AUDIT and GOVERNANCE COMMITTEE
14 January 2026

INTERNAL AUDIT 2025/26 PROGRESS REPORT

Report by the Executive Director of Resources & S151 Officer

RECOMMENDATION

1. **The Committee is RECOMMENDED to**

   Note the progress with the 2025/26 Internal Audit Plan and the outcome of the completed audits.

Executive Summary

2. This report provides an update on the Internal Audit Service, including resources, completed and planned audits.

3. The report includes the Executive Summaries from the individual Internal Audit reports finalised since the last report to the September 2025 Committee.

Progress Report:

Resources:

4. A comprehensive update on resources was provided to the Audit and Governance Committee in June 2025 as part of the Internal Audit Strategy and Plan for 2025/26. Since then, a new Principal Auditor joined the team at the end of July 2025. Our Intelligence and Data Officer, who supports both Internal Audit and Counter Fraud, has accepted a new role within the Council and will leave the team in Quarter 4. Work is underway to plan handover arrangements, identify and manage the impacts on delivery of planned work, and develop recruitment plans for a replacement.

2025/26 Internal Audit Plan:

5. The 2025/26 Internal Audit Plan, which was agreed at the June 2025 Audit & Governance Committee, is attached as Appendix 1 to this report. This shows current progress with each audit and any amendments made to the plan. The plan and plan progress are reviewed regularly with senior management.

6. There have been 8 audits concluded since the last update in September 2025, summaries of findings and status of management actions are detailed in Appendix 2.

7. Two recently finalised audits received an overall conclusion of Red. In line with established practice, reports graded Red are referred by the Audit & Governance Committee to the Audit Working Group for detailed review and discussion. Officers from the relevant service area will be invited to attend these sessions to present the audit findings and outline the action plan to address the identified weaknesses. These two audits have been scheduled for review at the 25 March 2026 Audit Working Group.

8. The completed audits (since the September 2025 update) are as follows:

Final Reports 2025/26:

Directorate	**Audit**	**Opinion**
IT Operations / Finance	ContrOCC – IT Audit	Amber
Environment & Highways / IT Operations	HIAMS (Highways Infrastructure Asset System) – IT audit.	Amber
HR & Cultural Change	Absence Recording	Amber
Childrens / Property & Assets	Safeguarding Transport	Red
IT Operations	IT Asset Management	Amber
Childrens	Childrens Transformation - including Financial Management	Amber
Childrens	Missing Children	Amber
Childrens	School Attendance	Red

9. There have been 5 grant certifications completed since last reporting to Audit & Governance Committee in September 2025:

- Local Transport Capital Block Funding (integrated transport and highways maintenance block), 2024/25, 31/7318
- Local Transport Capital Block Funding (Pothole Fund) 2024/25, 31/7319
- Local Authority Bus Subsidy (Revenue) Grant, 2024/25, 31/7227.

- Local Transport Capital Block Funding (Reallocated HS2 Resurfacing) 2024/25, 31/7320
- Disabled Facilities Grant 2024/25 (grant determination reference 31/7271) and additional allocation (grant determination 31/7605).

PERFORMANCE

10. The following performance indicators are monitored on a monthly basis.

Performance Measure	Target	% Performance Achieved for 25/26 audits (as at 11/12/25)	Comments
Elapsed time between start of the audit (opening meeting) and Exit Meeting.	Target date agreed for each assignment by the Audit manager, stated on Terms of Reference, but should be no more than 3 X the total audit assignment days (excepting annual leave etc)	77%	Previously reported year-end figures: 2024/25 61% 2023/24 67% 2022/23 71% 2021/22 59%
Elapsed Time for completion of audit work (exit meeting) to issue of draft report.	15 days	100%	Previously reported year-end figures: 2024/25 82% 2023/24 96% 2022/23 89% 2021/22 86%
Elapsed Time between receipt of management responses to draft report and issue of final report.	10 days	100%	Previously reported year-end figures: 2024/25 100% 2023/24 100% 2022/23 92% 2021/22 66%

The other performance indicators are:

- % of 2025/26 planned audit activity completed by 30 April 2026 - reported at year end.

- % of management actions implemented (as at 11/12/2025) – 71% of actions have been implemented. Of the remaining 28.5% there are 2.5%

of actions that are overdue, 17% partially implemented and 9% of actions not yet due.
(At September 2025 A&G Committee the figures reported were 75% implemented, 2% overdue, 15.5% partially implemented and 7.5% not yet due)

- Extended Management Team satisfaction with internal audit work - reported at year end.

Appendix 3

11. The table in Appendix 3 lists all audits with outstanding open actions, it does not include audits where full implementation has been reported. It shows the split between Priority 1 and Priority 2 actions implemented.

12. As at 11/12/2025, there were 78 actions that are not yet due for implementation (this includes actions where target dates have been moved by the officers responsible), 20 actions not implemented and overdue and 144 actions where partial implementation is reported.

Appendix 4

13. Appendix 4 is included for information purposes and lists the Internal Audit Definitions for overall conclusion gradings, management action priorities and root cause categories and descriptions.

Update on Internal Audit Standards and Self-Assessment.

14. As previously reported to the Committee, from 1 April 2025 internal audit teams in the public sector are expected to operate in accordance with the Global Internal Audit Standards (GIAS) and the accompanying Application Note, collectively referred to as the Global Internal Audit Standards in the UK Public Sector. These replace the former Public Sector Internal Audit Standards (PSIAS).

15. While 1 April 2025 marked the effective date of the new standards, full conformance was not required immediately. Internal audit teams are expected to work in alignment with the new standards from that date, progressively building conformance. By the end of the 2025/26 financial year, when the Head of Internal Audit annual opinion is issued, full conformance should be confirmed.

16. Professional standards require an external assessment of Internal Audit every five years. The last assessment, conducted in November 2023 against PSIAS, confirmed full conformance and was reported to the Audit & Governance Committee in January 2024. The next external assessment is scheduled for 2028.

17. Between external assessments, it is recommended practice to undertake a self-assessment. In November 2025, a self-assessment against the new standards was completed using CIPFA's comprehensive tool. This confirmed that the requirements of GIAS have already been implemented and that Internal Audit conforms to the new standards. Actions identified for completion by year-end to ensure full conformance include:

- Scheduling the Audit & Governance Committee Self-Assessment for 2026 (last completed in 2023).
- Scheduling, with the Monitoring Officer, the Review of Effectiveness of Internal Audit for reporting to the Committee in November 2026.
- Enhancing annual reporting (end of 2025/26) to include analysis of themes and root causes identified during audit assignments.
- Updating the Audit Manual to incorporate root cause methodology and adopt GIAS topical requirements – action now complete.

Counter-Fraud

18. A separate counter fraud update is being made to Audit & Governance Committee March 2026 meeting.

Financial Implications

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

Comments checked by: Lorna Baxter, Executive Director of Resources & S151 Officer,
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Legal Implications

20. There are no direct legal implications arising from this report which provides a summary of activity against the 2025/26 Internal Audit Plan, which was agreed at the June 2025 Audit & Governance Committee.

Jay Akbar, Head of Legal and Governance,
jay.akbar@oxfordshire.gov.uk

Staff Implications

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

Equality & Inclusion Implications

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

Sustainability Implications

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

Risk Management

24. The are no direct risk management implications arising from this report.

Lorna Baxter, Executive Director of Resources and S151 Officer

Annex:	Appendix 1: 2025/26 Internal Audit Plan progress report Appendix 2: Executive Summaries of finalised audits since last report. Appendix 3: Summary of open management actions. Appendix 4: Internal Audit Definitions
Background papers:	Nil
Contact Officers:	Sarah Cox, Chief Internal Auditor sarah.cox@oxfordshire.gov.uk

January 2026

APPENDIX 1 - 2025/26 INTERNAL AUDIT PLAN - PROGRESS REPORT

Service Area	Audit	Planned Qtr Start	Status as at 18/12/25	Conclusion
Cross Cutting	Capital Programme Delivery	4	Deferred to Qtr 1 of 2026/27 audit plan.	-
Cross Cutting	Grants (received)	2	Fieldwork	
Cross Cutting	Local Government Reorganisation.	4	n/a *See amendments to plan	-
Childrens	Transformation Programme – including Financial Management	2	Final Report	Amber
Childrens	Missing Children	2	Final Report	Amber
Childrens	Multiply	1	Complete	n/a – joint IA&CF work – CF team activity still in progress.
Childrens	School Attendance Orders	2	Final Report	Red
Childrens	Repairs & Maintenance in Schools	3	Fieldwork	
Adults	Discharge to Assess	4	Fieldwork	
HR & Cultural Change	Recruitment – Applicant Tracking System	3	Fieldwork	
HR & Cultural Change	Schools HR	3	Deferred to Qtr 1 of 2026/27 audit plan.	-
HR & Cultural Change	Absence Recording	2	Final Report	Amber
HR & Cultural Change	Addition to plan – Employee Case Relations	2	Fieldwork	
Financial & Commercial Services	Pensions Administration	3	Fieldwork	
Financial & Commercial Services	Pension Fund Investments	4	Draft Report	
Financial & Commercial Services	Insurance	4	Scoping	

Financial & Commercial Services	Duplicate Payments	3 / 4	Fieldwork	
Property & Assets	Vehicle Management Service	3 / 4	Fieldwork	
Property & Assets / Childrens	Safeguarding Transport	2	Final Report	Red
Environment & Highways	Highways	4	Scoping	
Environment & Highways	HIF1 (Didcot Garden Town Housing Infrastructure Fund)	1 / 2	Final Report	Green
Environment & Highways	Bridge Management	3 / 4	Fieldwork	
Environment & Highways / IT Operations	HIAMS (Highways Infrastructure Asset System) – IT audit.	2	Final Report	Amber
Economy & Place	S106 Developer Contributions	3	Scoping	
Transformation, Digital & Customer Experience	Freedom of Information Requests	1 / 2	Final Report	Amber
IT Operations	Database Security	4	Scoping	
IT Operations	ICT Backups	4	Scoping	
IT Operations	Bring Your Own Device (BYOD)	3	Fieldwork	
IT Operations	IT Disaster Recovery	2	Final Report	Amber
IT Operations	IT Asset Management	3	Final Report	Amber
IT Operations	GOSS – IT Audit	1	Final Report	Amber
IT Operations / Finance	ContrOCC – IT Audit	3	Final Report	Amber
Grant Certification completed:				
• Delivering Best Value in SEND Programme 2023/24 and 2024/25 – 31/6953				
• Bus Grant (Capital) 2025/26 – 31/7749				
• Local Transport Capital Block Funding (Pothole Fund) 2024/25, 31/7319				
• Local Transport Capital Block Funding (integrated transport and highways maintenance block), 2024/25, 31/7318				
• Local Authority Bus Subsidy (Revenue) Grant, 2024/25, 31/7227.				
• Local Transport Capital Block Funding (Reallocated HS2 Resurfacing) 2024/25, 31/7320				
• Disabled Facilities Grant 2024/25 (grant determination reference 31/7271) and additional allocation (grant determination 31/7605).				

Amendments to Internal Audit Plan:

HR – Employee Relations Case Audit	Previously reported to June 2025 Audit & Governance Committee meeting: ***Addition to 2025/26 plan:*** The audit was requested by the Director of HR and Cultural Change, approved by the Executive Director of Resources. The audit will provide assurance over the systems and processes in place to manage Employee Relations Cases.
Schools HR	***Deferred to Quarter 1 of 2026/27 plan:*** The audit has been deferred by 3 months from quarter 4 of 2025/26 to quarter 1 of the 2026/27 plan, due to internal audit resources, with delays to recruitment in quarter 1, a member of the team leaving in quarter 4 and additional days spent on recent red graded audits. The plan amendment has been approved by the Executive Director of Resources.
Capital Programme Delivery	***Deferred to Quarter 1 of 2026/27 plan:*** The audit has been deferred by 3 months from quarter 4 of 2025/26 to quarter 1 of the 2026/27 plan, due to internal audit resources, with delays to recruitment in quarter 1, a member of the team leaving in quarter 4 and additional days spent on recent red graded audits. The plan amendment has been approved by the Executive Director of Resources.
Local Government Reorganisation	*The provision of internal audit days for LGR for 2025/26 are being used to develop a forward plan for Internal Audit from 2026/27 onwards which will meet the governance and assurance needs during LGR, which ensures continuity of assurance, supports transformation and the harmonising of governance, risk and control frameworks for the new unitary / unitary authorities. The internal audit plans for 2026/27 and 2027/28 leading to vesting day, will need to ensure continued assurance over business-as-usual operations whilst providing assurance on transitional activities.

APPENDIX 2 - EXECUTIVE SUMMARIES OF COMPLETED AUDITS

Summary of Completed Audits since last reported to Audit & Governance Committee September 2025

ContrOCC - IT Audit 2025/26

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	Current Status:							
				Implemented		Due not yet Actioned		Partially complete		Not yet due	
				P1	P2	P1	P2	P1	P2	P1	P2
User Authentication	G	0	0	-	-	-	-	-	-	-	-
Access Rights	R	0	5	-	-	-	-	-	-	-	5
System Administration	A	0	4	-	1	-	1	-	-	-	2
Audit Trails	G	0	0	-	-	-	-	-	-	-	-
Backups	G	0	0	-	-	-	-	-	-	-	-
System Support	G	0	0	-	-	-	-	-	-	-	-
TOTAL		0	9								

ContrOCC is used for financial management in Adult's and Children's social care and there are separate databases for each area. In Children's services, it was implemented in 2019 alongside the Liquidlogic Children's System and has recently replaced the LIFT system for education early years payments. The review has found that users are appropriately authenticated to the system, user activity is logged in an audit trail, there are regular backups of data and system support arrangements are in place. The areas of greatest risk are the management and configuration of user access rights and system administration in terms of managing user accounts, including privileged access. Controls in both areas should be improved.

User Authentication User access to the system is subject to appropriate levels of authentication. All users must enter a valid username and password and have a unique account on the system.

Access Rights User access within the system is defined using security roles and users are allocated one or more of these roles. A review of how access rights are currently setup and managed within the system has identified a number of risks, including a lack of documentation to ensure security roles are

fully understood, segregation of duties not being enforced in key role and user access not being subject to any formal management review.

System Administration System administration is performed by the IT Applications and Systems Support team within the IT Service and there are procedures in place for managing user accounts in terms of starters and leavers. New user accounts are requested using an online form and we found they are not always authorised at a management level and do not define the level of access required by the new user. Leaver accounts are disabled on a timely basis but users who move roles within the Council and may no longer require access to the system are not highlighted to the system administration team so that their account can be disabled. A small number of users were found to have system administrator access when it is no longer required for their role.

Audit Trails The system comes with a built-in audit trail that can be used to see all changes to data, including provider records, care packages and user security permissions. The audit trail shows what data was changed, when and by whom. Reports can also be produced from the audit trail for a specific user and/or activity over a defined period of time.

Backups There is a full daily backup of the ContrOCC database and log files are backed up every two hours to minimise the risk of any data loss and to reduce the recovery point objective. In addition to the daily backup of the database, there is a full monthly backup of the underlying server. Suitable retention policies are applied to the daily and monthly backups.

System Support There has been ongoing contractual negotiations with the supplier which have delayed contracts being renewed, although support and maintenance of systems have continued. An agreement has recently been reached that a new contract will be signed and as there is already an open management action for this from another audit, it has not been included here. A review of all open support calls with the supplier confirmed they are being progressed, and the latest version of the application is being used.

Key Themes and Root Causes – The issues highlighted in this report identify underlying root causes in **Processes, Management / Governance, Systems/Technology and People**. Specifically, there are areas with no defined processes or procedures, weak oversight over controls, limitations in the IT system in regard to access rights configuration and a lack of staff knowledge and understanding of system security roles and permissions.

HIAMS (Highways Infrastructure Asset System) – IT audit 2025/26

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

RISK AREAS	AREA CONCLUSION	No of Priority 1 Manage	No of Priority 2 Manage	Current Status:			
				Implemented	Due not yet	Partially complete	Not yet due

		ment Actions	ment Actions			Actione d					
				P1	P2	P1	P2	P1	P2	P1	P2
User Authentication	**R**	**1**	**2**	**-**	**-**	**-**	**-**	**1**	**2**	**-**	**-**
Access Rights	**A**	**0**	**2**	**-**	**-**	**-**	**-**	**-**	**2**	**-**	**-**
System Administratio n	**A**	**0**	**3**	**-**	**-**	**-**	**-**	**-**	**3**	**-**	**-**
Audit Trails	**A**	**0**	**1**	**-**	**-**	**-**	**-**	**-**	**1**	**-**	**-**
Support and Maintenance	**A**	**0**	**2**	**-**	**2**	**-**	**-**	**-**	**-**	**-**	**-**
System Integration and New Technologies	**A**	**0**	**1**	**-**	**-**	**-**	**-**	**-**	**1**	**-**	**-**
TOTAL		**1**	**11**								

HIAMS is a key system within Highway Maintenance that is used to log requests for work relating to safety and non-safety checks and other scheduled activity. System administration is performed by a dedicated team within the service area. The review has identified areas where controls can be improved, such as the management of users and their access rights. The service area is looking to procure a new system, and a specification of requirements is being developed. This review has highlighted areas that should be incorporated within the specification of the new system, and we are planning some further work in this area later in the year.

User Authentication User access is subject to authentication and single sign-on (SSO) is used, where OCC users are authenticated using their Windows network credentials. External users also have access to the system and they login using a local account and entering a valid username and password. It was confirmed that these passwords comply with the corporate password policy. There is no evidence that user sessions timeout after a period of inactivity or that local system accounts lockout after a specified number of invalid logins. Implementing these controls will improve system security by strengthening the login process.

Access Rights User access rights within the system are defined using groups. There are a number of groups, and each has a set of permissions associated with it. A user can only be a member of one group at a time. Groups are not documented to show what access rights they provide and whilst there is currently an ongoing review of user access and rights, it is the first to be performed since the system was implemented in 2018. An annual review of user access should be undertaken to ensure all access is correct and valid for a person's role.

System Administration System administration in terms of managing user access to HIAMS is performed by a dedicated Application and Data

Management team within Highway Maintenance. We found there are no documented procedures for managing user accounts and hence there is a risk that consistent processes may not always be followed by members of the team when dealing with starters, leavers and movers. As SSO is used, access for OCC leavers is revoked once their network account is disabled by the IT Service as part of the corporate IT leavers process. There is no procedure for identifying and disabling redundant accounts belonging to external users and hence a risk that such accounts may be used for unauthorised access. There are also an excessive number of users with system administrator access, whereas this should be limited to the Application and Data Management team to ensure privileged access is not misused.

Audit Trails There is an audit trail in HIAMS for defects, which shows who logged them and any changes made. There are no other audit trails at an application level, although there could be some logging of user activity in the back-end database and details of this should be confirmed with the supplier.

Support and Maintenance There is a support and maintenance contract for the system, which is valid until March 2028. The Application and Data Management team seek supplier support when they cannot resolve a system issue or error themselves and have found the supplier to be responsive when dealing with such requests. A review of the contract for the system found it references aspects of security which are not supported with any evidence from the supplier. The contract does not include any reference to the security of the cloud environment or details of data backups. These areas should be followed up with the supplier to ensure there are appropriate security and safeguards in place over the system and data.

System Integration and New Technologies There is an up-to-date system map of all interfaces between HIAMS and other IT applications. Details about each individual interface are not documented to show what they do and how they work, which can present key person dependencies and a risk that IT processes are not fully understood when developing a specification for a new system. The service area are reviewing opportunities for using Artificial Intelligence (AI) and have done some work with the Customer Service Centre and are also looking at defect inspections. The Head of Highways chairs the national Local Council Road Innovation Group, which is useful for seeing and learning from other council's experiences of implementing AI.

Key Themes and Root Causes – The issues highlighted in this report identify underlying root causes in **Processes, Management / Governance** and **Systems / Technology**. Specifically, there are gaps in the definition of key processes and procedures, weak oversight to provide assurance that security controls are effective and potential limitations in the IT system in regard to audit trails.

Absence Recording 2025/26

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	Current Status:							
				Implemented		Due not yet Actioned		Partially complete		Not yet due	
				P1	P2	P1	P2	P1	P2	P1	P2
Policies and Procedures	**A**	**0**	**9**	-	-	-	-	-	-	-	**9**
Compliance	**A**	**0**	**11**	-	-	-	-	-	-	-	**11**
Performance Monitoring and Reporting	**A**	**0**	**4**	-	-	-	-	-	-	-	**4**
TOTAL		**0**	**24**								

The Council's internal policies and guidance require all annual leave and sickness absences to be recorded on the self-service system. The use of this system allows centralised monitoring of absences across services, enabling management to monitor how employees are using their annual leave entitlements throughout the year and the identification of patterns of absences: from identifying trends within specific areas of the Council, to individual-level insights that support early intervention. The effectiveness of this monitoring relies on the accuracy and completeness of the data recorded in the system.

Overall, sample testing found that annual leave and sickness absences are being correctly recorded, with exceptions noted where either the absence had not been recorded or had been recorded with incorrect details. Some areas of guidance were found to contain gaps or conflicting information, and a number of requirements listed within were also found to be incompatible with the functionality of the self-service system, often resulting in teams adopting offline workarounds.

Policies and Procedures – All internal policies and guidance relating to the recording of annual leave, sickness absences, flexi leave, and TOIL were reviewed. This identified gaps including a lack of consistency in the guidance for the carry-forward of annual leave for pro-rata employees; a lack of information for managers about how to monitor annual leave on the system; and outdated guidance regarding the method of recording of flexi leave and TOIL. For sickness absences, there was found to be a lack of accessibility and linkage to the Supporting Attendance Toolkit, which contains an instruction to record return-to-work conversations in ePF not contained elsewhere. Additionally, whilst it was noted that the shift to managers recording sickness absence start dates had improved the timeliness of recording (this was previously the responsibility of the individual employee), there was found to be conflicting system guidance that could create confusion over responsibility.

Compliance – In relation to annual leave, targeted sampling where low levels of annual leave had been observed reviewed 10 teams and 15 individuals, identifying three instances (relating to one individual) where the annual leave had not been recorded. A total of seven teams and five individuals confirmed that their annual leave was recorded offline, due to their working patterns not being supported by the leave-booking system. Additionally, there were found to be seven instances where annual leave taken and recorded in the employee's Outlook Calendar (from a sample of 100) had not been accurately recorded on the system, increasing the risk of staff taking more leave than they are entitled to.

The Council's internal guidance requires that the carry-forward of annual leave is limited to the equivalent of an employee's weekly working hours and is to be used by 31st May. However, the process was found to be reliant on managers entering the correct information as the system does not impose these restrictions. Of the employees who carried forward leave from 2024/25 to 2025/26, 6.4% had a carry-forward total of greater than one week. A total of 38.6% employees and 12.8% of distinct teams were identified as carrying forward leave using a deadline that was not 31st May. A total of four out of five teams sample tested confirmed that this was due to error. The remaining team manager confirmed that this non-typical date had been chosen deliberately due to staff shortages.

The audit also reviewed the processes used for the recording of flexi leave and Time Off in Lieu (TOIL), noting that a historic issue with the My Timesheet recording system had prompted the widespread return to use of offline systems for recording flexi hours. Although this system issue has since been resolved, the usage of it to record flexi leave since was observed to be very low, resulting in an inconsistent approach to managing flexi leave across the Council. TOIL was also found to be managed on an individual team basis.

Of those using the My Timesheet Recording system, there were 821 flexi days recorded by 115 employees from April 2024 to July 2025. This included 86 instances of non-compliance with the policy requirement that only up to one flexi day should be taken in a calendar month.

In relation to sickness absence, of ten teams with low levels of sickness absences sample tested, four teams confirmed the amount was incorrect and at least five absences were unrecorded, impacting a manager's ability to effectively monitor sickness absence and trigger points. There were also found to be 45 instances where consecutive one day sickness absences had been recorded (which can impact on sickness triggers), of which all ten-sample tested were confirmed to be the same illness, so should have been recorded as one sickness absence.

Performance Monitoring and Reporting – There are two dashboards that have been developed by HR to enable systematic monitoring of sickness absences recorded on the system: one published to the intranet quarterly that includes high level absence data, and a Power BI dashboard available to HR staff that contains drilldown functionality to the level of individuals. Both dashboards offer strong coverage and trend analysis, with Strategic People Partners confirming consistent engagement. It was noted that linkage to the exception flagging completed on a monthly basis by the Employee Relations

Team could improve the accuracy of the Power BI dashboard, where inaccuracies were found to be distorting the trend data.

There was also noted to be a historic ad hoc reporting arrangement in place for HR Business Partners to monitor annual leave balances annually, but the HR restructure has resulted in some lack of clarity about which types of reporting will be continuing, which could cause a gap in compliance monitoring. This is further substantiated by concerns raised by Strategic People Partners that there is an over-reliance on HR by line managers in regard to the responsibility of monitoring absences.

Key Themes and Root Causes – The issues highlighted in this report identify underlying root causes in both **Technology** and **Management / Governance**. Specifically, the system in use for the recording of absences presents limitations in functionality that are incompatible with some internal policy requirements. These system constraints have been enabled and sustained by gaps in the definition and consistent application of key processes for absence recording.

Safeguarding Transport 2025/26

Scheduled for review at the 25 March 2026 Audit Working Group

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

RISK AREAS	AREA CONCLUSION	No of Priority 1 Management Actions	No of Priority 2 Management Actions	Current Status:							
				Implemented		Due not yet Actioned		Partially complete		Not yet due	
				P1	P2	P1	P2	P1	P2	P1	P2
User Authentication	A	0	5	-	-	-	-	-	-	-	5
Access Rights	A	0	7	-	-	-	-	-	-	-	7
System Administration	R	0	9	-	-	-	-	-	-	-	9
Audit Trails	R	0	5	-	-	-	-	-	-	-	5
Backups	R	0	2	-	-	-	-	-	-	-	2
TOTAL		0	28								

Internal Audits focusing on Supported Transport Safeguarding have previously been undertaken in 2014/15 and 2017/18. The first audit, graded Red, identified significant weaknesses, and assurance could not be provided that there were adequate controls in place to manage external transport

arrangements. Following this audit, significant changes were made within the service to improve safeguarding controls, such as the implementation of Risk Assessments and Passenger Passports, and improved DBS, vetting, and training requirements. The follow up audit carried out in 2017/18 was graded Amber, recognising the impact these additional controls had on the safeguarding arrangements in place, but noting further areas for improvement to strengthen their effectiveness.

The Internal Audit Counter Fraud Team have undertaken several investigations which have included review of potential financial irregularities by external providers. These investigations identified control weaknesses and management actions were agreed to address these in an overall investigation report in March 2025. At the time of the audit, three of the 19 agreed actions were reported as fully implemented, with the remaining in progress. These continue to be monitored for implementation.

Within Fleet and Transport Services, there has been a recent change of leadership, who had already identified a number of issues and weaknesses found within this audit. As a result of this, there is ongoing work as part of the Supported Travel Improvement Programme to fundamentally strengthen the internal governance and control framework, alongside a service review and redesign. The new Head of Service has worked collaboratively with Internal Audit throughout this process, highlighting areas of concern and potential control weaknesses, and ensuring a robust management action plan is agreed within this report which coordinates with the improvement work already underway.

It is recognised that at the time of the audit, the service was not operating as business as usual, with various teams and officers pulled to cover the commissioning side of operations. As such, usual responsibilities could not be covered, having a direct impact on performance and operational effectiveness.

The audit found weaknesses and issues across the risk areas reviewed, specifically in contract management, quality assurance, and commissioning processes. While onboarding of new providers to the Dynamic Purchasing System (DPS) was found to be operating effectively, ongoing monitoring of contract requirements was inconsistent, with lapses in record-keeping and enforcement. Data integrity issues have led to unreliable records of transport arrangements.

The audit identified inefficiencies in the referral for, and creation and review of Passenger Passports and Risk Assessments, with delays and outdated information reducing their effectiveness. Management information and performance monitoring arrangements were found to be inconsistent, with key performance indicators not always actively reported on or monitored. Complaints management processes were also found to be inconsistent, with poor record-keeping and incomplete documentation, reducing transparency and accountability.

Key Themes and Root Causes - The system of internal control across all risk areas reviewed was found to be weak with risks not being effectively managed. The issues highlighted in this report identify underlying root causes in each of

the areas of: **Culture / Environment**, **Processes**, **People**, **Systems / Technology**, and **Management / Governance**.

IT Asset Management 25/26

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	Current Status:							
				Implemented		Due not yet Actioned		Partially complete		Not yet due	
				P1	P2	P1	P2	P1	P2	P1	P2
Corporate Policy	**A**	**0**	**1**	-	-	-	-	-	-	-	1
Procurement	**G**	**0**	**1**	-	-	-	-	-	-	-	1
Inventory Management	**G**	**0**	**1**	-	-	-	-	-	-	-	1
Hardware Disposal	**A**	**0**	**3**	-	-	-	-	-	-	-	3
TOTAL		**0**	**6**								

The IT Service are responsible for managing all end-user equipment, such as laptop computers, mobile devices and peripherals. There are good controls over the procurement of IT assets and inventory management. There are documented corporate policies on the management of IT assets and the disposal of assets, although we found they have not been reviewed in accordance with their stipulated review dates and are thus out-of-date. The disposal of IT assets is undertaken by a third-party and controls can be improved by confirming that all equipment collected for disposal is fully processed, including ensuring all data bearing items are securely wiped or physically destroyed. The specific obligations of the disposal company should also be added to the formal contract for the service.

The previous audit of this area was completed in 2020/21 and all agreed management actions have been implemented or are no longer applicable.

Corporate Policy - There is a documented IT Asset Management Policy, which covers key areas such as procurement, asset logging, compliance and equipment returns. The policy also has roles and responsibilities for ITID, service areas and line managers. We found the policy has not been reviewed since it was published in 2023 and some aspects are now out-of-date.

Procurement - All end user devices, such as laptops and mobile devices, are procured centrally by the IT Service and from a supplier who was awarded a contract following a full competitive tender in 2023. We sample tested recent

purchases of equipment and found they had been appropriately authorised, both technically and financially. There is a procedure for managing requests for non-standard equipment which we confirmed is being appropriately followed. All new equipment is delivered to the Depot and details of assets are added to the inventory immediately. We sample tested a recent delivery of laptops and mobile devices and confirmed their details have been logged on the inventory. New equipment is stored within a room at the Depot and whilst access restrictions are in place, there is scope for improving the security of this area to reduce the risk of any equipment going missing.

Inventory Management - An IT hardware inventory is maintained on the service desk system and includes sufficient details about each asset, including asset number, make, model and current user. When equipment is re-issued, details of all previous users is maintained. Equipment is held in stock at the Depot, especially during hardware refresh periods, but spot checks are not performed to confirm stock levels against inventory and hence missing equipment may not be identified on a timely basis.

There are procedures in place for collecting equipment from leavers which have recently been bolstered by the IT team. The leaver form initiates the process of collecting equipment and the new process involves email reminders being sent to line managers following the leave date. If equipment is not returned to the IT Service after four email reminders, the service area are charged for the device. This new process has improved the return rate of equipment to the IT Service. A sample test of recent leavers confirmed their equipment had been returned.

Hardware Disposal - There is a formal Disposal of ICT Equipment Policy, which was approved in 2023 but missed its stipulated review in May 2024 and has not been reviewed since. A new contract has been put in place for disposal services with the supplier of end user devices. The disposal service is provided by one of their partner's and whilst the contract references "secure and compliant disposal services", it does not place any specific obligations or requirements on the supplier. The new supplier has only recently carried out its first collection and has not yet issued any disposal reports. A review of previous collections under the old supplier found that disposal reports are not reconciled to the list of assets collected by the supplier to confirm all assets, especially data bearing items, are fully processed and securely wiped.

Key Themes and Root Causes – The issues highlighted in this report identify underlying root causes in both ***Processes*** and ***Management / Governance***. Processes are either not defined, out-of-date or are not being followed and there are areas where there is inadequate ownership or oversight of security controls.

Childrens Transformation Programme 25/26

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	Current Status:							
				Implemented		Due not yet Actioned		Partially complete		Not yet due	
				P1	P2	P1	P2	P1	P2	P1	P2
Governance, Roles and Responsibilities	G	0	0	-	-	-	-	-	-	-	-
Programme Management	A	0	1	-	-	-	-	-	-	-	1
Performance Management	G	0	0	-	-	-	-	-	-	-	-
Financial Management	A	0	4	-	-	-	-	-	-	-	4
TOTAL		0	5								

The audit found that the Children's Transformation portfolio is supported by a clear governance framework, with well-defined roles, responsibilities, and is aligned with strategic objectives. Programme management practices have been established which include standardised methodologies and tools, although some inconsistencies were noted in the way in which risk management is documented. Performance management was found to be working well, with meaningful metrics and reporting structures in place, although there are some areas where these capabilities are still being developed.

The audit noted that financial management is improving, particularly within Children's Social Care, with new strategies, tools, and training introduced, though it is acknowledged that further work is needed to embed these improvements across the service and ensure consistent financial management, monitoring and reporting.

A: Governance, Roles and Responsibilities – The audit has identified that there is a clear governance framework in place for management of the Children's Transformation portfolio. Projects, programmes and themes clearly align with the CEF (Children Education Families) 4-year business plan. The objectives of the transformation portfolio and the constituent programmes and SEND themes are clearly stated.

The CEF Transformation team has developed documented procedures and project templates which promote consistency and continuity as well as supporting good practice by including various aspects of programme management within the documentation.

Roles and responsibilities, including escalation routes, are clearly defined within the terms of reference and project initiation documents.

B: Programme Management – The CEF Transformation team uses a defined project management methodology and standard documentation to encourage a consistent approach which encompasses key aspects of good programme management disciplines. This includes a programme workbook which is used as a key tool by the project and programme managers to monitor delivery of programme objectives and for the production of performance information and reporting to the programme boards. The approach to project management aims to be proportionate to the size and complexity of each project. The audit noted some inconsistencies in the way in which the project workbook is being used which included the way in which risk management is being documented. There were examples where the management of risks was not recorded clearly or consistently. For example, some programme workbooks were not using the risk & issue log, issues were also noted with the risk scoring, and with the capture of mitigations. In some cases the mitigations and post-mitigation scores were empty even where the original risk was rated red. Therefore, it is not clear from the documentation whether risks are being appropriately managed.

C: Performance Management – Several established programmes have robust performance management arrangements in place, with key performance indicators being actively monitored and reported on. Examples include the Family Hubs, Family Safeguarding Approach and Fostering Improvement programmes. There is clear evidence that the metrics used are regularly reviewed, with ongoing discussions around data availability and the identification of additional indicators that would enhance future reporting.

Some programmes are still developing their performance management reporting, and there is evidence that this remains a high priority focus. For instance, the Supported Accommodation programme is at an early development / design stage of performance management reporting. The SEND transformation programme has KPI reporting already in place and a dedicated resource developing PowerBi dashboards across the programme for different audiences. The SEND Improvement & Assurance Board receives a high level overview whereas the SEND Partnership Delivery Group is provided with more detailed operational insights. These are good examples of meaningful performance information being measured and reported, to facilitate the achievement of the objectives of the programme. There is also evidence of continued review of the metrics to ensure that the data is meaningful and useful.

D: Financial Management – Due to ongoing financial challenges and pressures within the Service, there has been a recognised need to review financial management arrangements and make improvements where necessary to ensure that all those with budget responsibilities are clear on their financial roles, responsibilities and processes and can manage their budgets effectively.

A number of improvements have focussed on Children's Social Care. It is recognised that further improvements are required to fully embed these and extend financial management improvements across the Service including Education.

To support improved financial management there has been a reintroduction of the finance clinics. These have been reported to have been successfully implemented for some time accross Children's Social Care; and have recently commenced within Education.

The CEF Business Plan 2025-2029 includes a list of improvements under the subheading Finance within the slides of "Corporate enablers & dependencies" (this includes delivering against savings targets, developing robust skills in budget management, reviewing and clarifying budget codes and development of PowerBi dashboards to include financial KPIs). Whilst the Strategic Finance Business Partner has articulated, to Internal Audit, the work in progress to address each of these improvements, there is limited regular monitoring and reporting to provide assurance to Children's senior management on progress being made.

A CEF Finance Manual has been written and published within the Service which focusses on financial responsibilities of cost centre managers and accountable officers. Whilst this is a positive step in strengthening financial governance, the manual could be further enhanced by incorporating guidance or sign posting to related areas including contract management responsibilities and preferred procurement routes.

Cost centres have been reviewed and rationalised to align them with the organisational structure. There is also an ongoing review through the organisational redesign of the accuracy of the establishment data against service budgets. There have been challenges with the data which include historic issues such as unfunded posts. By aligning establishment data and budgets, the service will be able to more effectively manage their budgets.

Financial training has been delivered from a combination of sources within the Service and Finance. However, this has not been fully embedded across the Service and future arrangements for delivery have not yet been confirmed to ensure that managers have sufficient financial management training and support to ensure good financial management practices.

Key Themes and Root Causes – The issues highlighted in this report identify underlying root causes of both ***Processes*** and ***People***. Specifically, the application of processes in relation to programme / project risk management and, in relation to People, the support available to ensure good financial management skills and competencies.

Missing Children 25/26

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	Current Status:							
				Implemented		Due not yet Actioned		Partially complete		Not yet due	
				P1	P2	P1	P2	P1	P2	P1	P2
Policies, Procedures and Processes	A	0	3	-	-	-	-	-	-	-	3
Risk Assessment and Planning	A	0	2	-	-	-	-	-	-	-	2
Children Missing / Away from Care Without Authorisation	A	0	3	-	-	-	-	-	-	-	3
Return Interviews and Additional Safeguards	A	0	3	-	-	-	-	-	-	-	3
Performance Information and Monitoring	G	0	0	-	-	-	-	-	-	-	-
TOTAL		0	11								

Section 13 of the Children Act 2004 requires local authorities and other named statutory partners to make arrangements to ensure that their functions are discharged with a view to safeguarding and promoting the welfare of children. This includes planning to prevent children from going missing and to protect them when they do. Missing Children are defined by the police as 'the whereabouts of the child/young person cannot be established and where the circumstances are out of character or they may be the subject of crime, at risk of harm to themselves or others'. The missing children process is managed within Children's Social Care, with missing episodes allocated to an assigned social worker from the child's allocated team.

Overall, the audit found strong and effective processes in place to manage missing children, supported by well established performance reporting to provide management with weekly oversight of children that are / have been missing. Additionally, the Missing Children Exploitation Panel was found to be adequately addressing the needs of children identified as 'high risk'. Although risk management and planning processes are well-integrated, further improvement is required to ensure consistency. The Return Home Interview (RHI) process was also found to require improvement to ensure timely

completion, adherence to guidance, and that updates are reflected promptly on LCS.

Policies, Procedures and Processes: Guidance covering key processes and roles / responsibilities of the Council and partner agencies was found to be in place and accessible to staff, however two key pieces of guidance were found to contain overlapping information making it unclear for staff which guidance to refer to. Additionally, there were requirements within one piece of guidance which were not reflected in the other, meaning parts of the process could be missed if one piece is read in isolation. It was also noted that while one piece had been reviewed in January 2025, the other was dated April 2023, and neither had documented planned dates for review.

These weaknesses had already been identified by the service, with work underway to review, update, and streamline the guidance available to staff.

Risk Assessment and Planning: The majority of children's care plans reviewed appropriately documented the risk of going missing, with one exception noted in which this risk had not been clearly assessed or documented.

When potential risk is identified, a risk management plan is expected to be completed and reviewed as part of the care planning process. This is usually done via a Multi-Agency Risk Assessment and Management Plan (MARAMP); however, variations were found to have occurred in this process, including a case where a MARAMP was not carried out (despite the care plan noting the risk of going missing), and several cases where there was no evidence of the child's presence during the MARAMP (considered best practice). A case was also noted in which the MARAMP had not been reviewed within the expected timescale.

Pre-placement planning meetings should take place prior to, or within 72 hours of, a placement starting, and should include review of any known risks, including going missing. This was found to be taking place for the majority of cases, with one exception noted in which a pre-placement planning meeting could not be found on the child's LCS account, and another where the meeting notes did not fully document discussions held around the risk of going missing and appropriate measures to be put in place to address this, other than that if the child were to, it would be reported by the carer. The child, who had had 11 missing episodes prior to the placement starting, clearly had the risk documented in their care plan and in a MARAMP (although as noted above, this was overdue review at the time of testing).

Weaknesses were also noted in the saving of an up-to-date photo to a child's LCS account (where the child is known to Children's Social Care), which is required in line with guidance to facilitate safe identification and recovery. From the sample reviewed, one did not have a photo, and another had a photo from 2022.

Children Missing / Away from Care Without Authorisation: The audit observed that while various definitions are used by the DfE and Thames Valley Police to categorise the status of a child (such as 'missing', 'absent', and 'away from placement without authorisation'), in practice all episodes are categorised as 'missing' from the point at which the notification is received from the police.

There is no differentiation in process or LCS forms depending on the status of the child, thereby classing and reporting, all as missing when other terminology may have been more appropriate.

In terms of action taken upon receipt of a missing notification, the majority of missing episodes and reports were found to have started promptly on LCS, however some exceptions were noted where there had been a delay. All missing episodes were assigned to the correct team / social worker, and strategy meetings and referral to the Missing and Exploitation Panel were well documented, covered appropriate areas, and were in line with relevant guidance.

There is a clear process for escalating concerns when a child has been missing beyond an established timeframe or is at risk of significant harm - via a 'Need to Know' (NTK) notification. However, testing found that NTK documentation was not consistently saved to the child's LCS record.

Return Interviews and Additional Safeguards: Testing identified that while there is a clear process in place for Return Home Interviews (RHIs), these were not consistently completed within the statutory timeframe of within 72 hours of the missing child / young person being found. Exceptions were also noted regarding the quality of the documented interviews, with some holding little detail as to the discussions held.

Updates to LCS records with RHI information were not consistently made on a timely basis, although it was positive to note that the RHIs were signed off appropriately and follow up actions were taken where required. This includes instances in which an interview could not be completed, which require additional sign off by a Service Manager.

Performance Information and Monitoring: Weekly reporting is produced from LCS covering key components of the missing children process such as number of children who have gone missing, volume of missing episodes, and RHIs exceeding 72 hours. Additional reports are provided alongside to this to provide detail on the exceptions reported.

There are periodic meetings in the form 'DQIPP' where Service Mangers and Seniors in Children's Social Care meet to share information on trends / themes and lessons learned. Recently, themes have been identified leading a piece of work on the consistency of RHIs. These themes are now being considered in the Missing Children Exploitation Panel.

Testing confirmed the annual submission of figures to the DfE is carried out as required and checks are run on the validity of the data produced. As previously acknowledged within this report, data doesn't differentiate between 'missing' and 'absent' therefore reporting assumes all episodes are 'missing'.

Key Themes and Root Causes – The issues highlighted in this report identify underlying root causes in both **Processes** and **People**. Specifically, guidance was found to be duplicated with minor differences and omissions, making it unclear which process should be followed. Additionally, some procedures were not routinely adhered to (for example completion of Return Home Interviews within the statutory timeframe, and clear documentation of how risk had been assessed within a child's records).

School Attendance 2025/26

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

RISK AREAS	AREA CONCLUSION	No of Priority 1 Management Actions	No of Priority 2 Management Actions	Current Status:							
				Implemented		Due not yet Actioned		Partially complete		Not yet due	
				P1	P2	P1	P2	P1	P2	P1	P2
Policies and Procedures	**A**	**0**	**3**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**3**
Case Management and Recording	**R**	**0**	**14**	**-**	**1**	**-**	**-**	**-**	**-**	**-**	**13**
Legal and Regulatory Compliance	**A**	**0**	**7**	**-**	**2**	**-**	**-**	**-**	**-**	**-**	**5**
Management Oversight and Performance Monitoring	**R**	**2**	**0**	**-**	**-**	**-**	**-**	**-**	**-**	**2**	**-**
TOTAL		**2**	**24**								

The Department for Education (DfE) emphasises that every child, regardless of their circumstances, deserves an efficient, full-time education suitable to their age, ability, aptitude, and any special educational needs. Under Section 19 of the Education Act 1996, local authorities must ensure that children of compulsory school age receive this education. To fulfil these duties, our Council performs various functions, such as monitoring attendance, supporting schools and families to improve attendance rates, issuing School Attendance Orders, and, if necessary, taking legal action against parents/carers, including issuing fines or prosecuting them once all support avenues have been exhausted.

The audit has identified several weaknesses across the reviewed risk areas. These include system capability and compatibility, data integrity issues, outdated and incomplete internal guidance regarding the DfE's "Working Together to Improve School Attendance" paper, and delays and inconsistencies in managing individual children's cases. There are also issues with the timely escalation for legal action where appropriate, the effective management of issuing Penalty Notices as a last resort, monitoring payments, and some instances of poorly documented decision-making and actions taken. These issues are further compounded by a lack of oversight and performance reporting processes, which are crucial in providing assurance over the timeliness and effectiveness of case management activities.

Key Themes and Root Causes – The issues highlighted in this report identify underlying root causes related to **Systems/ Technology, Management/ Governance** and **People**. Specifically, system capability and compatibility have resulted in the absence of routine performance monitoring, which has led to a lack of oversight around the timeliness and effectiveness of case management activity. It was also found that documentation to support action taken is not always consistently recorded against pupils' accounts.

APPENDIX 3 – As at **11/12/2025** - all audits with outstanding open actions (excludes audits where full implementation reported):

	ACTIONS								
	P1 & P2 Actions			IMPLEMENTED			Not Due for Implementation	Not Implemented	Partially Implemented
Report Title	1	2	**Total**	1	2	**Total**			
OCC AI 24/25	-	13	**13**	-	5	**5**	-	-	8
OCC Absence Recording 25/26	-	24	**24**	-	-	**-**	24	-	-
OCC Childrens DP 24/25	-	35	**35**	-	25	**25**	-	-	10
OCC Childrens Placements CM & QA 23/24	-	17	**17**	-	16	**16**	-	-	1
OCC Childrens Transformation 2526	-	5	**5**	-	-	**-**	5	-	-
OCC Client Charging 24/25	-	11	**11**	-	10	**10**	-	-	1
OCC Climate Audit 22/23	5	12	**17**	5	11	**16**	-	-	1
OCC Corporate Website 24/25	-	8	**8**	-	7	**7**	-	-	1
OCC Data Mgmt 2425	-	10	**10**	-	4	**4**	-	-	6
OCC Disaster Recovery 25/26	-	8	**8**	-	-	**-**	-	2	6
OCC Educ IT System – processes 22/23	-	5	**5**	-	3	**3**	-	-	2
OCC EHCP Top Ups 24/25	-	12	**12**	-	7	**7**	-	-	5
OCC Employee Feedback 2425	1	7	**8**	-	1	**1**	-	3	4
OCC Feeder Systems 23/24	-	4	**4**	-	3	**3**	-	-	1
OCC Fleet Mgmt Compliance 21/22	-	5	**5**	-	4	**4**	-	-	1
OCC FM Follow up 22/23	-	13	**13**	-	11	**11**	-	-	2
OCC FOI 25/26	-	10	**10**	-	6	**6**	-	-	4
OCC Health Payments 23/24	1	7	**8**	1	5	**6**	-	-	2
OCC HIAMS 25/26	1	11	**12**	-	2	**2**	-	-	10
OCC HIF1 25/26	-	2	**2**	-	-	**-**	-	2	-
OCC Highways Contract 24/25	-	2	**2**	-	1	**1**	-	-	1
OCC Identity and Access Mgmt 24/25	-	11	**11**	-	7	**7**	-	-	4
OCC IROs 24/25	-	14	**14**	-	7	**7**	-	-	7
OCC IT Application ContrOCC 25/26	-	9	**9**	-	1	**1**	7	1	-
OCC IT Audit GOSS 25/26	-	7	**7**	-	6	**6**	-	-	1

OCC IT Asset Management 2526	-	6	**6**	-	-	**-**	6	-	-
OCC LAS IT Application 22/23	-	9	**9**	-	8	**8**	-	-	1
OCC Leases 22/23	-	10	**10**	-	8	**8**	-	-	2
OCC Local Transport Plan 23/24	1	8	**9**	1	6	**7**	-	-	2
OCC M365 Cloud 22/23	-	11	**11**	-	10	**10**	-	-	1
OCC Mandatory Training 24/25	-	5	**5**	-	-	**-**	-	-	5
OCC Multiply 24/25	-	3	**3**	-	-	**-**	-	3	-
OCC P Cards 23/24	1	20	**21**	1	18	**19**	-	-	2
OCC Payments to Providers 23/24	2	7	**9**	1	7	**8**	-	-	1
OCC Pensions Admin 24/25	-	6	**6**	-	4	**4**	1	-	1
OCC Physical Security Systems 23/24	1	13	**14**	1	12	**13**	-	-	1
OCC Planning Application Appeals 24/25	-	8	**8**	-	2	**2**	-	5	1
OCC Prop Strategy Implementation 24/25	-	1	**1**	-	-	**-**	-	-	1
OCC Property Health and Safety 23/24	2	28	**30**	1	24	**25**	-	-	5
OCC Property Strategy Implementation 24/25	-	1	**1**	-	-	**-**	-	-	1
OCC Risk Management 20/21	-	14	**14**	-	13	**13**	-	-	1
OCC Risk Mgmt 23/24	-	8	**8**	-	7	**7**	-	-	1
OCC S106 21/22	-	6	**6**	-	2	**2**	-	-	4
OCC S106 IT System 23/24	-	6	**6**	-	2	**2**	-	-	4
OCC S151 Schools Assurance 24/25	2	20	**22**	1	3	**4**	7	4	7
OCC Safeguarding Transport 25/26	-	28	**28**	-	-	**-**	28	-	-
OCC Strategic Contract Mgmt 24/25	2	10	**12**	2	3	**5**	-	-	7
OCC Street Works & Parking Income 24/25	-	11	**11**	-	8	**8**	-	-	3
OCC Supported Transport 23/24	6	9	**15**	6	7	**13**	-	-	2
OCC Utilities 2425	-	3	**3**	-	2	**2**	-	-	1
OCC Void Management 24/25	-	14	**14**	-	3	**3**	-	-	11
OCC YPSA 22/23	1	18	**19**	1	17	**18**	-	-	1
TOTAL	**26**	**545**	**571**	**21**	**308**	**329**	**78**	**20**	**144**

APPENDIX 4 – Internal Audit Definitions.

Overall Conclusion Gradings:

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.

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.

Green - There is a strong system of internal control in place and risks are being effectively managed. Some minor action may be required to improve controls.

Management Action Priorities:

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.

Supplementary Issue – Minor issues requiring action to improve performance or overall system of control.

Root cause categories and descriptions:

PROCESSES - Inefficiencies or gaps in workflows or procedures. Are processes clearly defined, documented and communicated and followed effectively. Are the processes efficient and effective.

PEOPLE - Skills gaps, unclear responsibilities, or cultural issues. Examines the human element, individual skills, training, competency, experience of staff, adherence to procedures, workload, communication and supervision.

SYSTEMS / TECHNOLOGY - System limitations, poor integration, or lack of automation. Assesses the technology and systems used, design, implementation and maintenance, suitability for intended purpose.

MANAGEMENT / GOVERNANCE - Weak oversight, policy non-compliance, or lack of accountability. Examines whether management is providing adequate direction, resources and oversight and if governance structures are effective. Willingness to acknowledge or learn from mistakes.

CULTURE / ENVIRONMENT - Market conditions, regulatory changes, or third-party dependencies. Looking at the broader context, including physical environment, workplace culture, external factors.