AUDIT AND GOVERNANCE COMMITTEE
4 JUNE 2025
ANNUAL REPORT OF THE CHIEF INTERNAL AUDITOR
Report by Chief Internal Auditor

RECOMMENDATION

1. **The Audit and Governance Committee is RECOMMENDED to**

   - consider and endorse this annual report.

Executive Summary

2. This is the annual report of the Chief Internal Auditor, summarising the outcome of the Internal Audit work in 2024/25, and providing an opinion on the Council's System of Internal Control. The opinion is one of the sources of assurance for the Annual Governance Statement.

3. The basis for the opinion is set out in paragraphs 22 – 35, followed by the overall opinion for 2024/25 which is that there is **satisfactory** assurance regarding Oxfordshire County Council's overall control environment and the arrangements for governance, risk management and control.

Background

4. The Accounts and Audit Regulations 2015 require the Council to maintain an adequate and effective Internal Audit Service in accordance with proper internal audit practices. The Global Internal Audit Standards (GIAS) in the UK Public Sector (effective from April 2025), sets out proper practice for Internal Audit, requires the Chief Internal Auditor (CIA) to provide an annual report to those charged with governance, which should include an opinion on the overall adequacies and effectiveness of the internal control environment, comprising risk management, control and governance. (This was required under the previous Public Sector Internal Audit Standards 2017 which the Global Internal Audit Standards now replaces).

5. Oxfordshire County Council's Internal Audit service fully conformed to the PSIAS 2017, and since April 2025 has implemented the new Global Internal Audit Standards in the UK Public Sector.

6. The Accounts and Audit Regulations 2015 require the Annual Governance Statement (AGS) to be published at the same time as the Statement of Accounts is submitted for audit and public inspection. In order for the Annual Governance Statement to be informed by the CIA's annual report on the system of internal control, this CIA annual report has been produced for the June Audit and Governance Committee meeting. This is the full and final CIA annual report for 2024/25.

Responsibilities

7. It is a management responsibility to develop and maintain the internal control framework and to ensure compliance. It is the responsibility of Internal Audit to form an independent opinion on the adequacy of the system of internal control.

8. The role of Internal Audit is to provide management with an objective assessment of whether systems and controls are working properly (financial and non-financial). It is a key part of the Authority's internal control system because it measures and evaluates the adequacy and effectiveness of other controls so that:

    - The Council can establish the extent to which they can rely on the whole system; and,
    - Individual managers can establish how reliable the systems and controls for which they are responsible are.

Internal Control Environment

9. Internal audit standards require that the internal audit activity must assist the organisation in maintaining effective controls by evaluating their effectiveness and efficiency and by promoting continuous improvement.

10. The internal audit activity must evaluate the adequacy and effectiveness of controls in responding to risks within the organisation's governance, operations and information systems regarding the:

    - Achievement of the organisation's strategic objectives;
    - Reliability and integrity of financial and operational information;
    - Effectiveness and efficiency of operations and programmes;
    - Safeguarding of assets; and
    - Compliance with laws, regulations, policies, procedures and contracts.

11. In order to form an opinion on the overall adequacy and effectiveness of the control environment, the internal audit activity is planned to provide coverage of financial controls through review of the key financial systems, and internal controls through a range of operational activity both within Services and cross cutting, including a review of risk management and governance arrangements. The Chief Internal Auditor's annual statement on the System of Internal Control is considered by the Corporate Governance Assurance Group when preparing the Council's Annual Governance Statement.

The Audit Methodology

12. The Internal Audit Service operates in accordance with the Public Sector Internal Audit Standards (PSIAS) and from April 2025 in accordance with the new Global Internal Audit Standards (GIAS). The annual self-assessment

against the standards is completed by the Chief Internal Auditor. It is a requirement of the standards for an external assessment of internal audit to be completed at least every five years. The external assessment was undertaken by CIPFA (Chartered Institute of Public Finance & Accountancy) in November 2023, the results were reported to the January 2024 Audit & Governance Committee meeting. The results of the assessment were very positive, with an overall conclusion that Oxfordshire County Council's Internal Audit Service FULLY CONFORMS to the requirements of the standards. There were no areas of either partial or non-conformance with the standards identified and no recommendations arising.

13. The Monitoring Officer conducted a survey of Senior Management on the effectiveness of Internal Audit in September 2023. The results from this survey were presented to the November 2023 Audit & Governance Committee meeting. The conclusion from the survey was that there was a strong level of satisfaction with the nature and effectiveness of the internal audit service.

14. The Internal Audit Strategy and Annual Plan for 2024/25 was presented to the May 2024 Audit and Governance Committee. The Committee then received quarterly progress reports from the Chief Internal Auditor, including summaries of the audit findings and conclusions.

15. The Internal Audit Plan, which is subject to continuous review, identified the individual audit assignments. The activity was undertaken using a systematic risk-based approach. Terms of reference were prepared that outlined the objectives and scope for each audit. The work was planned and performed so as to obtain all the information and explanations considered necessary to provide sufficient evidence in forming an overall opinion on the adequacy and effectiveness of the internal control framework.

16. Internal Audit reports provide an overall conclusion on the system of internal control using one of the following ratings:

GREEN	There is a strong system of internal control in place and risks are being effectively managed.
AMBER	There is generally a good system of internal control in place and the majority of risks are being effectively managed. However, some action is required to improve controls.
RED	The system of internal control is weak, and risks are not being effectively managed. The system is open to the risk of significant error or abuse. Significant action is required to improve controls.

17. In Appendix 1 to this report there is a list of all completed audits for the year showing the overall conclusion at the time audit report was issued, and the current status of management actions against each audit, (based on information provided by the responsible officers).

18. To provide quality assurance over the audit output, audit assignments are allocated to staff according to their skills and experience. Each auditor has designated either the Audit Manager or Chief Internal Auditor to perform quality reviews at four stages of the audit assignment: the terms of reference, file review, draft report and final report stages.

The Audit Team

19. During 2024/25 the Internal Audit Service was delivered by an in-house team, supported with the specialist area of IT audit. There were also six audits that were delivered using external resource.

20. Throughout the year the Audit and Governance Committee were kept informed of staffing issues, challenges with recruitment, long term sickness absence within the team and the impact on the delivery of the Plan.

21. It is a requirement to notify the Audit and Governance Committee of any conflicts of interest that may exist in discharging the internal audit activity. There are none to report for 2024/25.

Opinion on System of Internal Control

Basis of the Audit Opinion

22. The 2024/25 revised plan presented to the January 2025 Audit & Governance Committee meeting has been completed, with the exception to one audit (Delivery of Savings and Investments). The service has been managing a long-term sickness absence within the team for the last half of 2024/25, and whilst the rest of planned audits were redistributed amongst the team, who have all worked exceptionally hard to ensure they were completed, the final audit could not be resourced. It was agreed with Executive Director of Resources to remove the audit from the plan.

23. The plan is intended to be dynamic and flexible to change. 30 audits were undertaken in the year (26 in 2023/24, 30 in 2022/23, 26 in 2021/22). Since the last report of amendments to the plan at the January 2025 Audit & Governance Committee meeting (eight amendments consisting of four additions to the plan and four deferred to 2025/26 plan), there has been only one further amendment as noted above (deletion of the audit of Delivery of Savings and Investments).

24. The completed internal audit activity and the monitoring of audit actions through the action tracker system enables the Chief Internal Auditor to provide an objective assessment of whether systems and controls are working properly. In addition to the completed internal audit work, the Chief Internal Auditor also uses evidence from other audit activity, including counter-fraud activity, and attendance on working groups e.g., Corporate Governance Assurance Group.

25. In giving an audit opinion, it should be noted that assurance can never be absolute; however, the scope of the audit activity undertaken by the Internal Audit Service is sufficient for reasonable assurance to be placed on Internal Audit's work.

26. A summary of the work undertaken during the year, forming the basis of the audit opinion on the control environment, is shown in Appendix 1.

27. Of the 30 audits undertaken in 2024/25, it is positive to note that there were no audits with the overall conclusion of red. In 2023/24, three audits were graded as red, in 2022/23 one audit was graded red, in 2021/22 one audit was graded

red, and in 2020/21 one audit was graded red. (See also paragraph 36 for trend analysis on individual audit overall conclusions)

28. The overall opinion for each audit, highlighted in Appendix 1, is the opinion at the time the report was issued. The internal audit reports contain management action plans where areas for improvement have been identified, which the Internal Audit Team monitors the implementation of by obtaining positive assurance on the status of the actions from the officers responsible. The current status of those actions is also highlighted, in Appendix 1, for each audit. Reports on outstanding actions have been routinely reported to Directors and the Audit & Governance Committee. The Chief Internal Auditor's opinion set out below considers the implementation of management actions.

29. As part of governance arrangements developed when Oxfordshire County Council joined the Hampshire Partnership in July 2015, it was agreed that the Southern Internal Audit Partnership (SIAP) would provide annual assurance to Oxfordshire County Council on the adequacy and effectiveness of the framework of governance, risk management and control from the work carried out by the partnership, via the Integrated Business Centre (IBC). Due to the onboarding of three additional partners, since 2019/20 the assurance arrangements were amended. The Hampshire Partnership/IBC commissioned Ernest and Young (EY) to undertake a Service Organisation Controls review under International Standard on Assurance Engagements (ISAE 3402). This provides a framework for reporting on the design and compliance with control objectives related to financial reporting. In addition to this Partners can separately take a view on any additional risk-based pieces of assurance work that could be commissioned from SIAP covering any core elements of the control environment.

30. The ISAE 3402 report covering both the design and operating effectiveness of the internal control environment for 2024/25 has been made available to the Executive Director of Resources and the Chief Internal Auditor. This report provides assurance on the operation and effectiveness of internal controls across; Purchase to Pay, Order to Cash, Cash & Bank, HR & Payroll and IT General Controls. It has been confirmed that there are no substantial risks in relation to the control objectives within these areas.

31. The anti-fraud and corruption strategy remains current and relevant. In 2024/25 the Audit and Governance Committee and Audit Working Group have been updated on reported instances of potential fraud. Most of these are minor in nature. Work has been undertaken to address the control weaknesses identified in each area identified to reduce the possibility or reoccurrence.

32. Internal Audit continue to manage the National Fraud Initiative data matching exercise which is completed once every two years. Key matches are investigated, and results are reported to the Audit & Governance Committee in the quarterly updates.

33. It should be noted that it is the responsibility of management to operate the system of internal control, not Internal Audit's responsibility. Furthermore, it is management's responsibility to determine whether to accept and implement recommendations made by Internal Audit or, alternatively, to recognise and accept risks resulting from not taking action. If the latter option is taken by

management, the Chief Internal Auditor would bring this to the attention of the Audit & Governance Committee.

34. The matters raised in this report are only those which came to Internal Audit's attention during the internal audit work and are not necessarily a comprehensive statement of all the weaknesses that exist, or of all the improvements that may be required.

35. In arriving at the annual opinion, The Chief Internal Auditor has taken into account:

- The results of all audits undertaken as part of the 2024/25 audit plan;
- The results of follow up action taken in respect of previous audits;
- Whether or not any priority 1 actions have not been accepted by management - of which there have been none;

  (Priority 1 = Major issue or exposure to a significant risk that requires immediate action or the attention of Senior Management. Priority 2 = Significant issue that requires prompt action and improvement by the local manager)

- The effects of any material changes in the Council's objectives or activities.
- Whether or not any limitations have been placed on the scope of Internal Audit – of which there have been none.
- Assurance provided by ISAE 3402 report, covering both the design and operating effectiveness of the Hampshire Partnership/IBC internal control environment.
- Corporate Lead Assurance Statements on the key control processes, that are co-ordinated by the Corporate Governance Assurance Group (of which the Chief Internal Auditor is a member of the group), in preparation of the Annual Governance Statement.

Chief Internal Auditors Annual Opinion

In my opinion, for the 12 months ended 31 March 2025, there is **satisfactory** assurance regarding Oxfordshire County Council's overall control environment and the arrangements for governance, risk management and control.

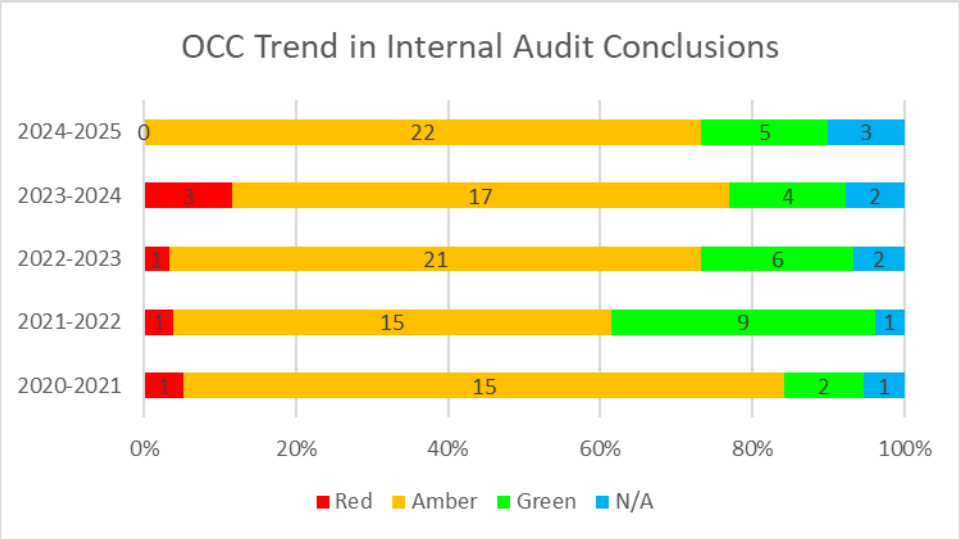
Where weaknesses have been identified through internal audit review, we have worked with management to agree appropriate corrective action and timescale for improvement.

This opinion will feed into the Annual Governance Statement which will be published alongside the Annual Statement of Accounts.

Oxfordshire County Council's Internal Audit service conformed to the Public Sector Internal Audit Standards (2017) during the year ending 31 March 2025.

See appendix 2 for definitions of overall assurance opinion.

36. The following table shows the percentage trend in individual audit conclusions.



Audits completed since last report to Audit and Governance Committee

37. The outcomes of the audits, including a summary of the key findings are reported quarterly to the Audit & Governance Committee. The summaries of the audits completed since the last report (March 2025) are attached as Appendix 3.

- Independent Reviewing Officers
- Schools Section 151 Assurance
- Pensions Administration
- Utilities Management
- Retention Employee Feedback
- Void Management
- Mandatory Training
- EHCP Tops Ups
- Planning Application Appeals
- Client Charging

38. Since the last report to the March 2025 Audit & Governance Committee the following grant certifications have been completed:

- SIPP Grant Certification for 2023/24 & 2024/25 (Smart Infrastructure Pilots Programme).
- 5GIR 2024/25 (5G Innovation Regions Programme)

Internal Audit Performance

39. The following table shows the performance targets agreed by the Audit and Governance Committee and the actual 2024/25 performance.

40. Issues, including the Principal Auditor being on maternity leave for the first half of 2024/25, performance targets not always met by the external contractor used for six audits during 2024/25, and another member of staff being on long term sickness absence for the second half of 2024/25 have impacted on the achievement of the service's performance indicators. Achieving the target date for the exit meeting for each audit assignment will continue to be area of focus for improvement. Performance for the timely issue of draft and final reports on completion of audit fieldwork, however, has continued to be good.

41. Completion of the 2024/25 plan has overrun by 4 weeks. 78% of the plan (including grant certification work) was completed by the end of April 2025, for the remaining audits all audit fieldwork was completed, however draft reports were still being agreed during May 2025. All audits have now been finalised.

42. Internal Audit are pleased to report the continued improvement in the implementation of management actions by the organisation, with the majority implemented or not yet due (80%).

43. Internal Audit customer satisfaction questionnaires continue to provide positive feedback.

Measure	Target	Actual Performance 2024/25 – as at 08/05/2025
Elapsed time between start of the audit (opening meeting) and the Exit Meeting	Target date agreed for each assignment by the Audit Manager, no more than three times the total audit assignment days	61% of the audits met this target. 2023/24 67% 2022/23 67% 2021/22 59% 2020/21 50%
Elapsed time for completion of the audit work (exit meeting) to issue of draft report	15 Days	82% of the audits met this target. 2023/24 96% 2022/23 93% 2021/22 86% 2020/21 85%
Elapsed time between receipt of management response to the draft report and the issue of the final report	15 Days	100% of the audits met this target. (Previously measured issue of draft report to the issue of the final report) 2023/24 100% 2022/23 100% 2021/22 66% 2020/21 80%
% of Internal Audit planned activity delivered	100% of the audit plan by end of April 2024.	78% of the plan was completed by the end of April 2025 (including grant certification work). 2023/24 100% 2022/23 83% 2021/22 87% 2020/21 74%
% of agreed management actions implemented within the agreed timescales	90% of agreed management actions implemented	As at end of April 2025: 748 actions being monitored on the system. • 74% implemented • 6% not yet due • 16% partially implemented • 4% overdue
Customer satisfaction questionnaire (Audit Assignments)	Average score < 2 1 - Good 2 – Satisfactory 3 – Unsatisfactory in some areas 4 – Poor	Average score was 1.2 2023/24 1 2022/23 1.2 2021/22 1.1 2020/21 1.06
Directors' satisfaction with internal audit work	Satisfactory or above	Review of effectiveness of internal audit completed by Monitoring Officer in September 2023 and reported to the Audit & Governance Committee in November 2023 – Satisfactory

Financial Implications

44. There are no direct financial implications arising from this report.

Comments checked by: Lorna Baxter, Executive Director of Resources
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Legal Implications

45. There are no direct legal implications arising from this report.

Kim Sawyer, Interim Head of Legal and Governance,
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Staff Implications

46. There are no direct staff implications arising from this report.

Equality & Inclusion Implications

47. There are no direct equality and inclusion implications arising from this report.

Sustainability Implications

48. There are no direct sustainability implications arising from this report.

Risk Management

49. There are no direct risk management implications arising from this report.

Sarah Cox, Chief Internal Auditor, May 2025.

Annex:	Annex 1: Overall conclusion and management action implementation status of 2024/25 audits Annex 2: Annual assurance opinion definitions Annex 3: Executive Summaries of Audits finalised since last report to Audit and Governance Committee.
Background papers:	None.
Contact Officer:	Sarah Cox, Chief Internal Auditor Sarah.cox@oxfordshire.gov.uk

APPENDIX 1 - Overall conclusion and management action implementation status of 2024/25 audits

Audit	Status	Conclusion	No of Mgmt Actions Agreed	Reported implementation status as at 21/05/2025
Cross Cutting				
Transformation - Programmes & Major Projects.	Final Report	Amber	13	7 implemented, 3 not yet due, 3 overdue
Strategic Contract Management	Final Report	Amber	12	1 implemented, 11 partially implemented
Social Value Policy	Final Report	Amber	8	8 implemented
Conflicts of Interest & Gifts and Hospitality	Final Report	Amber	12	6 implemented, 3 overdue, 2 not yet due, 1 partially implemented
Joint Internal Audit & Counter Fraud proactive review – Travel Mileage	Final Report	Amber	6	2 implemented, 2 not yet due, 1 overdue, 1 partially implemented
Delivery of Savings & Investments	Audit removed from plan	n/a	-	-
Follow Up – 2023/24 audits (Addition to plan)	Final Report	n/a	-	-
Childrens				
Independent Reviewing Officer	Final Report	Amber	14	7 not yet due, 7 overdue
Transformation Programme – including Financial Management	Deferred until 25/26 plan	-	-	-
Direct Payments	Final Report	Amber	35	16 implemented, 4 overdue, 15 partially implemented
Supported Families	Complete	n/a	-	-
EYES & LIFT - IT Application Review	Final Report	Amber	8	6 implemented, 2 partially implemented
Primary School 1	Final Report	Amber	36	31 implemented, 5 partially implemented
Multiply Grant (Addition to plan)	Final Report	n/a	3	3 overdue

Education Health Care Plan Top ups (Addition to plan)	Final Report	Amber	12	12 not yet due
Adults				
Client Charging	Final Report	Amber	11	10 not yet due, 1 implemented
Void Management	Final Report	Amber	14	14 not yet due
Discharge to Assess	Deferred until 25/26 plan	-	-	-
Property				
Property Strategy Implementation	Final Report	Green	1	1 partially implemented
Utilities Management	Final Report	Green	3	3 not yet due
Workforce & OD				
Recruitment – Applicant Tracking System	Deferred until 25/26 plan	-	-	-
Mandatory Training	Final Report	Amber	5	5 not yet due
Retention – Employee Feedback	Final Report	Amber	8	8 not yet due
Finance				
Pensions Administration	Final Report	Green	6	3 implemented, 3 not yet due
Schools S151 Assurance	Final Report	Amber	22	2 implemented, 20 not yet due
IT				
Identity and Access Management	Final Report	Amber	11	2 implemented, 1 overdue, 8 partially implemented
Artificial Intelligence	Final Report	Amber	13	1 implemented, 3 overdue, 9 partially implemented
Cyber Security	Final Report	Green	4	3 implemented, 1 partially implemented
Data Management and Utilisation	Final Report	Amber	10	2 implemented, 7 not yet due, 1 overdue
Corporate Website	Final Report	Amber	8	7 implemented, 1 partially implemented
Customers & Cultural Services				
Library System – IT Application review	Final Report	Amber	11	11 implemented
Environment & Highways				
Highways (new contract mobilisation)	Final Report	Green	2	2 partially implemented
Income Collection & Parking Account	Final Report	Amber	11	11 partially implemented

HIF1 (Didcot Garden Town Housing Infrastructure Fund)	Deferred until 25/26 plan	-	-	-
Environment & Place				
Planning Application Appeals (Addition to plan)	Final Report	Amber	7	7 not yet due
S106 – New IT System	Deferred until 25/26 plan	-	-	-

Grant Certification work completed during 2024/25:

- Local Authority Delivery Grant, Phase 3 (LAD3)
- Local Transport Capital Block Funding grant for 2023/24, no 31/6680 and 31/6681
- Local Authority Bus Subsidy (Revenue) Grant, 2023/24, 31/6909
- Disabled Facilities Grant 2023/24, initial grant allocation (grant determination reference 31/6672) and additional allocation (grant determination 31/6833).
- SIPP Grant Certification for 2023/24 & 2024/25 (Smart Infrastructure Pilots Programme).
- 5GIR 2024/25 (5G Innovation Regions Programme)

APPENDIX 2

Overall annual opinion – definitions based upon framework recommended by Institute of Internal Auditors.

Substantial

There is a sound framework of control operating effectively to mitigate key risks, which is contributing to the achievement of business objectives.

- no individual audit engagement graded as "red" or significant "amber".
- occasional medium risk rated weaknesses identified in individual audit engagements although mainly only low/efficiency weaknesses.
- internal audit has confidence in managements attitude to resolving identified issues.

Satisfactory

The control framework is adequate and controls to mitigate key risks are generally operating effectively, although a number of controls need to improve to ensure business objectives are met.

- medium risk rated weaknesses identified in individual audit engagements.
- isolated high risk rated weaknesses identified for isolated issues.
- no critical risk rated weaknesses were identified.
- internal audit is broadly satisfied with management's approach to resolving identified issues.

Limited

The control framework is not operating effectively to mitigate key risks. A number of key controls are absent or are not being applied to meet business objectives.

- significant number of medium and/or critical risk rated weaknesses identified in individual audit engagements.
- isolated critical and/or high risk rated weaknesses identified that are not systemic.
- internal audit has concerns about managements approach to resolving identified issues.

No Assurance

A control framework is not in place to mitigate key risks. The organisation is exposed to abuse, significant error or loss and/or misappropriation. Objectives are unlikely to be met.

- serious systemic control weaknesses identified through aggregation of individual audit engagements.
- significant number of critical and/or high risk rated weaknesses identified for isolated issues.
- internal audit has serious concerns about managements approach to resolving identified issues.

APPENDIX 3

Summary of Completed 2024/25 Audits since last reported to the Audit and Governance Committee – March 2025.

Independent Reviewing Officer 24/25

Overall conclusion on the system of internal control being maintained	**A**

RISK AREAS	AREA CONCLUSION	No of Priority 1 Management Actions	No of Priority 2 Management Actions
A: Governance and Training	**A**	**0**	**3**
B: Monitoring	**A**	**0**	**2**
C: Chairing the Child's Review	**A**	**0**	**9**
		0	**14**

Opinion: Amber	
Total: 14	Priority 1 = 0 Priority 2 = 14
Current Status:	
Implemented	0
Due not yet actioned	7
Partially complete	0
Not yet Due	7

The audit found that overall, there are clearly defined responsibilities and detailed guidance for key aspects of the Independent Review Officer (IRO) process. Areas for improvement were noted in relation to training and declaring conflicts, communication of changes in the child's circumstances by the social workers, issues with respect to chairing a child's review, including non-adherence to the required meeting timelines and documentation requirements, and monitoring of escalations.

A Governance and Training – The roles, responsibilities and accountabilities of the IROs are governed by the IRO Handbook, various legislation (e.g. The Children Act 1989), OCC Practice Standards as well as the Escalations process. These documents provide clarity on reporting lines, escalation paths, decision-making processes as well as requirements in relation to maintaining independence. We noted that it is the IROs responsibility to declare any conflicts of interest independence issues with their supervisor at the time cases are allocated to them, however there is no formal method of capturing this declaration (e.g. via a self-declaration form logged in LCS). As such, there is a risk that IROs may not be consistently or adequately declaring their

independence, which may lead to non-compliance with legal and regulatory requirements.

A mandatory training plan for IROs is provided through the Learning Zone. This is supplemented by an annual development plan to help facilitate continuous learning and progression. The annual development plan includes team meetings, face-to-face training and development sessions. Although line managers are provided with automated emails from the Learning Zone for monitoring purposes, a mechanism to have oversight over training compliance rates for all IROs at an overarching level, comprising all the different training sessions and meetings, is not in place and regularly reported to senior management.

Monthly Delivering Quality Improvement in Practice and Performance (What Good Looks Like Self Evaluation) (DQIPP) meetings are conducted to discuss what is working well, improvements identified and IRO concerns. On an annual basis, a report is compiled providing a qualitative and quantitative analysis on the overall performance of the function. The report covers the role and purpose of the IRO, service structure and staffing, quantitative analysis, performance and quality assurance monitoring and IRO service priorities.

Data on IRO caseloads is available via the Children We Care For (CWCF) tracker using PowerBI and is monitored by management on a weekly basis. Although the monitoring control is in place and operating effectively, we noted that as of January 2025, the current average IRO caseload stands at 63. This is approaching the upper limit of the guidance threshold outlined in the IRO Handbook (50 – 70 cases). Currently, no formal strategies or plans exist to ensure effective management of IRO caseloads numbers to ensure thresholds are not exceeded.

B Monitoring – The monitoring role of the IRO relates to how an IRO monitors and oversees cases in-between formal review meetings. Between formal reviews, if the care plan continues to meet the needs of the child there may be no need for any communication between the IRO and the social worker of the child. However, in the event of a change/ event in the child's life that is significant (e.g., placement changes, educational changes and family circumstances), social workers must inform the IRO, and the change/ event should be logged in LCS for record-keeping and documentation purposes. It was noted by management that IROs are not consistently being notified of such changes. The reason provided is that social workers do not appear to fully understand what constitutes a change in circumstances. The LCS system also lacks the functionality to flag and notify IROs of any significant changes, which reduces the effectiveness of the system being used as a monitoring tool.

Midpoint checks are the main mechanism used by IROs to ensure that progress of the care plan is on track and to address any issues or changes in circumstances that may arise. The meetings should always include the case social worker. This provides a forum for changes to be communicated (in case not already communicated at the time of the change). The IRO can also involve other relevant professionals (e.g. foster carers) as required. We noted that from August 2024, a template was developed and integrated into the LCS system to help capture and log notes and actions from midpoint review meetings. From January 2025, management have been collating and reporting on data internally around the completion of midpoint reviews. These two mechanisms are now ensuring that midpoint reviews are captured in LCS and are being performed in a consistent and effective manner.

C Chairing the Child's Review – Requirements and timescales in relation to chairing review meetings is outlined in the IRO Handbook. This is further supplemented by the OCC Practice Standards document, which provides more specific guidance on responsibilities, objectives and expectations. Sample testing performed over the review meeting process flagged several exceptions relating to first, second and subsequent review meetings being held outside of timescales and pre-review meeting reports not being uploaded to LCS in a timely manner.

All documentation related to a child's case is recorded on the LCS system. An internal tracker is also maintained by the team, which logs and contains details regarding cases, escalations and progress. Review meeting dates are recorded in both the internal tracker and the LCS system. There is scope for reconciling the two to validate the quality of data within LCS that is used for monitoring and reporting purposes.

The QUAD system is the main mechanism used by IROs to escalate issues, risks and concerns e.g. surrounding drift and delay or any part or aspect of the child's care plan that is not moving at the speed expected. We noted examples where social workers are not responding to escalations in a timely manner, where IROs are not effectively monitoring QUAD to check the status of escalations and where IROs are escalating issues outside of QUAD (i.e. informally), which limits the ability of social workers and IROs to maintain visibility and effectively monitor escalations raised.

We also identified that although there is a formal quality assurance management checking process in operation over adherence to IRO related processes, guidelines and timelines, there is no reporting to senior management or oversight of this process at present.

Schools Section 151 Assurance 24/25

Overall conclusion on the system of internal control being maintained	**A**

RISK AREAS	AREA CONCLUSION	No of Priority 1 Management Actions	No of Priority 2 Management Actions
Overall Oversight	A	1	1
Training (School Staff & Governors)	A	0	2
Schools Financial Value Standard (SFVS)	A	0	3
Budget Setting and Monitoring	A	0	8
Education Finance Service	A	1	0
Banking and Purchasing Cards	A	0	3
Financial Policies and Procedures	A	0	3
School Improvement	G	0	0

		2	**20**

Opinion: Amber	
Total: 22	Priority 1 = 2 Priority 2 = 20
Current Status:	
Implemented	2
Due not yet actioned	0
Partially complete	0
Not yet Due	20

There are a number of different Council teams, including the Finance Business Partnering Team, Education Finance Service (EFS), School Improvement and Governor Services, which provide support, guidance and / or training to the Council's maintained schools on finance and financial management processes and governance. These teams, along with others within Corporate Finance and HR, have a level of oversight of arrangements in place through their interactions with schools. They are therefore able to contribute to the assurance that can be provided to the S151 Officer that financial management and governance arrangements within these schools are sound and are in line with key frameworks including the Scheme for Financing Schools and the Financial Manual of Guidance. Within these interactions, there are opportunities to provide assurance and identify where there is a need for performance improvement, however there is currently a lack of systematic and consistent coordination between the different sources of assurance.

Findings from recent Internal Audit and Counter Fraud activity, together with the findings from this audit, note that whilst there is evidence that some examples of poor financial management in individual schools are being identified and flagged, this is not as a result of a systematic and consistent process. Furthermore, where poor performance is noted, there is currently no mechanism or process to ensure that there is proper review and consideration across all assurance sources to confirm whether there are wider issues which need to be addressed.

The Finance Business Partnering Team have a core responsibility for monitoring the financial management arrangements within maintained schools and rely on information from other teams in order to do this. We have confirmed that there are processes in place for key teams, including EFS and School Improvement, to feedback to and work collaboratively with Finance Business Partnering, to identify and provide further assistance to schools where concerns are identified, however this does not provide comprehensive and systematic oversight across the different sources of assurance. There is scope to strengthen and widen these arrangements to ensure that instances of poor financial management practices identified by any of the teams which provide assurance can be co-ordinated, shared and considered across all different teams involved. The importance of the development of a more collaborative approach has been highlighted by recent Internal Audit and Counter Fraud work which has demonstrated how poor financial management practices in one area often indicate poor financial management practices in others. Without systematic information sharing, collaboration and discussion, there is a risk that inappropriate practices or non-compliance will be missed or will not be resolved promptly and that the assurance the Finance Business Partnering team have will be incomplete.

Pensions Administration 2024/25

Overall conclusion on the system of internal control being maintained	**G**

RISK AREAS	AREA CONCLUSION	No of Priority 1 Management Actions	No of Priority 2 Management Actions
Regulatory Framework	**G**	**0**	**6**
Scheme Employer & Member Lifecycle	**G**	**0**	**0**
Debtor Management	**G**	**0**	**0**
		0	**6**

Opinion: Green	
Total: 6	Priority 1 = 0 Priority 2 = 6
Current Status:	
Implemented	3
Due not yet actioned	0
Partially complete	0
Not yet Due	3

Overall, audit testing found that controls and processes in relation to Pensions Administration are strong and working well. Since the previous audit, there have been significant changes in senior management within the service with a new Pension Services Manager and Head of Pension Fund appointed and in post. Both posts appear well established with new arrangements working well. It has been reported that there is work ongoing in areas where process improvements have been identified as necessary.

Regulatory Framework

An updated General Code of Practice was published by the Pensions Regulator in March 2024 with compliance required by the end of March 2025. Compliance across the service has been reviewed with progress reported to the Pension Fund Committee. An independent oversight and challenge exercise which will review compliance is due to be undertaken during 2025/26.

There is a project ongoing to progress action needed following on from the McCloud judgement (this is a court ruling which provides a remedy following Government reforms to public service pension schemes in 2014 and 2015 which have been found to potentially disadvantage some scheme members), which must be concluded, and any changes required to pension records by the statutory deadline of August 2025. Progress in the review and updating of scheme member records is being monitored on a weekly basis within the service and project progress is reported to the Pension Fund Committee.

There is also a project ongoing to implement the Pensions Dashboard, this is a national requirement which will enable individuals to view information on their different pensions in one place. This project appears to be on track with progress being reported to the Pension Fund Committee.

The team continue to monitor and report on performance against SLA targets, with routine reporting to the Pension Fund Committee. There is work ongoing to make performance reporting more efficient, comprehensive and system driven where possible. Further improvements are being made to enable comparison of performance across reporting periods and to review and refine what is being reported on the activity of the different teams within the service.

Staffing continues to be an issue with existing vacancies contributing to resourcing pressures within the team. It was reported that a workforce strategy has been developed and approved by Pension Fund Committee with additional budget to develop the workforce and build resilience within the service.

Scheme Employer & Member Lifecycle

The original modules identified for implementation as part of Administration to Pay system are all now live. Implementation of the enhanced version of this system is now being considered in order to further automate processes and reduce manual interventions where possible.

Sample testing completed as part of the audit confirmed that key administration processes are operating effectively for the cases sampled.

Debtor Management

Pension fund debts are managed by the Income and Banking team with a Standard Operating Procedure (SOP) in place. Debts are being reviewed on a monthly basis with the updated status being communicated to and / or any queries being discussed with the Pensions Administration team. Historic debts noted as outstanding during previous audits have now been resolved and the debt position is now significantly improved. The debtor position is reported on to the Pension Fund Committee as part of the Administration report on a quarterly basis.

Follow Up – there was 1 management action outstanding from the 2012/22 Pensions Administration audit and 3 management actions agreed as part of the 2023/24 audit. These have been confirmed as fully implemented.

Utilities Management 2024/25

Overall conclusion on the system of internal control being maintained	**G**

RISK AREAS	AREA CONCLUSION	No of Priority 1 Management Actions	No of Priority 2 Management Actions
Governance:	**A**	**0**	**3**
Operational Processes:	**G**	**0**	**0**
Financial Management:	**G**	**0**	**0**
		0	**3**

Opinion: Green	
Total: 3	Priority 1 = 0 Priority 2 = 3
Current Status:	
Implemented	0
Due not yet actioned	0
Partially complete	0
Not yet Due	3

Introduction

The Council has a predominantly centralised property asset management operating model, with the majority of associated resource, budgets, and contracts consolidated in Property & Assets. With regard to utilities, exceptions to this include street lighting (managed within Environment and Highways), and gypsy and traveller sites (managed by the Gypsy and Traveller Service, which, while part of Property & Assets, is managed independently of the corporate sites). For maintained schools, the metering portfolio is managed centrally by Property & Assets, with payments being the responsibility of individual schools.

The audit found a strong system of internal control in relation to utilities management across the teams and services responsible. While there is the opportunity to strengthen guidance and procedure notes for key processes within utilities management, it was evident throughout the audit that there is a clear understanding of roles and responsibilities, robust controls in place to ensure the accuracy and timely payment of invoices, and appropriate monitoring and oversight in place to identify issues and problems (e.g. a water leak). Budget management was also found to be operating effectively.

Governance

Roles and responsibilities in relation to key processes within utilities management were found to be clearly understood by the officers and teams involved, noting that those teams benefit from highly knowledgeable and experienced staff. However, there is a lack of documented procedures in some areas, which could result in

inconsistencies, errors and omissions within key control processes, especially in the event of staff absence or turnover.

It is acknowledged that for corporately managed utilities (managed by Property & Assets), there are written procedures covering operational processes, however the current guidance does not cover financial forecasting. It was also noted that no guidance is in place for the management of street lighting and highways assets, which sits within Environment & Highways. Another key activity, managing the metering portfolio (within Property & Assets) would also benefit from being documented, however it is noted the intention is that this will be carried out after the forthcoming Market-Wide Half Hourly Settlement (MHHS) reforms to the electricity industry, which will have a significant impact on the Council's metering arrangements, allowing improved billing accuracy due to the requirement of half hourly data from smart meters, rather than some bills being based on estimated usage.

Operational Processes

There are separate processes in place to manage the Council's metered portfolio (e.g. buildings) and the unmetered portfolio (e.g. street lighting and highways assets). Operational processes to ensure that utilities across council assets are appropriately monitored and managed were found to be working effectively. There are robust controls in place to identify and investigate anomalies, such as unexpected fluctuations in usage, with sample testing confirming the investigations are being carried out promptly and resolved appropriately.

The majority of the metered utilities are managed through the Property & Assets Directorate as part of the Corporate Landlord function. It is noted that there may be small pockets of utilities being managed independently of the Property & Assets Directorate; this risk is recognised by the service with work ongoing to ensure such pockets are brought within the Corporate Landlord function where appropriate.

The audit also considered how the management of utilities aligns with the Council's development of cost-effective schemes for energy and water efficiency and low carbon measures, acknowledging that the ideal approach to implementing such schemes can result in a trade-off between reducing costs and reducing carbon emissions.

Financial Management

Expenditure on utilities (electricity, gas and water) in 2024/25 was £5.45m (not including maintained schools).

Budget Monitoring and Forecasting

Acknowledging the considerable challenge the volatile energy market presents to budget management, the monitoring and forecasting arrangements for such budgets were found to be working effectively. Cost centres managers were clear on their responsibilities, with support from Corporate Finance as appropriate.

Payments

While processes for ensuring payments are made accurately and promptly vary depending on whether the utility is metered or unmetered, payment processes were found to be operating effectively. Payments for metered utilities are based on contractual arrangements for standing charges plus consumption. There is a robust validation process in place to ensure that invoices are correct, with any anomalies flagged for investigation. Audit testing confirmed this process is happening as

expected with issues investigated and resolved as appropriate. Charges for unmetered supply are based on the detailed, automated inventory of what the equipment is and how much energy it consumes during operation. This data is validated as part of the data submission and invoicing process.

It was reported across the different teams responsible for utilities that the accuracy of invoices from one particular utility provider was resulting in numerous issues leading to additional work and delays in payments. It was positive to note that as part of standard contract management processes communication has been ongoing with the provider, with a noted improvement in the issues. This is being kept under review with regular meetings taking place with the supplier, with attendance from relevant teams within the Council as appropriate.

Recharges

For the buildings managed by Property & Assets, utilities are initially paid from a central budget then recharged to the individual building's Statistical Internal Order (SIO) to enable analysis and oversight of buildings' costs. Sample testing confirmed this process is working effectively, with recharges being made accurately and on a timely basis.

Retention – Employee Feedback 24/25

Overall conclusion on the system of internal control being maintained	**A**

RISK AREAS	AREA CONCLUSION	No of Priority 1 Management Actions	No of Priority 2 Management Actions
A: Governance, Policies and Procedures	**A**	**1**	**0**
B: Feedback Mechanisms	**A**	**0**	**7**
C: Monitoring and Reporting	**A**	**0**	**0**
		1	**7**

Opinion: Green	
Total: 3	Priority 1 = 0 Priority 2 = 3
Current Status:	
Implemented	0
Due not yet actioned	0
Partially complete	0
Not yet Due	3

The Council is committed to being an Employer of Choice which includes improving employee retention and understanding the factors that influence staff satisfaction and engagement. To achieve this, various feedback mechanisms are used to gather

insights from employees across all levels of the Council. The key mechanisms utilised by the Council to obtain feedback from employees are engagement surveys and exit interviews. There is also a Raising Concerns (grievances) policy for employees and associated guidance on how these are dealt with. Other mechanisms for obtaining employee feedback include ongoing employee and manager performance and wellbeing discussions, the Colleague Forum and via Equality, Diversity and Inclusion (EDI) Networks.

Overall, we noted that although employee feedback mechanisms are in place, there is an opportunity to improve the effectiveness of the individual mechanisms and provide better oversight by collectively analysing the information to provide a holistic view. This will help identify key themes and areas for improvement to support employee satisfaction and retention.

A: Governance, Policies and Procedures

There is currently no overarching framework that enables comprehensive oversight across the various feedback mechanisms and how they collectively inform and influence employee retention. Action plans to respond to feedback are developed at a service level without a holistic view and with limited HR and employee visibility of the improvements made. Management are already aware and addressing this issue as part of an ongoing 'Engagement' project which is looking to establish an overarching governance framework. This will involve redefining what employee engagement means within the Council and implementing a cohesive approach for managing feedback effectively to help retain staff. The Council has established a working group of senior leaders and engagement specialists to lead this initiative.

B: Feedback Mechanisms

There is a defined process for exit interviews, which involves the quarterly collation and reporting of exit interview results with HR Business Partners across services. Results should then be cascaded down to individual services to action however there is no central visibility of action/improvement plans that services may be implementing; therefore, it is unclear if changes to support retention are being taken at a service level. It is noted that there is a low completion rate of exit interviews, which is an optional process. This is acknowledged by management who report that this may be due to a perceived lack of value or trust and are exploring methods to improve this.

As part of the Engagement project, improvements are currently being made to the employee engagement survey process. These include the commissioning of a new survey provider which will tailor future employee engagement surveys to the Councils objectives and further improve the feedback sought from employees.

The policies in relation to the management of employee grievances have recently been reviewed and updated. Areas where additional improvements are required were noted as the retention of formal documentation on case risk management meetings and monitoring controls regarding the timeliness of the management of grievance cases.

C: Monitoring and Reporting

Reporting is in place for the three employee feedback mechanisms reviewed as part of this audit. However, this consists of sharing the raw data rather than any detailed and combined analysis to determine strategic insights or themes. This reduces senior management's ability to proactively address retention challenges and impacts on the

effectiveness of decision-making processes to drive meaningful organisational improvements.

Void Management 24/25

Overall conclusion on the system of internal control being maintained	A

RISK AREAS	AREA CONCLUSION	No of Priority 1 Management Actions	No of Priority 2 Management Actions
A: Governance	A	0	3
B: Demand and Resource Management	A	0	3
C: Void Management	A	0	6
D: Performance Monitoring	A	0	2
		0	14

Opinion: Amber	
Total:14	Priority 1 = 0 Priority 2 = 14
Current Status:	
Implemented	0
Due not yet actioned	0
Partially complete	0
Not yet Due	14

Positive developments were noted including the creation of an Asset Register, which will centralise data on voids and placements, and steps being taken towards defining occupancy targets. However, the audit noted that there is still work to be done to ensure a robust, data led voids management process, supported by sound governance and performance monitoring. Clearly defining and streamlining governance structures, developing data led management tools and utilising performance metrics will improve the management of voids going forward.

A: Governance - The audit noted that there are several governance groups in operation who are responsible for void management. Some of the governance and reporting structures are not fully defined and documented. We also noted a lack of formally documented policies and procedures for the detailed end-to-end processes in relation to void management across the four categories reviewed. We noted that there is the potential for duplication of void related discussions across the governance groups and teams. There is an opportunity to review and streamline these structures.

B: Demand and Resource Management - Management are in the process of developing a new Asset Register which will be a positive step towards improving the management and oversight of placements and voids. All placement and void data will

be in one place. The Asset Register will remove the need for manual void spreadsheets and the Care Booking System, which will no longer be in operation post November 2025. However, the audit noted that the demand for Adult Social Care placements and how this links into the Asset Register is not yet confirmed. The process for managing demand is manual in nature and is currently managed outside of the Asset Register, which prevents management from having a clear and effective view of demand vs availability. Whilst target occupancy rates for certain contracts, such as OSJ (Order of St John's) and supported living, have recently been established, other categories still lack defined targets. Monitoring processes across contracts have not yet been developed. The absence of formal processes to monitor and report on these rates could impact on the ability to efficiently allocate resources and anticipate service needs.

C: Voids Management - The audit found that the Asset Register is not yet utilised as a tool for allocating OSJ placements (the largest block contract within Adult Social Care). These placements are currently managed manually through multiple spreadsheets. This could impact on the accuracy and completeness of the data recorded. Transitioning to the use of the Asset Register will improve data accuracy, completeness, efficiency and effectiveness of the voids management process. There is a reliance on manual notifications of voids from some providers, such as OSJ. This could mean that voids stay unfilled for longer if the notification is delayed. Other providers use a mandatory form process that once completed and submitted to the Council, automatically populates in the Asset Register e.g. supported living. Extending this automated system to other categories could enhance void management. It was noted there are no formal void management plans in place for each service category to enable efficient and effective void management.

D: Performance Monitoring - The audit highlighted the absence of formal key performance indicators (KPIs) for void management, which limits the ability to systematically assess performance in maximising the use of block contracts. Although some progress has been made in defining target occupancy rates, further discussions are needed to establish meaningful KPIs across the different block contract categories. Once KPIs are fully defined, there are opportunities to explore the full potential of PowerBI reporting from the Asset Register. Implementing robust performance metrics and reporting tools will assist in effectively and proactively managing voids.

Follow up:

We followed up on the implementation of 12 actions arising from the 2020/21 Order of St John's Contract Management audit.

- 4 out of 12 actions have been confirmed as having been fully implemented by management. These actions relate to brokerage performance monitoring, retention of evidence of vacancy notifications, outlook mailbox configuration and analysing void costs.
- The remaining 8 actions were either found not to have been effectively implemented or are no longer applicable. These previous actions related to the following up and escalation of late notifications, the block bed allocation process, the block bed spreadsheet, system controls and guidance for the Care Booking System and the void calculation verification and invoicing process. The remaining risk exposures will be addressed through implementation of management actions agreed within this report.

Mandatory Training 24/25

Overall conclusion on the system of internal control being maintained	**A**

RISK AREAS	AREA CONCLUSION	No of Priority 1 Management Actions	No of Priority 2 Management Actions
A: Governance, Roles & Responsibilities	**A**	**0**	**3**
B: Quality Assurance Processes	**G**	**0**	**0**
C: Performance Monitoring & Reporting	**A**	**0**	**2**
		0	**5**

Opinion: Amber	
Total:5	Priority 1 = 0 Priority 2 = 5
Current Status:	
Implemented	0
Due not yet actioned	0
Partially complete	0
Not yet Due	5

Positive progress has been noted in the oversight and reporting on mandatory induction training for all staff and on elements of mandatory training for managers. A dashboard has been developed and implemented which reports on completion rates and enables monitoring and oversight of non-completion and is updated on a monthly basis. Additional improvements to the oversight and monitoring of role and service specific mandatory training would strengthen this further and would provide senior management with more complete and comprehensive assurance over the Council's mandatory training requirements.

Governance – There is clarity over roles, responsibilities and expectations for the completion of corporate mandatory induction training, essentials for managers training and service specific training within Adults and Children's service areas. Managers are able to access information on corporate mandatory training completed by their direct reports via the Learning Zone platform and there is now corporate oversight of completion of mandatory corporate induction training and some of the mandatory training for managers via the recently developed dashboard. There is a need to develop a process for the identification and oversight of role based mandatory training to provide assurance that this training is completed as required and that content is kept under review to ensure that it remains relevant.

Quality Assurance Processes – There are clear quality assurance processes in place in relation to the mandatory induction training modules, which includes annual review of content with subject matter experts and consideration of learner feedback

provided following course completion. The essentials for managers programme is also kept under regular review to ensure that the content is fit for purpose.

Performance Monitoring & Reporting – A dashboard has been developed and implemented which shows completion rates and information on non-completion of mandatory induction training and some mandatory training for managers. A process for the follow up on non-completion of mandatory courses reported on via the dashboard has also been implemented, along with reporting to senior management. However, there is a lack of agreed consistently applied sanctions where mandatory training is not completed despite numerous reminders.

There is currently no monitoring or reporting on role or service specific mandatory to provide assurance to senior management within those particular service areas, that mandatory training requirements are being met.

EHCP Top Ups 24/25

Overall conclusion on the system of internal control being maintained	**A**

RISK AREAS	AREA CONCLUSION	No of Priority 1 Management Actions	No of Priority 2 Management Actions
A: Funding Allocations	**A**	**0**	**8**
B: Payments	**A**	**0**	**2**
C: Outcomes	**A**	**0**	**2**
		0	**12**

Opinion: Amber	
Total: 12	Priority 1 = 0 Priority 2 = 12
Current Status:	
Implemented	0
Due not yet actioned	0
Partially complete	0
Not yet Due	12

SEN provision includes top up funding which is made up of different processes, involving different teams and validation routines. The audit has focussed on the secondary bonus top up process. It is acknowledged that the service have been looking at changes in approach to the payment of this funding going forward and have been actively trying to make improvements to existing processes where possible. The audit has noted that improvements are required to establish a mechanism which can provide better assurance that EHCP top up funding is being used as intended and outcomes for pupils are being delivered.

Funding Allocations – there is information available to primary, secondary and special schools on what EHCP top up funding is available, although some content was noted to be out of date and areas were noted where greater clarity could be provided on process.

Audit testing focussed on the secondary bonus top up process. Secondary bonus top ups were first paid in 2020/21 through what was initially intended to be a one-off exercise. However, since then, the process has continued on an annual basis to provide additional funding support. As a result, the processes and controls in place in relation to this exercise have evolved resulting in some inherent weaknesses in the approach followed. These top ups involve complex spreadsheet based manual calculations and validation processes, undertaken by two key members of staff. There is no documented guidance for the processes they follow. The way in which information returned by schools is reviewed and evaluated also has the potential for inequity and inconsistency. For example, scrutiny processes involve review of costed provision maps (CPMs) against returns provided by schools detailing the hours of support provided. However CPMs are not requested for all pupils, they do not follow a specified format and minimum information requirements are not clear. This impacts on the effectiveness of the scrutiny process, makes it difficult and time consuming. This is acknowledged within the service and in the longer term, it is agreed that a different approach is required to providing this funding, with work ongoing to determine how this can best be achieved. Prior to implementation of a different approach, improvements in the interim are still required.

From review of the way in which top up funding (element 3) is calculated, it was noted that there is an anomaly in relation to element 2 funding. This is relevant as the element 2 funding is taken into account when calculating top up funding. Guidance for schools on element 2 funding states that schools are expected to meet the first £6K of support for each child with additional needs from their delegated budget, this is in line with government requirements. However, calculations for top up funding are based on the first 15 hours of funding being covered by schools from their delegated budget. This has been discussed at Schools Forum and is in the process of being reviewed by the Service and the Finance Business Partnering team.

Payments – Detailed testing was focussed on the secondary bonus top up process. Testing included review of the accuracy and timeliness of payments made as a result of the 23/24 bonus top up exercise. Although testing did not identify any materials issues with payment accuracy, it was noted that there is currently no reconciliation between calculations and payments made which could delay identification and correction of any errors.

It was noted that secondary bonus top ups reviewed as part of this audit were not made in accordance with the expected timescales communicated to schools. This was due to a combination of factors including delays in receipt of the required information from some schools and the complexity of the checking / validation process. Improvements to the confirmation and communication of information requirements relating to CPM submissions could assist in limiting delays for any future bonus top up exercises.

There were also some accuracy issues with special school top up funding payments made in 24/25 which were identified and resolved by the Finance Business Partnering team prior to this audit. It has been reported that the process for calculating these top ups has been fully reviewed to ensure that payments are accurate in future. It was

also reported that the accuracy of primary and secondary top up funding payments was reviewed and no issues were identified.

Outcomes – SEND provision is funded through a combination of different elements, some of which are directly linked to individual pupils and the specific level of support being provided (e.g. secondary bonus top up, exceptional top up funding and primary top ups) and some of which are not (e.g. element 1 and 2 funding provided via the schools delegated budget and element 3 secondary high needs block funding).

Top up funding cannot be considered in isolation in looking at how provision is funded and whether funding is being used as intended, as this is only part of the picture. In addition, the information requested (the CPM) in relation to secondary bonus top up funding in particular, which links the support being provided by the school back to the EHCP is not provided for all pupils and is not provided in a consistent format. This also complicates any attempt to track funding back from the information which schools are currently expected to have available.

By improving and more effectively targeting the checks and validation of bonus top up returns and by introducing the requirement to provide more specific and accurate detail on the TA support being provided, assurance over whether funding being spent as intended would be improved.

Currently, assurance over outcomes from the SEND provision delivered by the school and funded by the Local Authority using funding mechanisms including top ups can only really be obtained at individual pupils level via the EHCP annual review process.

Planning Application Appeals 24/25

Overall conclusion on the system of internal control being maintained	**A**

RISK AREAS	AREA CONCLUSION	No of Priority 1 Management Actions	No of Priority 2 Management Actions
A: Policies and Procedures	**A**	**0**	**3**
B: Decision Making and Policy Compliance	**A**	**0**	**1**
C: Management of Planning Application Appeals	**A**	**0**	**2**
D: Management Information and Performance Reporting	**A**	**0**	**1**
		0	**7**

Opinion: Amber	
Total: 7	Priority 1 = 0 Priority 2 = 7
Current Status:	
Implemented	0
Due not yet actioned	0
Partially complete	0

Not yet Due	7

Introduction

The management of planning application appeals within the County Council varies depending on which Council is the Local Planning Authority (LPA – the public authority whose duty through legislation is to carry out specific planning functions, including responsibility for determining planning applications). In the event of a planning application appeal for which the County Council is the LPA, it must defend its reasons for refusal to the Planning Inspectorate justifying any S106 planning obligations, which may include contribution requests or direct delivery of infrastructure. In the event of a planning application appeal for which a District Council is the LPA, and where this is a ground for refusal based on a County Council's objection, the County Council may support and assist the District Council in substantiating the County Council's ground/s for refusal, with the teams associated with each refusal reason co-ordinating to submit the evidence and any subsequent rebuttals.

In all cases (whether the County Council or a District Council is the LPA), the County Council must satisfy the Inspector that any planning obligations sought by the County Council meet the test of Regulation 122 of the Community Infrastructure Levy (CIL) Regulations 2010; and must ensure all decisions are legally sound, align with planning policy, and are properly documented. Depending on the type of appeal, attendance may also be required at round table sessions, where the Council takes questions from the Inspector. For appeals where the County Council is the LPA, the appeals process is managed by the Development Management Team. For appeals where the LPA is the District Council, this is done by the Infrastructure Funding Team.

Following a recent District Council appeal case where the Planning Inspector concluded that the District and the County Council acted unreasonably and awarded considerable costs against both the District Council and the County Council, it was agreed an internal audit would take place to provide an evaluation of the adequacy and effectiveness of the internal controls that are in place to manage planning application appeals. It is noted the District Council relevant to this case has also undertaken an internal review; this internal audit has been carried out independently of that review.

While the case referred to was included in the audit sample the audit did not focus exclusively on the details and action taken during this appeal, instead looking at a wider sample to assess the controls in place to manage and monitor appeals.

Overall Findings

The audit has identified opportunities for improvements to strengthen the management of planning application appeals, for both appeals in which the County Council is the LPA and appeals for which a District Council is the LPA. This includes improvements to guidance across the different services involved in appeals, the retention requirements of key documentation and supporting evidence, review of the different systems currently in use to log, track and monitor appeals with a view to improving the consistency and efficiency of approach, ensuring lessons learnt reviews are undertaken and appropriate actions identified, and that management information requirements on appeals data are clearly defined and implemented.

Client Charging 24/25

Overall conclusion on the system of internal control being maintained	**A**

RISK AREAS	AREA CONCLUSION	No of Priority 1 Management Actions	No of Priority 2 Management Actions
A: Policies & Procedures	**A**	**0**	**4**
B: Financial Assessments	**A**	**0**	**4**
C: Client Charging	**G**	**0**	**2**
D: Management Information	**G**	**0**	**1**
E: Deprivation of Assets	**G**	**0**	**0**
		0	**11**

Opinion: Amber	
Total:11	Priority 1 = 0 Priority 2 = 11
Current Status:	
Implemented	1
Due not yet actioned	0
Partially complete	0
Not yet Due	10

It is positive to note recent developments in relation to client charging which aim to automate and provide greater efficiency across the financial assessment process. An Online Financial Assessment form can now be completed and submitted via the Council's public website which feeds directly into the Adult Social Care finance system. Performance targets have been reviewed and a performance reporting dashboard has been developed and implemented. Overall, financial assessment and charging processes were found to be working well. Some improvements are required in relation to ensuring that team guidance is up to date and consistent and in ensuring that expectations in relation to management oversight are clear and consistent.

Policies & Procedures – There is documented guidance in place for the Financial Assessments Team, however this has not been reviewed for some time with some out of date and duplicated content noted. It was also noted that some key Team Leader processes are not currently documented. The need to review, update and consolidate current team guidance is acknowledged within the service with work underway to complete this. Information on the financial assessment process was found to be available for Social Care staff, although there is a need for greater oversight of and input to this content by the Financial Assessment Team management going forward to ensure that the information is kept up to date and relevant. Detailed information on

the financial assessment process was found to be in place and available for people we support and other members of the public.

Financial Assessments – Testing identified that overall, for the sample of assessments tested, financial assessment processes are working well and are being followed consistently. Whilst some testing exceptions were noted in relation to some of the residential cases reviewed, these did not have a material impact on the outcome of the financial assessment and will be addressed by improvements agreed in relation to guidance, and more consistent management oversight via the monthly sample checking process. Team management are also reviewing and updating team training arrangements where appropriate. Quality assurance over the financial assessment process is monitored via a monthly 10% sample check on assessments by Team Leaders, however it was noted that these checks are not being completed and documented consistently. Expectations over coverage, frequency and documentation of the checking completed require confirmation.

It is noted that the Online Financial Assessment system has been implemented which aims to automate and speed up the financial assessment process. Audit testing noted that some further development is required to fully bring the online form in line with the routine financial assessment application to ensure consistency of information requirements.

Client Charging – Data analysis was carried out of the whole population of Residential people we care for with a financial assessment banding (people we care for who contribute towards their care costs) which identified 453 people we care for who had died during 2024/25. The audit testing has provided positive assurance that the vast majority of those cases had care packages ended on the correct date with accurate charges applied. A very small sample of cases (4) were identified the date of death had been incorrectly recorded, but only by one day. These anomalies are not considered to be significant. There is exception reporting in place to pick up inaccuracies in end dates. It was also noted that there can be delays in recording deaths due to late notifications from providers, which can lead to overcharges being made which then need to be refunded. One case reviewed during testing identified that the provider was late in notifying the Council of the persons death which resulted in an overcharge of £13K. This has already been identified and resolved by the relevant team prior to audit testing.

The audit reviewed a sample of 216 non-residential people we care for who had died, and who were paying part or full cost, ten exceptions were identified where non-residential provision was recorded on dates after the date of the persons death, however these exceptions only resulted in one case where there was a small overcharge to the person which had been subsequently identified and resolved by the relevant team.

Management Information – It is noted that the Financial Assessments performance dashboard went live in October 2024. This provides real time information on team activity with additional improvements implemented since go live to enable performance monitoring of the key team targets on the timeliness of completion of the financial assessment process. Further enhancements are planned to enable comparison of performance from month to month on team case allocations at both Support Officer and Financial Assessment Officer level. It was noted that there is ongoing monitoring of team activity and key tasks by the Team Leaders, the Financial Assessment

Manager and the Social Care Finance & Systems Manager and that performance is being reviewed at the monthly Adult Social Care Finance Managers meeting.

Deprivation of Assets – There is a clear process in place for the identification, assessment, follow up and monitoring of potential instances of deprivation of assets. A comprehensive review of this process has recently been undertaken by management with updated guidance published in January 2025. Testing completed as part of this audit noted that key processes are being completed and documented consistently for the samples reviewed.