities that sit within another organisations plan.
f. Identify all contingencies as described in the Reasonable Worst-Case Scenario.
g. Confirm that partners have risk assured their own business continuity capability and plans.
h. Provide support with multi-agency peer reviews of plans.
i. Provide support with individual agency scrutiny panels where requested.

Noting the collapsing timelines, both PRT and KRF acknowledged that success depended on a best endeavour approach, open and collaborative work amongst partners, and an accurate and honest independent review of plans allowing the PRT to inform KRF strategic and tactical decision-making processes.

Through a combination of document review, access to all meetings and interviews with key stakeholders, the PRT rapidly established a functional understanding of the planning environment and the status of key plans.

The OP Fennel Strategic Co-ordinating Group (SCG) requested support from members of the PRT beyond 11 December. Through continued participation at meeting of both the Tactical Co-ordinating Group (TCG) and SCG, KCC Internal Audit observed that steps were being taken to address and close out these key residual issues.

Conclusion

By highlighting issues and making associated recommendations in a timely manner, the PRT provided the Op FENNEL Strategic and Tactical Commanders with intelligence about vulnerabilities within Op FENNEL Plan. Prompt assignment and prioritisation of remedial actions, or acceptance of now known risks was observed, resulting in most of the issues being closed by mid-December 2020. Consequently, Internal Audit observed increased confidence across all members of the TCG and SCG that the Op FENNEL Plan is coherent and comprehensive across its constituent parts.

Appendix C – Implementation of Agreed Actions

3+ Years						
Engagement Reference	**Engagement Name**	**Audit Opinion**	**Title**	**Risk Rating**	**Directorate**	**Status**
ICT07-2015	PCI DSS	Limited	Issue 1 - Business Areas Processing Card Transactions	High	ST	**In Progress**
RB01-2018	Members Induction and Training	Adequate	Issue 2 - Mandatory Training	Medium	ST	**In Progress**
RB45-2017	National Driver Offender Retraining Scheme – Phase 2	Adequate	Issue 1 - Trainer Recruitment and Retention	High	GET	**In Progress**
RB45-2017	National Driver Offender Retraining Scheme – Phase 2	Adequate	Issue 2 - Forecasting and Procurement	High	GET	**Implemented**

2 - 3 Years						
Engagement Reference	**Engagement Name**	**Audit Opinion**	**Title**	**Risk Rating**	**Directorate**	**Status**
CA03-2018	Risk Culture	Substantial	Issue 3 - Risk transparency with decision reports	Medium	ST	**Risk Accepted**
ES05-2018	OPPD Day Services Themed Report	Adequate	Issue 1 - Utilisation	High	ASCH	**In Progress**
ES05-2018	OPPD Day Services Themed Report	Adequate	Issue 2 - Inclusivity	High	ASCH	**In Progress**
ES05-2018	OPPD Day Services Themed Report	Adequate	Issue 3 - Letting Policy	Medium	ASCH	**In Progress**
RB46-2019	Coroners Service - Financial Controls	Adequate	Issue 2 - Due Diligence and Cost Control	Medium	GET	**In Progress**

1 - 2 Years						
Engagement Reference	**Engagement Name**	**Audit Opinion**	**Title**	**Risk Rating**	**Directorate**	**Status**
CA09-2018	Departmental Governance Review – Adult Social Care and Health	Adequate	Issue 3 - Information flow – DMT and DivMTs	Medium	ASCH	**Implemented**
CA09-2018	Departmental Governance Review – Adult Social Care and Health	Adequate	Issue 5 - Independence of reporting lines for the Chair of the Adult Safeguarding Board	Medium	ASCH	**In Progress**
CA09-2018	Departmental Governance Review – Adult Social Care and Health	Adequate	Issue 6 - Committee Terms of Reference	Medium	ASCH	**In Progress**
CS01-2019	Payment Processing	Adequate	Issue 2 - Retrospective Purchase Orders	Medium	ST	**In Progress**
CS01-2019	Payment Processing	Adequate	Issue 3 - Authorisation of manual invoices	Medium	ST	**In Progress**
CS01-2019	Payment Processing	Adequate	Issue 5 - Vacation Rule in iProc	Medium	ST	**In Progress**
RB02-2019	Property - Statutory Compliance	Limited	Issue 3 - Tenanted Properties – Requirement to notify KCC of Compliance Checks	Medium	ST	**In Progress**
RB20-2019	LD Lifespan Pathway Post Implementation	Adequate	Issue 1 - Pathway Plans and Assessments	High	CYPE	**In Progress**
RB34 2020	Foster Care	Adequate	Issue 3 - Voice of the Child	Medium	CYPE	**In Progress**
RB42-2019	Virtual Schools Kent	Adequate	Issue 2 - Clear statements from VSK about the quality of the ePEPs	Medium	CYPE	**Implemented**
RB55-2017	Kent Resilience Team Phase 3 and Follow-up	Adequate	Issue 3 - Business Case	Medium	GET	**In Progress**

Less than 1 Year						
Engagement Reference	**Engagement Name**	**Audit Opinion**	**Title**	**Risk Rating**	**Directorate**	**Status**
CA01-2021	Annual Governance Statement	Adequate	Issue 2 - New Issues Raised from 2019/20	High	ST	**In Progress**
CA02-2019B	Developer Contributions Community Infrastructure Levy	Limited	Issue 1 - Procedures for optimising developer contributions through the Community	Medium	GET	**In Progress**
CA02-2019B	Developer Contributions Community Infrastructure Levy	Limited	Issue 4 - Consulting services about future infrastructure needs	Medium	GET	**Implemented**
CA06-2020	Data Protection Deep Dive	Adequate	Issue 1 - Record of Processing Activity (ROPA)	High	ST	**In Progress**
CA06-2020	Data Protection Deep Dive	Adequate	Issue 2 - Data Breaches	Medium	ST	**In Progress**
CA11-2019	Strategic Commissioning Overview	Adequate	Issue 3 - Relationships between the SC Division and directorates	Medium	ST	**In Progress**
CS05-2020	Schools Financial Services – School Compliance Regime	Substantial	Issue 1 - Escalation Process for Implementation of Recommendations	Medium	CYPE	**Implemented**
CS06-2020	Payroll	Substantial	Issue 1 - Timely Notification of Staff Leavers	Medium	ST	**Implemented**
CS06-2020	Payroll	Substantial	Issue 2 - Exception Reporting and Learning Lessons	Medium	ST	**Implemented**
ES01-2020	Establishments Themed Review - Day Services	Substantial	Issue 1 - Utilisation	Medium	ASCH	**In Progress**
ICT02-2020	Wireless Network Security and Capacity	Adequate	Issue 1 - User Access to the Data Centres.	Medium	ST	**Implemented**
ICT02-2020	Wireless Network Security and Capacity	Adequate	Issue 2 - Forward Planning for Wireless Infrastructure	Medium	ST	**Implemented**
ICT02-2020	Wireless Network Security and Capacity	Adequate	Issue 3 - Service Set Identifier (SSID)	Medium	ST	**Implemented**
ICT03-2020	Software Licensing	Substantial	Issue 2 - Software Licencing Issue	Medium	ST	**In Progress**
ICT04-2020	ICT Change – Project Benefits Realisation	Adequate	Issue 1 - ICT Project Management Response	High	ST	**Implemented**
ICT05-2020	Members ICT	Adequate	Issue 1 - ICT Support for Members	Medium	ST	**In Progress**
ICT05-2020	Members ICT	Adequate	Issue 2 - ICT Acceptable Use Policy	Medium	ST	**In Progress**
RB03 -2020	Customer Feedback	Substantial	Issue 6 - Customer feedback reporting	Medium	ST	**Implemented**

Less than 1 Year						
Engagement Reference	**Engagement Name**	**Audit Opinion**	**Title**	**Risk Rating**	**Directorate**	**Status**
RB04-2020	Agilisys Contract Management	Adequate	Issue 1 - Administering the Contract through an effective Contract Management System	Medium	ST	**In Progress**
RB04-2020	Agilisys Contract Management	Adequate	Issue 3 - Tracking and Reporting Performance Issues	Medium	ST	**Implemented**
RB04-2020	Agilisys Contract Management	Adequate	Issue 2 - Ambiguities between the Contract documents	Medium	ST	**Implemented**
RB04-2020	Agilisys Contract Management	Adequate	Issue 4 - Complaints and Feedback from Kent Residents and KCC's Stakeholders	Medium	ST	**Implemented**
RB04-2020	Agilisys Contract Management	Adequate	Issue 5 - Assurance around Risk Management and Business Continuity	Medium	ST	**Implemented**
RB04-2020	Agilisys Contract Management	Adequate	Issue 7 - Relationship Management	Medium	ST	**In Progress**
RB08-2020	Public Health Grant - Sexual Health Spend	Substantial	Issue 3 - Reconciliation of LARC Drug Costs	Medium	ST	**Implemented**
RB11-2019	Public Health - Partnership with Kent	Substantial	Issue 2 - Project/Workstream ownership and service development	Medium	ST	**Implemented**
RB12-2021	Personal Protective Equipment (PPE)	Substantial	Issue 1 - ASCH PPE Lead Function	Medium	ASCH	**Implemented**
CA07-2019	Data Protection	Adequate	Issue 2 - Data Protection Impact Assessments - Project & Programme Management and	Medium	ST	**In Progress**
RB21-2020	Customer Care & Complaints	Advisory	Issue 1 - Feedback Forums - Under Representation	Medium	ASCH	**Implemented**
RB21-2020	Customer Care & Complaints	Advisory	Issue 2 - Logging of Customer Feedback - Compliments/ Merits	Medium	ASCH	**Implemented**
RB21-2020	Customer Care & Complaints	Advisory	Issue 4 - Acceptance of Complaints - Customer Contact	Medium	ASCH	**Implemented**
RB21-2020	Customer Care & Complaints	Advisory	Issue 6 - Acceptance of Complaints - Formal Response Deadline	High	ASCH	**In Progress**
RB21-2020	Customer Care & Complaints	Advisory	Issue 8 - Acceptance of Complaints - Supporting Evidence	Medium	ASCH	**Implemented**
RB25-2020	DoLs – Progress with Addressing Backlog	Adequate	Issue 1 - Timely Processing of Applications	High	ASCH	**Not Implemented**
RB32-2020	Change for Kent Children	Adequate	Issue 2 - Monitoring of Savings and Cost Avoidance	Medium	CYPE	**In Progress**
RB32-2020	Change for Kent Children	Adequate	Issue 5 - Risk Management	Medium	CYPE	**Implemented**
RB35-2020	Care Leavers	Adequate	Issue 4 - Costing of the Care Offer	Medium	CYPE	**In Progress**
RB35-2020	Care Leavers	Adequate	Issue 5 - Staff Induction & Training	Medium	CYPE	**Implemented**