REPORT TITLE:	INTERNAL AUDIT UPDATE
ACTIVITY SUMMARY – 1 MAY 2026 TO 31 AUGUST 2026	

1. Audit Work Completed

1.1 This report provides an overview of the Internal Audit Team's activities undertaken between 1 May 2026 and 31 August 2026. It includes a summary of performance against key indicators, planned work for the next quarter, and an update on wider Internal Audit developments and Counter Fraud activity during the period.

2. Merseyside Pension Fund

2.1 The Benefits Payable Audit is currently in progress and is at draft report stage. The review is examining the adequacy and effectiveness of controls relating to retirement benefits and the establishment of new pension payroll payments, with a particular focus on the accuracy of benefit calculations, authorisation arrangements, data integrity, audit trails and compliance with Local Government Pension Scheme (LGPS) Regulations and Fund procedures. Audit work includes detailed walkthroughs of key processes, assessment of key controls and compliance testing of a sample of in-year retirements to provide assurance over the validity, accuracy and timeliness of benefit payments. The audit is also being undertaken to support the co-operative working arrangements with the Fund's external auditor, Grant Thornton.

2.2 The MPF Local Investments audit is currently in the planning stage and is intended to provide assurance that appropriate controls and processes are in place to support local investment decisions and ensure they are made in accordance with Merseyside Pension Fund's investment strategy, fiduciary responsibilities and approved governance framework. The review will assess the adequacy and effectiveness of governance, oversight and decision-making arrangements operating throughout the local investment process within Merseyside Pension Fund.

2.3 The Team are currently planning the development of an annual summary of audit work to be provided to the Pension Board in December 2026.

3. Council Audits

3.1 The following audits have been completed since the last meeting in June 2026.

3.2 <u>Foxfield School</u>

3.3 An audit of Foxfield School was completed during the period to evaluate the effectiveness of the control environment within the school, with particular focus on governance, financial management and compliance with established procedures. The audit resulted in an overall opinion of **Requires Significant Improvement**. Whilst the review identified some positive practices, including active governor oversight through standing agenda items, strengthened induction arrangements for

new staff, and planned improvements to asset management processes, the review identified weaknesses across key governance, financial management and internal control arrangements. A total of 26 recommendations were agreed with management, of which 13 were assessed as high-priority, reflecting the need for prompt action to strengthen governance, oversight and financial control arrangements. A management action plan has been agreed, and Internal Audit will monitor implementation of the recommendations through the established follow-up process.

3.4 The high-priority recommendations relate to:

- Strengthening governor financial skills assessments, training records and evidencing financial competency.
- Establishing a dedicated Finance Committee to enhance financial scrutiny and oversight.
- Increasing the frequency of budget monitoring reports presented to governors, particularly in light of the school's forecast deficit position.
- Obtaining and maintaining Conflict of Interest declarations from all staff and governors, including nil returns.
- Implementing a formal process for the review, assessment and management of Conflict-of-Interest declarations.
- Ensuring reasons for the absence of financial reporting to governors are documented and evidenced within meeting minutes.
- Strengthening governor oversight and challenge of the school's staffing structure to ensure affordability and sustainability.
- Developing and implementing a formal Purchasing Procedure approved by governors.
- Enhancing oversight of the school's Contracts Register through regular governor review and monitoring.
- Updating and approving the Financial Procedures Manual and establishing formal handover arrangements for key financial responsibilities.
- Reviewing and maintaining up-to-date delegated authority limits and authorised signatory arrangements.
- Introducing a purchasing card and ceasing the use of personal credit cards for school expenditure.
- Developing and implementing a formal Income Policy and supporting procedures for the collection, recording and banking of income.

3.5 The recommendations are intended to strengthen the school's governance framework, improve financial oversight and ensure compliance with expected standards of financial management and stewardship.

3.6 The audit concluded with a **Major** organisational risk rating.

3.7 <u>St Joseph’s Catholic Primary School Wallasey</u>

3.8 An audit of St Joseph’s Catholic Primary School Wallasey was completed during the period to evaluate the effectiveness of the control environment within the school, with particular focus on governance, financial management and compliance with established procedures. The audit resulted in an overall opinion of **Requires**

Improvement. Whilst the review identified positive practices, including strong financial knowledge demonstrated by senior leaders, effective governor engagement in financial discussions, and constructive use of Local Authority financial support, several opportunities were identified to strengthen governance and financial control arrangements. A total of 15 recommendations were agreed with management, no high-priority recommendations were identified. The recommendations are intended to strengthen the school's governance framework, improve financial oversight and ensure compliance with expected standards of financial management and stewardship.

3.9 An action plan has been agreed with management and Internal Audit will monitor implementation through the established follow-up process.

3.10 The audit concluded with a **Moderate** organisational risk rating.

3.11 Artificial Intelligence Governance Audit

3.12 As previously reported to Members, the Council has employed the Information Technology (IT) Technical Audit team at Salford Council to provide two Information Technology reviews one of which was on the use of Artificial Intelligence (AI). The AI audit opinion was "**Reasonable**" which is broadly equivalent to the **Moderate** rating at Wirral Council.

3.13 The report Executive Summary recognises that the Council has proactively established governance arrangements ahead of widespread AI adoption and is taking a measured approach to managing emerging AI-related risks. Although, the report highlighted that there are opportunities to strengthen AI governance arrangements further, most notably: AI Inventory and AI risk management.

3.14 The report includes four recommendations of which two are priority 1 which is equivalent to high risk at Wirral Council. The report also includes one Advisory point that if implemented should enhance the current control environment.

3.15 The priority 1 recommendations are:

- A central inventory of AI-enabled systems, tools and agents, in use across the organisation should be maintained. The inventory should capture key information including the business owner, purpose, AI functionality, data processed, risk classification and approval status. The council should also implement proportionate measures to provide visibility of undeclared potentially high-risk AI usage (shadow AI), e.g. agents created in M365 Copilot.
- Management should establish and maintain a formal documented AI risk management process to ensure AI-related risks are consistently identified, assessed, documented, monitored, and reviewed. The process should provide evidence of risk assessments, risk ownership, mitigating controls, and periodic review activities. Whilst management has demonstrated awareness of a number of key AI risks and has implemented or is considering mitigating actions in several areas, a formal process would help provide assurance that AI risks are being comprehensively and consistently managed across the organisation.

3.16 Sefton Council Risk Management

3.17 As part of a tripartite arrangement, Wirral Council's Internal Audit Service undertook a review of the effectiveness of Sefton Council's risk management framework. The audit assessed the adequacy of arrangements for identifying, evaluating, mitigating, monitoring and reporting strategic, operational, financial and compliance risks, and considered whether the framework supports informed decision-making, promotes accountability and enhances organisational resilience.

3.18 The audit has now been completed and the final report issued to Sefton Council. An agreed management action plan has been developed to address the findings arising from the review. In accordance with the agreed tripartite arrangement, responsibility for monitoring the implementation and completion of the recommendations, rests with Sefton Council and, therefore, no follow-up activity will be undertaken by Wirral Council's Internal Audit Service.

3.19 Emergency Planning

3.20 An audit of Emergency Planning was completed during the period to assess the adequacy and effectiveness of the Council's Emergency Planning arrangements. The review considered the emergency response procedures and plans, arrangements for testing and exercising those plans, and the training provided to officers with emergency planning responsibilities.

3.21 The audit review has identified several areas where further development and strengthening are required. Key findings included the need to review and update emergency planning information held on both the Council's intranet and public website, together with documentation available through the Emergency Planning Teams channel. Consideration should also be given to storing key emergency planning documentation on the Cabinet Office's Local Resilience Direct Portal and ensuring that all relevant officers are granted appropriate access.

3.22 The review identified that there was only one emergency plan in place, and a lack of evidence demonstrating that certain plans have been tested, exercised, and subject to lessons learned reviews. In addition, no training matrix was in place to record and monitor the competencies and training requirements of officers with emergency planning responsibilities. The audit also found that risk assessments evidencing current and emerging emergency planning risks could not be provided. Furthermore, the associated risk register requires review to ensure that identified risks remain relevant and that documented controls are operating effectively. Opportunities were also identified to strengthen arrangements relating to Emergency Rest Centres, including the development of comprehensive plans and the undertaking of testing and exercising activities to assess their effectiveness in the event of an emergency. A total of 27 recommendations and one observation were raised, of which 11 were assessed as high priority. Management has agreed an action plan to address the issues identified, and Internal Audit will monitor the implementation of the agreed actions through its established follow-up process.

3.23 The high-priority recommendations relate to (including the observation):

- Developing and implementing a formal process to identify, assess, and capture risks and emerging risks on a regular and consistent basis.
- Undertaking as assessment to determine which emergency plans are required for Wirral MBC for example Beach Pollution Emergency Plan. An action plan should be devised which lists each emergency plan, with the proposed owner of the production of each of the plan and the proposed date of completion.
- Ensuring grab bags include action cards which are short set of instructions on how to deal with each emergency type.
- Ensuring Emergency Rest/ Assistance Centre Plans are produced and tested
- Undertaking a review to ensure that designated Emergency Centre venues are sufficient in number, appropriately distributed geographically, adequately staffed, and that personnel have received the necessary training.
- Ensuring Emergency plans are appropriately documented on the Microsoft Teams Channel and the RD Portal, maintained and subject to regular testing to confirm their effectiveness.
- Ensuring the outcomes of all testing exercises should be formally documented, retained, and subject to review and analysis to identify lessons learned and opportunities for continuous improvement, ensuring a clear and auditable trail is in place
- Undertaking a skills assessment for all staff involved in the Emergency Planning Process to ensure that they have received adequate training to undertake their role for example MAGIC training where appropriate.
- Ensuring officers who are identified as having gaps in their skill set or who have not had the appropriate training are provided with the necessary development and training to address these deficiencies.
- Ensuring the Emergency Planning service risks are reviewed to assess whether the risks are being effectively identified, managed and controlled
- Reviewing the Corporate Risk Register in relation to Emergency Planning to assess whether identified risks are being effectively controlled. Where controls are found to be inadequate or no longer in place, they should be removed or appropriately updated.
- Management should ensure that a corporate Business Continuity Plan is developed and maintained, with testing arrangements aligned to relevant emergency scenarios. An action plan has already been drafted, and this has an action implementation date of September 2026.

3.24 The audit concluded with an overall assurance opinion of **Major.**

3.25 <u>Grant Certification</u>

3.26 The Internal Audit team has completed grant certification work across a range of schemes as detailed in the table below. All grant claims were reviewed to confirm compliance with funding requirements, eligibility of expenditure, and the accuracy of supporting evidence. No issues were identified that affected the validity of the claims.

Table 1 details the grants that were certified by the Internal Audit Team during the period

Grant	Value £s
Birkenhead Central Gateway - Birkenhead Waterfront Qtr. Quarter 4 25/26	194,819.23
City Region Sustainable Transport Settlement (CRSTS) Highways Maintenance Work and Non-Highways Maintenance Work Quarter 3 25/26	3,177,543.81
City Region Sustainable Transport Settlement (CRSTS) Highways Maintenance Work and Non-Highways Maintenance Work Quarter 4 25/26	2,458,502.98
Transport Development Work - Funding for Wirral Projects – Hind Street/Birkenhead Town Centre Dock Branch Park LCWIP Delivery Highways and Safety Proposals Quarter 4 25/26	80,166.32

4. Audits in Progress

4.1 Residential Home Care Payments

4.2 The audit is currently at the fieldwork stage and is designed to provide assurance that payments made to providers are valid, accurate, appropriately authorised, and processed in accordance with contractual requirements and Council policies. The review also assesses the effectiveness of key controls within the payment process, including reconciliation procedures, segregation of duties, and arrangements for ensuring payment accuracy. In addition, the audit evaluates the adequacy of income recovery processes and the effectiveness of management oversight, monitoring, and governance arrangements in supporting the proper administration of provider payments.

4.3 New Brighton Primary School

4.4 A review of the school's financial, risk, and control frameworks is currently in progress and is at draft report stage. The purpose of this audit is to assess the effectiveness of the school's control environment, with a specific focus on governance arrangements, financial management practices, and compliance with established procedures

4.5 St Johns Infants School

4.6 A review of the school's financial, risk, and control frameworks is currently in progress. The purpose of this audit is to assess the effectiveness of the school's control environment, with a specific focus on governance arrangements, financial management practices, and compliance with established procedures

4.7 St Josephs Upton Primary School

4.8 A review of the school's financial, risk, and control frameworks is currently in progress. The purpose of this audit is to assess the effectiveness of the school's control environment, with a specific focus on governance arrangements, financial management practices, and compliance with established procedures

4.9 Direct Payments – Children's

4.10 The audit is currently at the fieldwork stage and is intended to assess the effectiveness of the Council's arrangements for the management of Children's direct payments. The review will determine whether direct payments are appropriately authorised, supported by robust assessments and contractual agreements, and used in accordance with their intended purpose. It will evaluate the adequacy of policies, procedures, and guidance in place for both clients and officers, as well as the effectiveness of financial monitoring, audit, and oversight arrangements. In addition, the audit will assess whether robust processes exist to identify, investigate, suspend, terminate, and recover payments where funds are not used appropriately, ensuring compliance and the safeguarding of public funds

4.11 Petty Cash

4.12 The audit is currently at the draft report stage and is intended to assess the effectiveness of the Council's overarching governance and control framework for the management of petty cash. Its primary objective is to evaluate existing controls and identify opportunities to strengthen governance and address any areas of weakness.

4.13 Declarations of Interest

4.14 The audit is currently in the fieldwork stage and is intended to assess the adequacy and effectiveness of the Council's arrangements for managing declarations of interest. The review will determine whether declarations are appropriately identified, recorded, maintained and monitored, and whether effective arrangements are in place to ensure compliance and address instances of non-compliance. It will also evaluate governance, oversight and accountability arrangements, including roles and responsibilities for review and challenge, and the effectiveness of controls to manage potential conflicts of interest. In addition, the review will consider compliance with statutory requirements, the Council's Constitution and internal policies, and whether controls are sufficient to mitigate the risk of undisclosed conflicts influencing decision-making or causing reputational harm.

4.15 External Review of Cyber Security

4.16 As previously reported, the Council appointed Salford City Council to provide specialist IT audit support following the departure of the Internal Audit team's IT audit resource. An audit of Cyber Security and the Council's response to cyber incidents is currently in the fieldwork stage. The review is assessing the adequacy and effectiveness of the Council's cyber security governance, risk management arrangements, technical controls, and incident response processes. Testing and evidence gathering are ongoing in accordance with the agreed audit scope and methodology. Internal Audit continues to maintain regular liaison with the auditor to monitor progress, provide oversight, and ensure the review is completed in accordance with professional standards and agreed timescales.

4.17 Direct Payments – Adults

4.18 The audit is currently at the draft report stage. Fieldwork has been completed and the draft findings have recently been discussed with officers at the closing meeting. The review was designed to assess the effectiveness of the Council's arrangements for the management of Adult Social Care Direct Payments. This included evaluating whether direct payments are appropriately authorised, supported by robust assessments and contractual agreements, and used in accordance with their intended purpose. The audit also considered the adequacy of policies, procedures and guidance available to both clients and officers, together with the effectiveness of financial monitoring, audit and oversight arrangements. In addition, the review assessed whether appropriate processes are in place to identify, investigate, suspend, terminate and recover payments where funds have not been used appropriately, thereby supporting compliance and the safeguarding of public funds.

5. **Follow up of Audits**

5.1 The Global Internal Audit Standards for UK Public Sector (GIAS) states at 15.2 that Internal Audit must confirm that Management have implemented Audit recommendations and action plans following an established methodology.

- Inquiring about the progress of implementation.
- Performing following up using a risk-based approach
- Updating the status in a management system.

5.2 If management has not progressed the implementation of the actions according to the proposed implementation dates, then internal auditors must obtain and document an explanation from management and discuss with the chief audit executive (Head of Risk and Compliance at Wirral Council). The chief audit executive is responsible for determining whether senior management by inaction or delay, has accepted the risk that exceeds the risk tolerance (of the Council).

5.3 Previous update in June 2026 highlighted that the Internal Audit Team were reviewing the way that follow up of audit recommendations was being carried out and reported internally to management and to Members. Following the completion of the review of the process it has been identified that overall the system is reactive rather than proactive.

- Implementation dates on audit recommendations are often extended on multiple occasions leading to control weaknesses not being addressed in a timely manner
- Unrealistic timescales are often given to Internal Audit by management at the time of the issue of the draft report leading to the first point.
- Management are often unclear of their responsibilities and accountability to implement the recommendations.
- There are often challenges in obtaining progress from staff members responsible for implementing actions from an audit.
- Internal Audit is challenged by ARMC when there are issues on the completion of actions when it is management’s responsibility failure to implement on a timely basis.
- There is no visibility at SLT on current performance to implement recommendations.

- The focus on reporting to ARMC is too granular at individual audit level rather than a holistic level providing visibility across all recommendations providing trends and analysis in particular on recommendations not implemented on time.

5.4 The approach has been to change from individual follow ups by auditors to a centralised approach using the database already in use and reviewing how the information is reported on Power BI.

5.5 Performance targets have been set for follow ups in line with the Audit Plan presented to Members in March 2026 and discussions by Members at the meeting.

5.6 Revised procedures have been devised and issued to the Internal Audit Team and the Executive Leadership Team on 2 July 2026. The revised process includes:

- The implementation date provided by management at the time of the draft report will not be extended under any circumstance, and any delays will be reported to Senior Leadership Team and Audit and Risk Management Committee with the management team response and potential attendance to explain.
- Management are responsible for designing the appropriate action to the recommendation, providing a reasonable implementation date and ensuring it is implemented on time. Directors are accountable for this. To provide clarity Internal Audit will ensure that the Directors have visibility of the management response to audit findings and will be given regular information on the recommendations that are due to be implemented within the next three months. This has already started. Progress should be picked up at the DMT meetings on a regular basis which will be tested at some point.
- Escalation process designed to involve senior managers where there is a difficulty obtaining response/evidence and potentially where there is continued no response the outcome feedback to SLT and ARMC.
- Reporting to Senior Leadership Team on a regular basis, granular details by audit and recommendation where there is an issue will be provided as well as overall holistic position for the Council. First report August 2026.
- Improved reporting to ARMC with the same focus as SLT and invites for Directors and senior management to explain the delays in person.
- Process designed, in accordance with the Global Internal Audit Standards for UK Public Sector, where as the “chief audit executive” from the standards, that the failure to implement the action on time or not carry out the recommendation at all is outside of the Council’s risk tolerance is reported ultimately to ARMC.

5.7 Every five weeks the performance on audit recommendation performance is presented to Senior Leadership Team which started on 26 July 2026.

5.8 The following table provides an update on performance on the implementation of audit recommendations between 1 April 2026 to 31 August 2026.

Table 2: Percentage of recommendations implemented by agreed target date between 1 April 2026 to 31 August 2026

Performance Objectives	Target	Result
Total Recommendations	70%	65%
High-Priority Recommendations	80%	50%
Medium Priority Recommendations	75%	67%

5.9 There are currently 32 outstanding recommendations where the original due date has been exceeded. Although we have a response in some cases there is insufficient detail to determine if it has been completed or where it has been stated Internal Audit have requested evidence, but this has not been provided to date. The details of the outstanding recommendations are in the attached document.

5.10 Audits in the escalation process include:

- Accounts Payable Module
- Birkenhead Market Referral Investigation
- Contracts Compliance
- Council Tax
- Contract Governance
- Schedule of Rates
- Section 106

5.11 It should be noted that Revenue and Benefit (Council Tax audit) have agreed revised dates for the completion of the outstanding audit recommendations and Internal Audit are closely monitoring the completion. There is one recommendation for Accounts Payable Module audit and Section 106 audit where we are chasing up on the proposed implementation date.

5.12 Overall performance is weak and below target. The removal of the ability to change dates on the implementation of audit recommendations is a substantial culture change to the organisation which management will need to address.

5.13 There is limited engagement from some service areas, together with delays in the provision of information, has affected the timely assessment of progress against agreed actions. In some instances, information relating to future actions, implementation status and completion dates has lacked sufficient clarity and detail on what has been implemented and instead focuses on what will be implemented in the future.

5.14 The follow up process instead of being relatively straightforward with management monitoring through Departmental Management Teams, providing proactive updates as audit recommendations are being addressed along with evidence alongside a straightforward assessment of progress is instead protracted, inefficient and

resource hungry. The current management response to provide a holistic picture on the implementation of audit recommendations has detrimentally impacted on the delivery of the audit plan as additional auditor and management time is needed to address responses and chase up.

5.15 Internal Audit's opinion is that the organisation has accepted a level of risk that sits outside the Council's current approved risk appetite by not providing timely and sufficient evidence that recommendations have been implemented. This is particularly relevant to the Contract Compliance, Schedule of Rates and Birkenhead Market audits. In the absence of assurance that recommendations have been implemented and are operating effectively, Internal Audit cannot conclude that the identified risks have been adequately mitigated. This position will remain until satisfactory evidence of progress is provided and implementation has been validated through follow-up testing.

6. Internal Audit Performance Indicators

6.1 A suite of performance indicators continue to be used to measure delivery of the Internal Audit Plan and the effectiveness of the Internal Audit Service, with performance reported to each meeting of the Audit and Risk Management Committee.

6.2 As previously mentioned to Members, the performance indicators being used for 2026/27 have been revised to reflect the requirements and principles of the GIAS. The performance measures were included in the Annual Plan paper which was presented and to Members in March 2026. The updated measures provide a broader assessment of Internal Audit performance, encompassing quality, stakeholder engagement, professional standards compliance, continuous improvement and service delivery, thereby providing a stronger link between performance reporting and the expectations of the Global Internal Audit Standards.

6.3 The Service will continue to evaluate and monitor its effectiveness and productivity through the key performance indicators set out in the table below.

Table 3 Details of Internal Audit Performance Indicators, Annual Target and the actual % delivery on 31 August 2026

Internal Audit Performance Measure	Target 31 March 2027	Actual Delivery on 31 August 2026
Coverage of high-risk auditable units within the approved Internal Audit Plan.	90%	100%
Percentage of recommendations implemented by agreed target date	70%	65% (See table 2)

Stakeholder Survey Completion Rate	50%	100%
Percentage of approved Internal Audit Plan delivered	90%	31%
Ratio of advisory engagements compared to the overall Internal Audit Plan	5%	10%
Completion of External Quality Assessment, achieving at least a "Generally Conforms" rating	March 2027	Planning Stage
Completion of staff competency assessments and individual development plans	100%	100% competency completed – individual development plans in progress
Completion of the Annual Training Plan and Continuing Professional Development requirements	90%	29%

6.4 The percentage of the Internal Audit Plan delivered during the period was lower than the target set by the service. This was due to resourcing challenges, including the long-term absence of a member of the audit team and the time required to onboard and support three new members of staff. As expected, a proportion of available audit resources was necessarily directed towards induction, training and development activities to ensure new team members developed the knowledge, skills and competencies required to undertake audit assignments effectively and in accordance with professional standards. In addition, the team completed a number of audit engagements carried forward from the 2025/26 Internal Audit Plan, which required the allocation of audit resources before work on the 2026/27 Audit Plan could commence.

6.5 During the period, a significant amount of audit resource was also dedicated to the follow-up of agreed audit recommendations, including obtaining implementation updates and supporting evidence from service areas. This involved considerable engagement with officers to secure responses and ensure the accuracy of reported implementation progress. Furthermore, revised follow-up and reporting arrangements have been developed and implemented to strengthen governance, improve the monitoring of audit recommendations, and enhance accountability for the timely implementation of agreed actions across the Council.

6.6 Whilst these factors have impacted overall plan delivery, they represent an investment in the long-term capacity, resilience and effectiveness of the service. As the new team members become fully integrated into the service and the

enhanced recommendation follow-up arrangements become embedded, the rate of audit plan delivery is expected to increase.

6.7 A revised Internal Audit Plan is therefore presented to Members for consideration and approval. The revised plan reflects current resource capacity, progress against planned work, and emerging priorities, ensuring that available audit resources continue to be directed towards the areas of greatest risk and significance to the Council whilst maintaining appropriate assurance coverage. The proposed revisions have been developed based on the service's current understanding of available resources. As this position may change during the year, the Audit Plan will remain under review and may be further amended to reflect changes in resource availability, organisational priorities, and emerging risks. Should further significant revisions to the Audit Plan be required, an updated plan will be presented to the Audit and Risk Management Committee in January 2027 for consideration and approval. To support this approach, the 2026/27 Audit Plan has been reviewed and updated, resulting in audits being removed from the current year's plan and considered for inclusion in the 2027/28 Audit Plan where appropriate.

6.8 The audits removed are:

- Public Health Outcomes
- Organisational Culture
- Grant Management
- MPF Governance Arrangements 1
- MPF Governance Arrangements 2
- Business Planning
- Safeguarding
- Treasury Management
- Eureka
- Hind Street
- Care Package Assessments

6.9 The Organisational Culture audit has been deferred pending completion of the ongoing internal review, and the Safeguarding audit will be revisited in 2027/28 following the CQC review. The Merseyside Pension Fund Governance Arrangements audits have been deferred due to continuing developments in pooled arrangements and governance structures including the commissioning of an external governance review. Hind Street has been removed from the plan due to assurance being provided through external review activity. In addition, assurance originally intended through the Care Package Assessments audit will be provided through the Direct Payments and Residential Care audits. The remaining deferred audits will be considered for inclusion within the 2027/28 Internal Audit Plan. The CDM Working Group Advisory has been removed from the Audit Plan as management has agreed not to proceed with the establishment of the Board.

6.10 The following audits have been added to the Audit Plan:

- Warrington Counter Fraud Review

- Sefton Risk Management Review
- Business Continuity Review

6.11 These reviews form part of the tripartite arrangement between participating authorities. In accordance with the GIAS, audits covering areas for which the Head of Risk and Compliance has operational responsibility are undertaken by a partner authority to maintain independence and objectivity. As part of this arrangement, Salford Internal Audit will undertake the Business Continuity Review on behalf of Wirral. Wirral Internal Audit has completed the Sefton Risk Management Review and will also undertake the Warrington Counter Fraud Review.

6.12 A revised Audit Plan is detailed at Appendix 2.

7. Other areas of audit advice and support

7.1 Internal Audit have provided the following additional support to teams on

- The refreshing of the content within the Schemes of Delegation operating within the Council.
- Providing advice and guidance on the use of Financial Schemes of Delegation.
- Supporting the organisation's PCI DSS compliance efforts by participating when required in collaboration meetings focused on PCI DSS requirements and best practices.
- Supporting the Waste & Refuse Collection and Street Cleansing Contract Strategic Board.
- Supporting the Environment and Climate Emergency Action Group
- Advisory role with the Active Wirral Board from September 2026.
- Advisory role in CCOG and the Corporate Governance Board.

7.2 The Internal Audit Service maintains an effective working relationship with the Council's external auditors through regular liaison meetings held throughout the year. These arrangements facilitate the timely exchange of information, coordination of audit activities, and discussion of planned work, key findings, and emerging risks. This collaborative approach helps to minimise duplication of effort, maximise assurance coverage, and ensure that matters requiring attention are identified and addressed promptly by the respective assurance providers.

8. Internal Audit Developments

8.1 <u>GIAS</u>

8.2 Work to achieve compliance with the GIAS is ongoing. The Internal Audit team continues to progress the implementation of the agreed action plan arising from the Domain 2 self-assessment, with a focus on strengthening policies, procedures, and supporting documentation. Activity is also continuing to ensure that the requirements of Domain 5 are appropriately assessed and aligned with the standards.

8.3 In addition, a self-assessment against the requirements of Domain 3 has been completed and an action plan developed to address identified compliance gaps and support achievement of full conformance with the Standards. Table 4 below details the results of the compliance assessment. The overall assessment for Domain 3 was determined as Partially Achieved, reflecting that many of the key requirements of the Standards are in place and operating effectively, whilst a number of opportunities for further enhancement were identified. An action plan has been developed to address the areas requiring improvement and to support continued progress towards full conformance with the Global Internal Audit Standards.

Table 4 Domain 3 Self-Assessment Results

Principle	**Conformance Assessment**
Principle 6: Authorised by the Board	Generally Achieved
Principle 7: Positioned Independently	Partially Achieved
Principle 8: Overseen by the Board	Partially Achieved
Overall Position - Domain 3	Partially Achieved

8.4 As discussed with members previously the Internal Audit Team should undertake an External Quality Assessment (EQA) every five years and the last EQA was completed in 2019/2020 financial year and is now overdue. The previous EQA on the Council's compliance with the Public Sector Internal Audit Standards was completed by a peer review involving Heads of Internal Audits from other neighbouring local authorities. The Internal Audit Team are continuing to carry out initial planning to carry out the EQA during 2026/2027.

8.5 The CIPFA Northwest Heads of Internal Audit Group, of which Wirral is a member, is currently exploring the development of a programme of External Quality Assessments. Discussions remain at an early stage, and the detail of how the arrangement will operate and develop is still being considered. Wirral has expressed an interest in participating in the programme and will continue to engage with the Group as proposals are progressed and evaluated.

8.6 Internal Audit will continue to monitor developments and determine the most appropriate approach for undertaking the External Quality Assessment. A further update will be provided to Members at the next meeting.

8.7 <u>Resourcing</u>

8.8 Internal Audit has experienced resourcing pressures during the period, including the long-term absence of a member of staff from early July 2026 to the end of the period.

8.9 In addition as the team includes three (60%) new staff members, of which two are new to the profession, the requirement to induct, train and support three new members of the audit team, together with the development and supervision of a graduate CIPFA Finance trainee has also impacted. Whilst this has reduced the amount of resource available for direct audit delivery in the short term, it has been necessary to ensure that new staff develop the knowledge, skills and competencies required to undertake audit work effectively and in accordance with professional standards.

8.10 In addition, audit resource has been committed to completing audits carried forward from the previous year, strengthening the follow-up and reporting arrangements for audit recommendations, and engaging with service managers to obtain implementation updates and supporting evidence. These activities have impacted the rate of audit plan delivery during the period; however, they are expected to strengthen the overall effectiveness, capacity and resilience of the service.

9. Counter Fraud Activity

9.1 Members should note that a separate item on the agenda for this meeting presents the Annual Counter Fraud Report for 2025/26, which provides a comprehensive overview of counter fraud activity, outcomes and performance for the full financial year ended 31 March 2026.

9.2 During the reporting period, the Counter Fraud Team completed 129 reviews of fraud allegations received and issued an Administrative Penalty. These allegations relate to Housing Benefit, Council Tax Support, Discretionary Payments, Council Tax Discounts and Exemptions. There were 43 instances of fraud and error identified, resulting in financial savings. The table below summarises the instances of fraud and error identified during this period and the associated financial savings.

Table 5 details the categorisation and value of the monies to be recovered from 1 May 2026 to 31 August 2026.

Result Type	Value
Housing Benefit	£72,880.99
Council Tax Support	£37,279.85
Council Tax Discounts	£15,660.34
New Liability	£34,187.26
Discretionary Payments	£210.00
Administrative Penalty	£1,000.00
Total	£161,218.44

9.3 In addition to the recoverable amounts detailed in Table 5, the Counter Fraud Team identified estimated future savings through the prevention of ongoing incorrect payments and discounts. These future savings are valued at £5,781.90 for Council Tax Support and £8,057.54 for Council Tax Discounts.

9.4 During the period, the Team received one referral relating to a potential conflict of interest issue, which is currently under investigation. The Team also continued to progress four investigations previously reported to Members. In two of the four cases, fraud was not substantiated; however, the investigations identified internal control weaknesses, and the Internal Audit Team is now working with the relevant service areas to strengthen the control environment.

9.5 Criminal investigations and prosecution activity continued during the period. Outcomes will be reported to Members through Internal Audit Update Reports and the Head of Risk and Compliance Annual Report, as appropriate.

9.6 The Team continued to collaborate with the Department for Work and Pensions, enhancing operational efficiency and supporting a coordinated approach to identifying potential fraud and error.

9.7 Proactive, intelligence-led fraud detection activity continued during the reporting period. This included targeted reviews of areas identified as presenting a higher risk of fraud, error or non-compliance, resulting in corrective action where appropriate and referrals for further investigation.

10. Managing the Risk of Fraud and Corruption Self-Assessment

10.1 During the period, the action plan arising from the fraud risk self-assessment was finalised. Further details of the assessment findings agreed actions and planned improvements are included within the Annual Counter Fraud Report presented to Committee at this meeting.

11. National Fraud Initiative

11.1 Investigative work arising from the 2024/25 National Fraud Initiative (NFI) exercise is approaching completion, with a number of investigations having been undertaken as a result of data matches identified through the exercise. To date, the exercise has identified £103,666 of recoverable savings and delivered a range of additional outcomes, including the cancellation of 459 Blue Badges and the removal of 25 applicants from the Housing Waiting List. These outcomes demonstrate the continued value of the NFI in detecting potential fraud and error and safeguarding public funds.

11.2 Further details, including the categorisation and value of fraud and error identified, together with Cabinet Office estimates of future fraud and error prevented, are set out in the Annual Counter Fraud Report presented to Committee at this meeting. Preparatory work has also commenced for the 2026/27 NFI exercise, including engagement with Council services and planning for the submission of required datasets to support participation in the exercise.

11.3 The Counter Fraud and Revenues and Benefits Teams continue to jointly review Council Tax Single Person Discount matches uploaded to the Cabinet Office NFI site in January 2026. The findings will be reported to Members upon completion of the exercise.

11.4 The NFI exercise also provides assurance to management that key controls and processes are operating effectively where fraud and error are not identified.

12. National Anti-Fraud Network

12.1 The Council receives regular fraud alerts from the National Anti-Fraud Network (NAFN). The Counter Fraud Team is responsible for receiving, logging and disseminating these alerts to relevant departments. During the reporting period, 24 alerts were distributed across Council services, helping to raise awareness of emerging fraud risks and enabling preventative action to be taken where appropriate. This proactive approach strengthens the Council's overall fraud risk management and supports early intervention where necessary.

13. Counter Fraud Team planned work for 2026-27

13.1 This section outlines the programme of work scheduled for delivery across Quarters 2 and 3. The activities detailed reflect priority areas identified within the service and are being progressed in accordance with the 2026/2027 Counter Fraud Plan, as endorsed by this Committee.

13.2 Delivery of this work will support the Council’s wider objectives in strengthening the counter fraud framework, increasing resilience to fraud risk, and ensuring that appropriate preventative and detective measures are consistently applied. Progress will be monitored throughout the period to ensure that delivery remains aligned to planned objectives and timelines.

13.3 Work currently underway, or identified for delivery within Quarters 2 and 3, includes:

- Implement actions identified within the Counter Fraud Action Plan arising from the fraud risk self-assessment.
- Review and update of the Counter Fraud Strategy and related policies.
- Finalise the review of the Anti-Money Laundering Policy.
- Finalise the development of the Fraud Risk Universe.
- Deliver awareness initiatives for Departmental Management Teams and service areas to enhance understanding of the Failure to Prevent Fraud offence.
- Deliver targeted fraud awareness training sessions to front line Revenues and Benefits staff members.
- Work with departments to develop and implement Action Plans, ensuring lessons are learnt from the 2024-25 NFI exercise.
- Undertake the planned Revenues and Benefits proactive exercise to identify potential fraud, error, or control weaknesses.
- Investigate allegations of fraud.
- Work with all service areas to produce Fraud Risk Assessments.
- Prepare the fraud awareness campaign to coincide with International Fraud Awareness Week in November 2026.
- Work with service areas to prepare for the NFI 2026-27 exercise, commencing in October 2026.
- Finalise the review and updating of the Fraud, Bribery and Corruption e-Learning mandatory training.