

AUDIT AND GOVERNANCE COMMITTEE
20 MAY 2026
ANNUAL REPORT OF THE HEAD OF INTERNAL AUDIT
Report by Head of Internal Audit & Counter Fraud

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 Head of Internal Audit, summarising the outcome of the Internal Audit work in 2025/26, 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 2025/26 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 Head of Internal Audit 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 Head of Internal Audit's annual report on the system of internal control, this Head of Internal Audit annual report has been produced for the June Audit and Governance Committee meeting. This is the full and final Head of Internal Audit annual report for 2025/26.

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 Head of Internal Audit'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 Global Internal Audit Standards (GIAS) in the UK Public Sector. The annual self-assessment against the standards is completed by the Head of Internal Audit. 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. The survey is due for completion again during 2026.
14. The Internal Audit Strategy and Annual Plan for 2025/26 was presented to the June 2025 Audit and Governance Committee. The Committee then received quarterly progress reports from the Head of Internal Audit, 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 Head of Internal Audit 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 2025/26 the Internal Audit Service was delivered by an in-house team, supported with the specialist area of IT audit.
20. Throughout the year the Audit and Governance Committee were kept informed of staffing / resourcing updates and 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 2025/26.

Opinion on System of Internal Control

Basis of the Audit Opinion

22. The 2025/26 revised plan presented to the January 2026 Audit & Governance Committee has had one further amendment, with the deferral of the audit of S106 until quarter 1 of the 2026/27 internal audit plan (reported in appendix1). The revised plan has been fully completed subject to two audits at draft report stage which will be finalised during May.
23. The plan is intended to be dynamic and flexible to change. 28 audits were undertaken in the year (30 in 2024/25, 26 in 2023/24, 30 in 2022/23, 26 in 2021/22).
24. The completed internal audit activity and the monitoring of audit actions through the action tracker system enables the Head of Internal Audit to provide an objective assessment of whether systems and controls are working properly. In addition to the completed internal audit work, the Head of Internal Audit 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 28 audits undertaken in 2025/26, there were four audits with the overall conclusion of red. In 2024/25 there were no audits graded red, 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 Head of Internal Audit'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 2025/26 has not yet been made available to the Deputy Chief Executive (and S151 Officer) and the Head of Internal Audit. The Hampshire partnership are waiting for EY to complete and report on their work. This report will provide assurance on the operation and effectiveness of internal controls across; Purchase to Pay, Order to Cash, Cash & Bank, HR & Payroll and IT General Controls. Whilst the report for 2025/26 is still awaited, however there has been no notification of any material concerns. Once the report is received, the Audit & Governance Committee will be updated.
31. The anti-fraud and corruption strategy remains current and relevant. In 2025/26 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 Head of Internal Audit 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 Head of Internal Audit has taken into account:
- The results of all audits undertaken as part of the 2025/26 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 Head of Internal Audit is a member of the group), in preparation of the Annual Governance Statement.

Head of Internal Audit's Annual Opinion

In my opinion, for the 12 months ended 31 March 2026, 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.

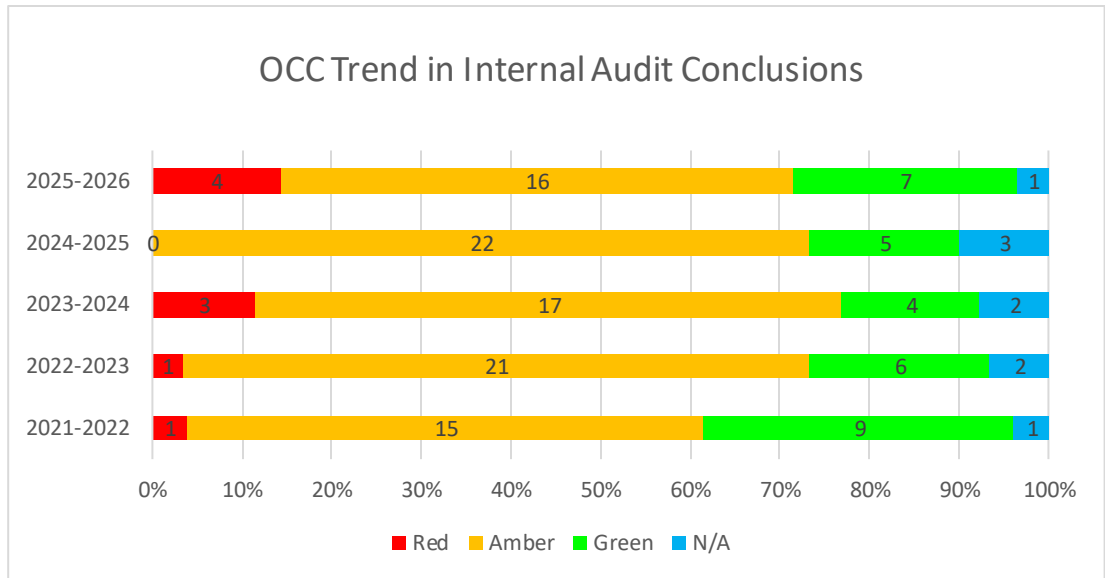
This opinion will feed into the Annual Governance Statement which will be published alongside the Annual Statement of Accounts.

Oxfordshire County Council's Internal Audit service conformed to the Public Sector Internal Audit Standards (2017) during the year ending 31 March 2026.

See appendix 2 for definitions of overall assurance opinion.

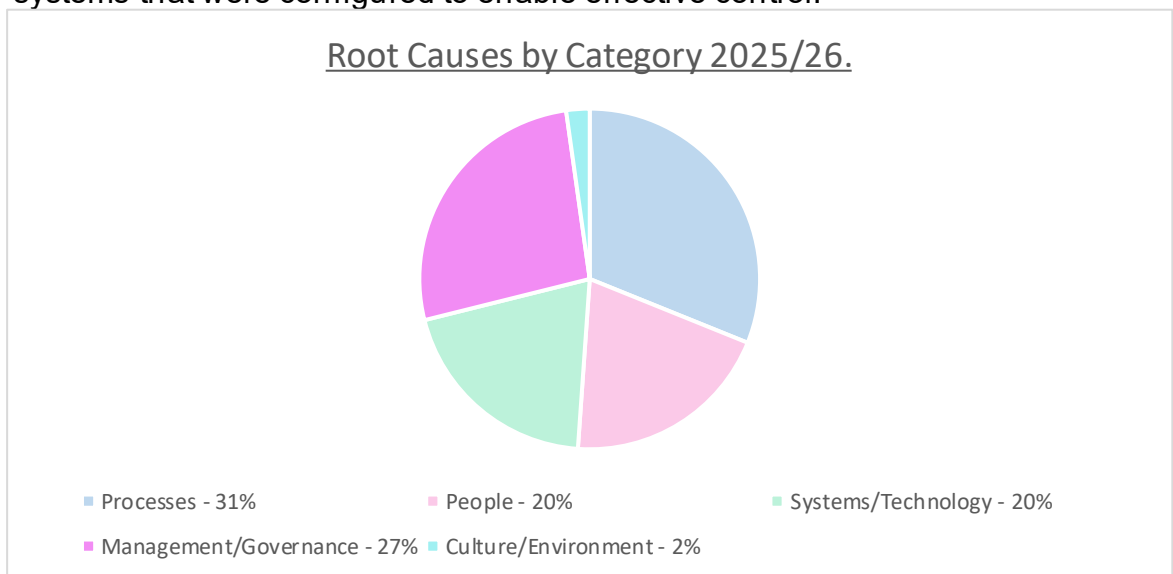
Individual audit conclusions

36. The following table shows the percentage trend in individual audit conclusions.
37. Included within Appendix 4 of this report for information, are the overall category gradings, management action priorities and root cause categories and descriptions.



Key themes & root cause analysis

38. During 2025/26, Internal Audit identified 45 underlying root causes across 19 audits. The majority related to process design and consistency (31%), governance and oversight (27%), and systems or technology limitations (20%), with people-related factors (20%) and culture or environment (2%) also contributing. In many cases, weaknesses were multi-factor rather than attributable to a single point of failure. Recurring themes included unclear or outdated procedures, unclear accountability and inconsistent control oversight, and continued reliance on spreadsheet or email-based processes that drive manual workarounds and limit the quality of management information. Collectively, these issues resulted in process variability, inconsistent compliance with requirements, and systems that do not fully support effective service delivery. In contrast, audits assessed as Green consistently demonstrated well-defined processes, stronger oversight arrangements and systems that were configured to enable effective control.



Audits completed since last report to Audit and Governance Committee

39. 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 (January 2026) are attached as Appendix 3.
- Bring Your Own Device (BYOD)
 - Pension Fund Investments
 - ICT Backups
 - Database Security
 - Applicant Tracking System
 - Pensions Administration
 - Employee Relations
 - Insurance
 - Duplicate Payments
 - Vehicle Management Service
 - Grants Management
 - Highways Contract Management
 - Bridge Management

Two recently finalised audits, Bring Your Own Device and Bridge Management received an overall conclusion of Red. In line with established practice, reports graded Red are considered for referral by the Audit & Governance Committee to the Audit Working Group for detailed review and discussion. When reports are referred to the Audit Working Group, officers from the relevant service area are invited to attend these sessions to present the audit findings and outline the action plan to address the identified weaknesses.

The following audits are currently at draft report stage. The outcomes of the audits are included within the annual opinion, the executive summaries of the reports once finalised will be included in the next internal audit quarterly update to committee.

- Repairs & Maintenance in Schools
- Discharge to Assess

Internal Audit Performance

40. The following table shows the performance targets agreed by the Audit and Governance Committee and the actual 2025/26 performance.
41. Staffing changes during the year affected the service's capacity and contributed to delays in plan delivery. This included the departure of a team member returning from long-term sickness in Quarter 1, the delayed recruitment of the Principal Auditor who did not commence until the end of July 2025, and the loss of the Data and Intelligence Officer in Quarter 4 to another role within the Council. In addition, four Red-graded audits were issued during the year, each requiring a higher level of input and additional audit days to complete.

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, continues to fully meet the performance target.

42. 94% of the revised plan (including grant certification work) was completed by the end of April 2026, for the remaining audits all audit fieldwork was completed, however draft reports were still being agreed during May 2026.
43. 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 (71%).
44. Internal Audit customer satisfaction questionnaires continue to provide positive feedback.

Measure	Target	Actual Performance 2025/26 – as at 13/04/2026
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	70% of the audits met this target. 2024/25 61% 2023/24 67% 2022/23 67% 2021/22 59%
Elapsed time for completion of the audit work (exit meeting) to issue of draft report	15 Days	100% of the audits met this target. 2024/25 82% 2023/24 96% 2022/23 93% 2021/22 86%
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) 2024/25 100% 2023/24 100% 2022/23 100% 2021/22 66%
% of Internal Audit planned activity delivered	100% of the audit plan by end of April 2026.	94% of the plan was completed by the end of April 2026 (including grant certification work). 2024/25 78% 2023/24 100% 2022/23 83% 2021/22 87%
% of agreed management actions implemented within the agreed timescales	90% of agreed management actions implemented	As at end of April 2026: 724 actions being monitored on the system. <ul style="list-style-type: none"> • 63% implemented • 8% not yet due • 25% 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 2024/25 1.2 2023/24 1 2022/23 1.2 2021/22 1.1
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. Next review planned for Autumn 2026.

Annex 4: Internal Audit Definitions

Background papers: None.

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APPENDIX 1 - Overall conclusion and management action implementation status of 2025/26 audits

Audit	Status	Conclusion	No of Mgmt Actions Agreed	Reported implementation status as at 13/04/2026
Cross Cutting				
Capital Programme Delivery	Deferred to Qtr 1 of 2026/27 audit plan.	-	-	-
Grants Management	Final Report	Green	5	5 not yet due
Local Government Reorganisation.	Days utilised for LGR internal audit planning	-	-	-
Childrens				
Transformation Programme – including Financial Management	Final Report	Amber	5	2 implemented, 1 partially implemented, 1 not yet due, 1 overdue.
Missing Children	Final Report	Amber	11	4 implemented, 2 partially implemented, 5 overdue.
Multiply	Complete	n/a – joint IA&CF work	-	-
School Attendance Orders	Final Report	Red	26	13 implemented, 11 partially implemented, 1 not yet due, 1 overdue.
Repairs & Maintenance in Schools	Draft	Amber	TBC	TBC
Adults				
Discharge to Assess	Draft	Amber	TBC	TBC
HR & Cultural Change				
Recruitment – Applicant Tracking System	Final Report	Amber	20	2 implemented, 3 partially implemented, 13 not yet due, 2 overdue.
Schools HR	Deferred to Qtr 1 of 2026/27 audit plan.	-	-	-
Absence Recording	Final Report	Amber	24	24 partially implemented.
Employee Case Relations (addition to plan)	Final Report	Amber	17	17 not yet due.

Financial & Commercial Services				
Pensions Administration	Final Report	Green	11	11 not yet due.
Pension Fund Investments	Final Report	Green	6	2 implemented, 2 partially implemented, 2 not yet due.
Insurance	Final Report	Green	4	4 not yet due.
Duplicate Payments	Final Report	Green	3	1 implemented, 2 not yet due.
Property & Assets				
Vehicle Management Service	Final Report	Amber	10	10 not yet due.
Safeguarding Transport	Final Report	Red	28	2 implemented, 10 not yet due, 16 overdue (pending update from responsible officers)
Environment & Highways				
Highways Contract Management	Final Report	Amber	15	15 not yet due.
HIF1 (Didcot Garden Town Housing Infrastructure Fund)	Final Report	Green	2	2 implemented.
Bridge Management	Final Report	Red	16	16 not yet due.
HIAMS (Highways Infrastructure Asset System) – IT audit.	Final Report	Amber	12	6 implemented, 6 partially implemented.
Economy & Place				
S106 Developer Contributions	Deferred to Qtr 1 of 2026/27 audit plan.	-	-	-
Transformation, Digital & Customer Experience				
Freedom of Information Requests	Final Report	Amber	10	9 implemented, 1 partially implemented.
IT Operations				
Database Security	Final Report	Amber	5	1 implemented, 2 partially implemented, 2 not yet due.
ICT Backups	Final Report	Green	4	1 implemented, 1 partially implemented, 2 not yet due.

Bring Your Own Device (BYOD)	Final Report	Red	9	6 implemented, 3 overdue.
IT Disaster Recovery	Final Report	Amber	8	2 implemented, 5 partially implemented, 1 overdue.
IT Asset Management	Final Report	Amber	6	2 implemented, 1 partially implemented, 3 overdue.
GOSS – IT Audit	Final Report	Amber	7	7 implemented.
ContrOCC – IT Audit	Final Report	Amber	9	1 implemented, 4 partially implemented, 4 overdue.

Grant Certification work completed during 2025/26:

- 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, 31/7320H
- Home Upgrade Grant (Phase 2) 2023/24 and 2024/25
- Disabled Facilities Grant 2024/25 (grant determination reference 31/7271) and additional allocation (grant determination 31/7605).

Amendments to 2025/26 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	Previously reported to January 2026 Audit & Governance Committee meeting: 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	Previously reported to January 2026 Audit & Governance Committee meeting: <i>Deferred to Quarter 1 of 2026/27 plan:</i> 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	Previously reported to January 2026 Audit & Governance Committee meeting: *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.
Section 106	<i>Deferred to Quarter 1 of 2026/27 plan:</i> 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.

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 2025/26 Audits since last reported to the Audit and Governance Committee – January 2026.

Bring Your Own Device (BYOD) 2025/26

Overall conclusion on the system of internal control being maintained	R
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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	R	0	1	-	-	-	1	-	-	-	-
Device Enrolment	R	0	2	-	-	-	2	-	-	-	-
Device Security	A	0	6	-	6	-	-	-	-	-	-
TOTAL		0	9								

Bring Your Own Device (BYOD) is the concept of allowing personal devices and equipment to be used for work purposes. This has benefits for staff, in terms of using a device they are familiar with, and also to the Council as it reduces the costs associated with issuing corporate devices and supports flexible working. BYOD comes with a number of risks associated with the fact that personal devices often have weaker levels of security than corporately owned and managed devices. The audit has identified the need to strengthen the management control framework around BYOD by documenting a formal policy, agreeing the scope of BYOD and ensuring technical security controls are applied consistently across all personal devices and reflect good practice.

Corporate Policy - There is no formal documented corporate policy on using personal devices and equipment for work purposes. As such, standards and requirements are not defined, including who can use such devices and equipment, the type of devices that can be used, what they can access and how they will be managed and secured.

Device Enrolment - Users can self-enrol their personal devices and equipment to be used for work purposes without any management approval or oversight. Guidance on how to connect personal devices is available from the IT service desk. The lack of control in this area can lead to personal devices being used when there is no justification for doing so and presents risks around the security of data. Users are also

not made aware of their security responsibilities for safeguarding data at the time they enrol their personal devices and equipment.

There is a formal process for requesting non-standard applications to be made available on a user’s personal device or equipment. All such requests are approved by the user’s line manager, technical cyber lead and the Information Management team where applications have access to any personal data. The controls in this area were tested and confirmed to be working effectively.

Device Security - A mobile device management solution is used to enforce technical security controls on all personal devices and equipment. It can also be used to wipe corporate applications and data from devices that are reported as lost or stolen. A review of the technical security controls currently in place has identified a number of areas where they can be improved.

Key Themes and Root Causes – The issues highlighted in this report identify underlying root causes in **Management/Governance, Processes** and **People**. There is no formal and documented policy on using BYOD, supported by a clear business case. Some processes are not defined and there is also human error/oversight in regard to the implementation of technical security controls.

Pension Fund Investments 2025/26

Overall conclusion on the system of internal control being maintained	G
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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 & Strategy	A	0	4	-	2	-	-	-	-	-	2
External Providers	G	0	2	-	-	-	-	-	2	-	-
Financial Transactions	G	0	0	-	-	-	-	-	-	-	-
Pension Fund Assets	G	0	0	-	-	-	-	-	-	-	-
TOTAL		0	6								

Overall, audit testing found that controls and processes in relation to management of the Pension Fund are strong and working well. There are clear governance structures in place, and transactional level processes were found to be comprehensive and robust. Contractual arrangements with some of the fund’s external providers are in the process of being reviewed with re-tendering exercises taking place during 2026.

Following the government's national review of LGPS (Local Government Pension Scheme) pooling arrangements, the Oxfordshire Pension Fund is required to move to a different pool with effect from April 2026. This is a significant project and is being managed centrally by the pool the fund is moving to with input from relevant officers within the Pensions service. The relevant officers are involved in setting up the arrangements for the move, risks are regularly reviewed and updated, and there is regular reporting to the Pension Fund Committee on progress.

Governance & Strategy Audit testing noted that there are clear governance structures in place for the management of the Pension Fund and fund objectives and strategy are clearly defined. The achievement of fund objectives and adherence to the strategy was also found to be adequately monitored and managed with risk management arrangements in place which appear to be working effectively.

The Pensions Regulator issued a new General Code of Practice in March 2024 with compliance required by the end of March 2025. Compliance was assessed prior to deadline, with regular reporting to the Pension Fund Committee. During 2025/26 an independent review was commissioned to provide additional assurance on the Fund's compliance. This work is ongoing, however early findings indicate the fund is well positioned to meet the new requirements.

It is positive to note that the majority of the induction training required for new Pension Fund Committee members has been completed, with the remaining training due to take place before the end of December 2025, however the recording and monitoring of the training for Board and Committee members in subsequent years is inconsistent and there is a lack of clarity over some of the requirements. The National Knowledge Assessment exercise, which was due to be completed by Committee and Board members who had been in their role for more than a year as part of the 25/26 Training Plan, was not run during 2025, in part due to the need to prioritise the induction training for the new committee members. It was reported that the Service has identified training as an area for improvement during 2026 with plans in place to increase training and to further improve recording and monitoring. It is also planned that the National Knowledge Assessment exercise will be completed in Autumn 2026.

From the review of reporting to the Pension Fund Committee on the value and performance of the fund, inconsistencies were identified between the reporting provided by the Investment Pool and the ad hoc reporting received during the period reviewed. The Committee also raised concerns regarding the scope of reporting, with several requests for information on how the performance of investments managed by the Pool compared to those managed outside the Pool. It was noted that there was some uncertainty about how this information should be presented; however, an action was agreed at the September Committee meeting to address this issue.

External Providers Testing included review of the contractual arrangements in place for the different external providers, including the Custodian, Actuary, Independent Financial Adviser and the Investment Pool, engaged by Pension Fund to manage and oversee its investments. Testing has noted that there is appropriate oversight and reporting in place with the Head of Pensions and the Financial Manager Pension Fund Investment involved on an ongoing basis in discussing and reviewing performance with the different providers.

It was noted that some of the contractual arrangements will be re-tendered during 2026 with the Head of Pensions working with the Procurement service to ensure that the new arrangements are comprehensive, appropriate and compliant with the relevant procurement processes.

Financial Transactions The audit reviewed whether operational transactions are monitored and processed appropriately. It was found that robust systems are in place to ensure that contributions received from scheme employers are accurate and received on a timely basis, with a clear and effective process for addressing any issues. It was also found that robust systems are in place to process and monitor investment transactions including interest, drawdowns and distributions and to process fees and charges, including arrangements to recharge either within the Council or to the appropriate employers. Bank reconciliation procedures and cashflow monitoring were also reviewed and found to be appropriate and operating effectively.

Pension Fund Assets The audit reviewed the processes and controls for monitoring and management of assets including reporting arrangements. Assets are predominantly held with the Custodian, with a small portfolio managed in-house, and it was found that effective arrangements are in place including regular reconciliations and transactional controls, to ensure that our records are accurate and remain so. It was found that there is regular reporting to the Pension Fund Committee on the performance and valuation of the Pension Fund. Regardless of some issues with accuracy of reporting mentioned under Governance above, it was found that the quarterly valuations of the pension fund reviewed as part of the audit are accurate. It was found that there is regular and robust monitoring of both short- and long-term cash flow to ensure that fund assets are sufficient to meet liabilities.

ICT Backups 2025/26

Overall conclusion on the system of internal control being maintained	G
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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	-	-
Operational Arrangements	G	0	1	-	1	-	-	-	-	-	-
Media Security	G	0	0	-	-	-	-	-	-	-	-
Recovery Testing	A	0	2	-	-	-	-	-	-	-	2
TOTAL		0	4								

A regular and reliable programme of IT backups is required for business continuity, operational resilience and compliance. We found that digital systems and data are subject to a daily backup and that databases are backed up on a more frequent basis for a shorter recovery point. There are effective procedures in place for monitoring backup jobs to ensure they have completed successfully and all backup copies are held securely and include an off-site and off-line copy. Controls over backups can be further strengthened by regularly testing them to confirm they are reliable and by also maintaining backup related documentation, such as the backup and recovery policy.

The previous audit of this area was completed in 2019/20 and all agreed management actions have been implemented or are superseded.

Corporate Policy A Backup and Recovery Policy was documented following our last audit of this area in 2019/20 but has not been reviewed since and is now out-of-date. It is important that policies are maintained up-to-date to ensure they reflect current standards and requirements. A review of the policy also found it does not cover a number of key areas relating to backups, such as roles and responsibilities, management/monitoring of backup jobs and testing.

Operational Arrangements A new backup solution was implemented in 2025 and is configured to take regular backups of digital systems and data. There is a daily backup of servers and SQL databases and, in addition, SQL log files are backed up every two hours for increased resilience and to provide a shorter recovery point. There are appropriate retention policies applied to all backups. A new backup solution has also recently been implemented to take daily backups of data within the Microsoft 365 cloud service for applications such as Teams, Exchange, SharePoint and OneDrive. This data was not previously subject to any backup.

There is a daily documented check to confirm that backup jobs have completed successfully and any reported errors are logged and followed up. Testing confirmed that this procedure is working effectively. There is also a daily report of servers that are not subject to any backup but it is currently only received by one person, which presents a key person dependency risk. A review of user access to the new backup solution found it is restricted to members of the IT team who need access to perform backup and recovery procedures.

Media Security All backups are taken to digital media and encrypted. The backup data domain is located at the secondary data centre, which is geographically remote from the primary data centre and ensures backups are automatically off-site when they are taken..

Recovery Testing Digital systems and data in the primary data centre are replicated to a secondary data centre, which reduces reliance on backups in the event of a hardware loss or failure, as services can be switched over to the secondary site. Backups are required to restore data in the event of it being lost, corrupted or compromised in a cyber incident. We found there is no scheduled testing of backups to confirm they are reliable and hence a risk that any issues or errors are not identified and remediated. A restore procedure for recovering from backups on the new backup solution has started to be documented but is not complete. It should be finalised to ensure a recovery can be performed quickly, efficiently and is not dependent on the availability of key persons.

Database Security 2025/26

Overall conclusion on the system of internal control being maintained	A
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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	-	-
Roles and Responsibilities	G	0	0	-	-	-	-	-	-	-	-
Documentation	G	0	1	-	-	-	-	-	-	-	1
Security	A	0	3	-	1	-	-	-	1	-	1
TOTAL		0	5								

Databases provide an organised collection of data that can be accessed and retrieved by IT applications and users. SQL Server databases are used for P1 systems such as LAS (Liquidlogic Adults Social Care) and LCS (Liquidlogic Children's Social Care) and they were the focus of this review. It was confirmed that database administration roles and responsibilities are defined and there is documentation on the different databases in use. A number of technical configurations are in place to secure the databases, although some security risks have been identified which need to be addressed.

Corporate Policy The security of databases is governed by existing corporate IT policies, covering areas such as access management, security patching and backups. Whilst these IT policies are relevant, they do not address specific aspects of database security which should be formalised in a documented standard to ensure security is setup in a consistent and agreed way.

Roles and Responsibilities Responsibility for database administration is defined within the IT team structure and staff were found to be appropriately skilled and experienced in SQL Server databases. There are no key person dependencies in place.

Documentation Hardware and software details about IT systems are held on the IT service desk system. A review of the details found they generally relate to server infrastructure and not databases, such as different instances and their version numbers. This level of information on databases has recently been developed but is not held on the service desk system and so may not be available for wider support purposes. The Database Administrators are developing some automated routines and it was confirmed that they are being documented.

Security The LCS and LAS databases are under vendor support and there are technical security configurations in place which reduce the potential attack surface of the two databases. Some security exceptions have been identified for review.

Key Themes and Root Causes – The issues highlighted in this report identify underlying root causes in **Management/Governance** and **Processes**.

Applicant Tracking System 2025/26

Overall conclusion on the system of internal control being maintained	A
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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	A	0	8	-	2	-	1	-	1	-	4
Operational Processes	A	0	8	-	-	-	1	-	2	-	5
User Experience and Accessibility	A	0	2	-	-	-	-	-	-	-	2
Management Reporting	A	0	2	-	-	-	-	-	-	-	2
TOTAL		0	20								

The Council implemented the applicant tracking system, Tribepad, in September 2024 as part of the transition to bringing recruitment activity back in-house. The system is designed to support end-to-end recruitment processes and enable self-service for hiring managers, with support and oversight by the Resourcing Team. Since implementation, there have been a number of challenges related to the operation of the system and associated hiring processes. Whilst some of these are linked to inherent system limitations, they also reflect the Council’s chosen configurations, evolving recruitment processes, some lack of clarity in communications, and variability in hiring manager understanding of the system.

The audit found that the system of internal controls governing the use of the applicant tracking system is effective in achieving its primary objective of successfully appointing suitable candidates to roles. Over the past year, a number of targeted improvements have been implemented or are in progress, including the introduction of a new vacancy approval process integrated with the system; the development of external reports and Power BI dashboards to improve efficiency and oversight; regular updates to system and process guidance; and the further development of onboarding workflows and questionnaires to reduce the need for retrospective queries. Whilst these actions have

strengthened controls, further work is required to improve the robustness of processes and ensure the system operates effectively for the council.

Governance The audit found that the guidance supporting the use of the system and related recruitment processes is generally well structured, accessible, and supports hiring managers in understanding their responsibilities. However, there were some minor gaps and inconsistencies found where guidance had not kept up with process changes. In addition, the guidance does not sufficiently address deviations from the standard recruitment process, particularly in relation to internal recruitment and appointments made under the Job-Sharing Scheme.

Current contract management arrangements were found to lack clearly defined responsibilities and robust processes for managing issues. There was also found to be a lack of clarity over ownership of the Data Protection Impact Assessment, alongside weaknesses in guidance relating to the handling of candidate data exported or retained separately to the system.

Operational Processes The audit found that system limitations and configuration issues, combined with inconsistent use by hiring managers, have resulted in a number of manual workarounds and fixes, which cause small but cumulative delays at several stages of the recruitment process.

Testing identified non-compliance with policy requirements regarding the upload of recruitment information by hiring managers, with 42% of jobs sampled missing a copy of the shortlisting grid, and 90% of jobs sampled missing a copy of the candidates' interview notes. In addition, there were found to be seven roles (35% of the sample tested) where an internal candidate had been hired for a role that had not been advertised on the applicant tracking system, in conflict with recruiting procedures.

The audit noted that the Resourcing Team retain candidate documentation within secure SharePoint folders, as well as the applicant tracking system. This process is designed to support the manual transfer of data to SAP, and to ensure key documentation is not lost when the applicant tracking system deletes candidate data after six months of no activity (in line with agreed retention periods). Whilst this approach is effective in achieving its primary objective, maintaining documentation in two locations has created issues around data consistency. There were six exceptions found where the system record had not been updated with the candidate's Right to Work or DBS check result, and one further exception where a candidate's DBS check had been uploaded to the wrong profile, although it is understood controls around both of these processes have recently improved to allow a higher level of automation. Data analysis and sample testing further identified 18 instances (45%) where candidates who had commenced employment were not recorded as 'Hired', reducing the reliability of information held on the system.

User Experience and Accessibility The audit identified challenges related to the usability of the system and level of support available to hiring managers. Whilst the system guidance available is comprehensive, there is no additional training available. The Resourcing Team reported a high volume of requests for support, placing pressure on limited capacity. Additionally, there is currently no structured approach to capturing, analysing, and learning from feedback or complaints to identify systemic issues and inform targeted improvements.

Management Reporting The development of external reporting solutions for recruitment activity has significantly strengthened oversight and mitigated a number

of system limitations. In particular, the Power BI dashboard used to track candidate progress and the bespoke report supporting data transfer into SAP were found to be effective and frequently used. However, the process for extracting custom reports is manual and complex, and the ongoing reliance on one technical staff member to maintain these tools reduces resilience in the event of staff absence or changes in support arrangements. The lack of understanding of the system's built-in reporting capabilities within the Resourcing Team also means that requests for external reporting may be a duplication of functionality that is already available.

Key Themes and Root Causes The issues highlighted in this report identify underlying root causes in both **Systems / Technology** and **Processes**. Specifically, the applicant tracking system presents limitations in functionality, configuration and integration. These constraints have been compounded by processes that are still developing following the transition to in-house recruitment, resulting in reliance on manual workarounds and compensating controls to achieve the desired outcomes.

Pension Administration 2025/26

Overall conclusion on the system of internal control being maintained	G
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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
Regulatory Framework	G	0	3	-	-	-	-	-	-	-	3
Scheme Employer & Member Lifecycle	A	0	8	-	-	-	-	-	-	-	8
Debtor Management	G	0	0	-	-	-	-	-	-	-	-
TOTAL		0	11								

Overall, the audit noted that controls and processes in relation to Pensions Administration are strong and working well. There is work ongoing to progress key projects and to identify and implement changes to systems and processes to increase efficiency where possible, with regular reporting to the Pension Fund Committee on key areas of activity.

Regulatory Framework The team continue to monitor and report on performance against SLA targets, with routine quarterly reporting to the Pension Fund Committee. Work is continuing to make performance reporting more efficient, comprehensive and system driven where possible with the focus to date being on reporting relating to benefits team tasks. Further development is underway in relation to reporting on

employers and systems team tasks. From review of current reporting arrangements to Committee, reporting could be improved by ensuring that it is possible to more clearly link agreed SLA targets with the data reports being presented. There is now high level comparative reporting in place, although this does not show comparisons at individual SLA target level. It is noted that revised performance targets, reflecting the increasing complexity of some key tasks, are to be proposed to the Committee for agreement shortly.

Review of staff guidance as part of this year's audit focussed on the Employers team. Overall, it was noted that the guidance in place sufficiently covers key tasks, with some improvements noted as being required to ensure consistent documentation is retained relating to the completion of employers data vetting checks.

It was noted that a breach report was submitted to the Pensions Regulator, as reported to the June 2025 Pension Fund Committee, in relation to delays in the issue of fire scheme active and deferred benefit statements due to unresolved regulatory queries and case complexities relating to the age discrimination remedy. It is reported that the remaining statements are due to be issued by the revised deadline of end of March 2026. Over 99% of annual benefits statements were issued by the 31 August deadline for non-fire related scheme members.

The Service continues to work on a number of key projects. This includes the project to complete actions required relating to 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). Originally set to finish by the end of August 2025, a request was made to extend the deadline for completion of the required tasks to 31 August 2026 due to the complexities with some of the cases. Project progress is being monitored and is routinely 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, progress on this project is also being reported on routinely to the Pension Fund Committee.

There continue to be staffing vacancies which are contributing to ongoing resource pressures across the team. Recruitment exercises are ongoing and a Workforce Strategy which aims to determine and implement an effective approach to address staffing challenges going forward, has been produced and has recently been presented to the Pension Fund Committee.

Scheme Employer & Member Lifecycle The process, roles and responsibilities in relation to the agreement of debt settlement, where a scheme employer leaves the Local Government Pension Scheme requires confirmation to ensure a consistent approach.

A single member of staff currently holds all of the operational knowledge in relation to the management of system user roles and permissions, and there is currently a lack of comprehensive documentation supporting this. Options for the resolution of these issues are already being reviewed including discussions with the system provider to ensure resilience is strengthened.

The Payjour reporting process, in place to strengthen segregation of duties arrangements, requires some further review to ensure that checks being made on

specific administration tasks are effective, that coverage is appropriate and that checks are clearly and consistently documented.

Sample testing completed as part of the audit confirmed that most key administration processes are operating as intended, with effective management oversight in place, for the cases sampled. Minor exceptions were noted.

Implementation of the enhanced version of Administration to Pay, which will increase automation of some processes and reduce the need for manual intervention, is ongoing with implementation planned for the summer of 2026.

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. Testing confirmed that the debt recovery process is working effectively. At the time of testing debts had been paid or were following the defined debt recovery process. It was confirmed that the debtor position is reported to the Pension Fund Committee as part of the Administration report on a quarterly basis.

Employee Relations 2025/26

Overall conclusion on the system of internal control being maintained	A
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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	A	1	10	-	-	-	-	-	-	-	10
Employee Relations Processes	A	0	7	-	-	-	-	-	-	-	7
TOTAL		1	17								

As part of the Council's key objective to be an Employer of Choice, strong employee relations is essential to reduce staff turnover, improve morale and productivity, enhance the organisations reputation, support performance management and employee conflict resolution and ensure that grievances and disciplinary processes are followed appropriately and consistently.

The Employee Relations team is responsible for the oversight and provision of advice and guidance to managers on a range of employee relations issues which can vary in complexity. Line managers across the Council are responsible for compliance with key HR policies and procedures and seek advice from and are supported by the Employee Relations team where appropriate.

Since the start of 2025 work has been ongoing to ensure that there is clarity across the Council in relation to employee relations policy and process. Following a review and refresh of employee relations guidance for line managers, mandatory training for line managers was rolled out during the first quarter of 2025/26. The reorganisation of HR and Cultural Change in the second half of 2025 and the implementation of a revised Employee Relations team structure has ensured clarity over the expectations of roles and responsibilities within the Employee Relations team. Alongside the implementation of the new team structure, team processes have been reviewed and, as part of this, an ER Improvement Plan has been developed. Identification and implementation of improvements is ongoing.

Key areas where audit testing has identified areas for improvement are in relation to quality assurance, management oversight and reporting.

It is positive to note that discussions with trade union representatives as part of the audit highlighted positive engagement between the union, senior management across the Council and the Employee Relations team both in terms of employee relations case progression and management and in the development of policy and process.

Governance – Whilst there is evidence of discussions with senior management within HR & Cultural Change and within service areas on complex employee relations cases, there is a lack of an effective process for ensuring appropriate routine reporting and oversight. Within HR & Cultural Change, Employee Relations Team Case Progress Meetings have been re-established with work ongoing to ensure that these meetings are effectively focussed. It is also planned that Case Management Meetings, which will provide HR senior management with ongoing oversight of cases and key performance metrics, will be re-established. Arrangements for reporting within service areas are currently ad hoc, but these are under review. Escalation processes are also being reviewed, refined and implemented.

A key area of focus is on systems, data and reporting with work ongoing to implement a new case management system, to review and identify management information and performance reporting requirements and implement improved reporting, including dashboards, both to senior management within HR and in service areas. It is anticipated that the implementation of the new system and reporting arrangements will resolve key limitations identified with the current arrangements. Document retention processes are also being reviewed and updated as part of this work.

As referenced above, mandatory training for line managers on “Managing Conduct and Grievance” and “Managing Capability & Poor Performance” was introduced in 2025 to ensure that line managers have clarity on their role and responsibilities in these key employee relations issues. Audit testing noted that completion of this training across the Council is currently at 68% and whilst there had been a mechanism in place for reporting and follow up of non-compliance with senior management within service areas, this appears to have slipped since the new structure was implemented. Line managers are expected to take the lead in management of employee relations cases for their direct reports, and this mandatory training is the key mechanism for communicating these expectations. The training also highlights the existence of HR toolkits which have been produced to provide key information, guidance and support on employee relations issues. Audit testing noted some areas where updates and review is required.

Governance, Strategy, & Oversight	A	0	3	-	-	-	-	-	-	-	3
Risk Identification & Insurance Coverage	G	0	0	-	-	-	-	-	-	-	-
Claims Handling & Case Management	G	0	0	-	-	-	-	-	-	-	-
Management Information	G	0	1	-	-	-	-	-	-	-	1
TOTAL		0	4								

The Council's Insurance Team manages insurance for the Council, ensuring that assets and liability risks are sufficiently protected by insurance or alternative methods. The team also handle insurance claims for the Council and have contracted arrangements with two external insurers, who manage larger and more complex claims.

The audit found a strong system of internal control in place for the management of insurance, and risks are being effectively managed. Some areas for improvement were identified, particularly around strategic oversight and performance monitoring.

Governance, Strategy, and Oversight The audit noted that there is currently no documented insurance strategy in place setting out the Council's overall approach to insurance. As a result, key elements are not formally articulated, how insurance supports Council objectives, service delivery, and statutory responsibilities; aligns with the risk management framework, and reflects the Council's risk appetite and approach to insuring or self-insuring specific risks.

Regular meetings were found to be taking place with the insurers and brokers, with clear lines of communication for escalation queries, concerns, and issues, although it was noted these meetings are not routinely minuted, with no formal record retained of what has been discussed and actions to be taken.

In terms of guidance, roles and responsibilities were found to be clearly defined both within the team via clear job summaries and procedure documents, and to Council and school staff via intranet guidance. While all guidance was found to be comprehensive and accessible, some areas were noted that require updating, such as out of date information or broken links.

Risk Identification and Insurance Coverage The audit reviewed the controls in place to ensure all Council assets are appropriately insured, noting guidance available to staff is clear in placing responsibility for the notification of changes in assets on service areas. This reliance on services to proactively notify the Insurance Team creates a risk that, where changes are not reported in a timely manner, assets may not be appropriately insured. However, testing of a sample of vehicles, buildings, and engineering equipment found that all assets reviewed had appropriate insurance cover in place. It was also found that as an additional control, services are contacted at the start of each new insurance policy period to confirm whether there have been any changes to activities, processes, or assets that may affect insurance cover.

Testing was also undertaken to confirm appropriate controls are in place around third party contracts and associated insurance requirements, finding a new process is to be implemented shortly which will shift most insurance-cover decisions to the commercial/procurement function using pre-set parameters. Specialist input will be reserved for high-risk, complex or exceptional cases, streamlining approvals, reducing unnecessary escalation, and speeding up contracting.

Claims Handling and Case Management Testing of a sample of 50 insurance claims, covering different claim areas, outcomes, appeals, and those referred to the external insurers, identified good practice across the Insurance Team. Claims were found to have been handled consistently and in line with established processes, with all claims reviewed thoroughly investigated, fraud red flags highlighted and examined where necessary, and, where payments were made, these had been signed off correctly signed off and accurately made. This is particularly positive to note given the significant increase in claims received during the months the audit was undertaken.

Financial management was also reviewed, confirming regular reconciliations and monitoring of account balances, along with the annual reconciliation as part of the close down process. Additional controls are also in place for large payments, with Insurance Manager / Deputy Insurance Manager sign off required for any payments over £10k being paid out by the external insurers, and S151 authorisation for any payments over £200k.

The audit confirmed that an independent actuarial review is undertaken annually to assess the adequacy of insurance provisions and reserves for self-insured claims, analysing claims over the previous 12 months and considering longer-term trends to forecast future claims exposure and inform the appropriate size of the insurance fund. The most recent actuarial review was carried out in May 2025 and was used to support financial planning and reserve setting, and ensuring that current insurance arrangements, including excess levels, are in place to mitigate the risk of unplanned financial pressure.

Management Information Management information surrounding insurance and claim management was found to currently be either ad-hoc, or limited to high risk areas, for example, a quarterly management reports are produced for Highways, supported by follow up meetings with the service, but other service areas are not in receipt of regular reporting. It is acknowledged that a new role has recently been created within the team, with a focus on risk and compliance. While this post is still underdevelopment, it is intended to provide analysis of trends and patterns in insurance claims and to work with services to develop and implement action plans aimed at reducing claim volumes within specific service areas. This role will therefore have a key impact in improving the current limitations in reporting.

It was also found that within the team, there are no defined performance indicators for claims handling, and there is no regular reporting of operational or strategic performance (e.g., timeliness of claim acknowledgement, claim lifecycle, repudiation rates, financial trends).

Duplicate Payments 2025/26

Overall conclusion on the system of internal control being maintained	G
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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
Duplicate Payment Prevention	G	0	0	-	-	-	-	-	-	-	-
Duplicate Payment Detection	A	0	3	-	-	-	-	-	-	-	3
TOTAL		0	3								

The audit found a strong system of internal control in place to prevent and detect duplicate payments. The Council has used the Hampshire Partnership Integrated Business Centre's (IBC) controls for duplicate payment detection since May 2025, following the conclusion of a three-year contract with external provider. The contract had focussed on retrospective analysis of Accounts Payable transactions dating back to April 2014, and resulted in total recoveries of approximately £2.5 million. In comparison, the controls provided by the IBC focus on real-time prevention of duplicate payments as they are posted on SAP for processing, using AI software to identify potential matches, which are then investigated before the payments are cleared.

Duplicate Payment Prevention – The audit found that appropriate preventative controls are in place across the five payment mechanisms reviewed (VIM, One-Time Vendor, Business Data Upload and Foreign and CHAPS payments) to minimise the risk of duplicate payments. Clear guidance exists for all payment routes, setting out required processes that support the prevention of duplicate payments. All payment routes reviewed were also found to operate with adequate segregation of duties and oversight over payment processing. In addition, there are appropriate channels in place to communicate changes to payment processes where these could increase the exposure of duplicate payments.

Duplicate Payment Detection – The audit assessed the effectiveness of the Council's duplicate payment detection and recovery processes across both the retrospective and current arrangements. To evaluate controls in place prior to the adoption of IBC's processes, testing was completed using National Fraud Initiative (NFI) duplicate creditor payment matches from the 2024/25 exercise, with a sample of 100 matches reviewed in detail. This did not identify any unresolved duplicate payments; where duplicate or erroneous payments had been paid, it was confirmed that the funds had already been recovered.

Financial Management	G	0	0	-	-	-	-	-	-	-	
TOTAL		0	10								

Following previous audits which had identified control weaknesses and inconsistencies which occurred when management of the Council's fleet was decentralised, a decision was made in 2021 to adopt a coordinated approach to fleet management to improve oversight of fleet assets and enable greater consistency and efficiency in vehicle procurement, management and disposal. This followed the Council's decision, in 2020, to commit to achieving net zero carbon from Council operations by 2030. Subsequently, a plan was approved in 2023 which included the centralisation of vehicle management (excluding Oxfordshire Fire & Rescue Service) and the replacement of fossil-fuelled vehicles with electric vehicles by the end of 2025/26. This led to the creation of the Vehicle Management Service (VMS). Since then, the team have worked to develop processes and controls to manage and oversee the Council's fleet operations and have sought specialist support to enable further improvements. Audit testing has confirmed that compliance and operational control have improved significantly since the previous audit, though further work is required to fully embed governance, clarify roles and responsibilities and strengthen management information and oversight.

Governance & Oversight – The audit noted that there is a clear strategy in place for VMS and its operations, defined as part of the One Fleet Project Business Case, approved by Cabinet in 2023. In addition to centralising the management of the Council's fleet, this includes the move to a fully electric fleet, in line with the Council's commitment to become carbon neutral in its own operations by 2030. To ensure that the replacement of the fleet is completed effectively, considering key aspects such as asset life, utilisation levels, whole life cost considerations, funding and approval arrangements, a clear policy approach is being developed with the input of a subject matter expert. Whilst this means that the original timescale for replacement of the fleet (due to take place by the end of 2025/26) will not be met, it will help to ensure that the electrification of the Council's fleet is completed effectively in a way that will ensure that the Council's needs in relation to fleet are met, taking into account financial and market considerations as well as being aligned with environmental and carbon reduction commitments.

The centralisation of fleet management has involved changes to roles, responsibilities and processes for teams across the Council. Whilst the audit noted that the VMS team has made good progress in working with services to develop these new arrangements, there is a need to clearly define, document and agree roles, responsibilities and processes. A Service Level Agreement has been drawn up which will clarify and formalise the arrangements and expectations of VMS and its service users including responsibilities of line managers. There is also a need to develop information and guidance on VMS processes available to staff via the intranet, to increase understanding of the role of the VMS team, the services they provide and the policies and processes that staff are expected to follow. Guidance specific to drivers of Council fleet vehicles also requires development to ensure that there is clarity over areas including acceptable use, expectations relating to vehicle checks and defect reporting.

Whilst the current IT system in use within the VMS team has been populated with operational information to enable appropriate oversight of routine team tasks, this is limited and there is a need to develop this further to capture key information (for example mileage and utilisation data) consistently. Vehicle tracking is currently only installed on a small proportion of the fleet. Improvements to the capture and reporting on key information metrics will enable better insights into the use of the Council's fleet and will be able to aid decision making to ensure that what is in place is meeting the Council's needs and is cost effective.

Operations Including Compliance & Risk Management – It is positive to note that there have been significant improvements since the previous audit in relation to compliance with regulatory fleet management requirements following the centralisation of the Council's fleet and the creation of the VMS Team. Audit testing found there to be clear processes in place for monitoring of compliance with regulatory aspects of fleet management including insurance, road tax and MOT. The audit included whole population testing which confirmed that controls are operating effectively in these areas.

Clear processes are also in place in relation to the scheduling of routine inspections, servicing and maintenance. Whilst it was reported that there have been some instances of vehicles not being presented for inspection at the required time, the development and agreement of the Service Level Agreement will provide clarity over expectations for compliance in this area. There is also a need for a clear process for the monitoring, reporting and escalation of any instances of non-compliance. Management have identified that the current arrangements for the way in which fleet servicing is sourced require review to ensure that future arrangements meet the Council's needs and provide appropriate value for money going forward.

As noted above, vehicle tracking and telematics capabilities require development to ensure that there is consistent and appropriate management information available across the Council's fleet. A project is currently underway to review how telematics could be used across the fleet, with costs and benefits being explored for the different options available.

An area where significant control weaknesses have been noted as part of previous audits relates to the use of fuel cards. Due to inherent risks relating to potential misuse, it is important that expectations over appropriate use are clearly defined and communicated and that there is a clear and consistent approach to management monitoring and oversight of card use. Improvements have been made since this area was last audited with card administration processes now centralised within the VMS team and with the review and improvement of invoicing processes. However, further improvements are required in relation to the development of a clear corporate policy and operating processes and the confirmation of roles, responsibilities and processes for centralised management within the VMS Team.

The contract for the IT system used within the VMS team is due to expire later in 2026. A procurement exercise is in the process of being completed and as part of this it is planned that the current software will be evaluated to identify any gaps, inefficiencies and improvements required as part of the new contractual arrangements.

Acquisition & Disposal – It was confirmed that a clear process is in place to ensure that vehicles can only be procured through VMS and include appropriate involvement of procurement colleagues. The approach to vehicle acquisition and disposal is being

developed, with input from the subject matter expert, as part of the fleet replacement policy.

Financial Management - Regular budget monitoring and forecasting is in place. The audit confirmed that finance have oversight and involvement in how vehicle purchase and the related financial recording, VAT and recharging processes operate in order to comply with relevant financial regulations and requirements. There is systematic recharging to services and there have been recent improvements implemented to improve the timeliness of those recharges. As mentioned above, the strategy for future funding arrangements of the fleet is being considered as part of the development of the fleet replacement policy. Detailed testing of individual transactions was not undertaken during this audit.

Key Themes and Root Causes

The issues highlighted in this report underlying root causes of **Processes** and **Systems / Technology**. Processes are either not fully defined or are out of date and there is limited management information and oversight (for example telematics and vehicle tracking data not being available across the fleet).

Grants Management 2025/26

Overall conclusion on the system of internal control being maintained	G
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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
Grant Governance	A	0	3	-	-	-	-	-	-	-	3
Grant Monitoring	G	0	0	-	-	-	-	-	-	-	-
Grant Reporting and Returns	G	0	2	-	-	-	-	-	-	-	2
TOTAL		0	5								

The Council applies for and receives grant funding, mainly from central government departments, for various different projects, initiatives and services across service areas. In 2024/25 this included £147M in capital grant funding and £538M in revenue grant funding. Delivery of the activity or outcomes relating to grant funding received is managed within service areas, with oversight from Corporate Finance in relation to capital grant funding and from both Corporate Finance and Finance Business Partnering in relation to revenue grant funding.

Overall, audit testing noted that roles, responsibilities and processes relating to the management and oversight of grant income received and the delivery of grant funded

activities are clearly defined and understood. However, there are areas for improvement which include the development of a centralised, more detailed, record of revenue and capital grants and development of corporate guidance to support officers in effectively managing grant funding and related activity.

Grant Governance For the sample of grants tested as part of this audit, there were defined responsible officers within service areas with clearly understood roles, responsibilities and processes for the monitoring of grant spend and delivery of the activity, project or service the grant funding was received for. Corporate Finance and Finance Business Partnering have oversight of capital and revenue grants received, with revenue grants recorded in the Grants Annex of the budget book and tracked through the year as part of the Business Management and Monitoring Report (BMMR) process. Corporate Finance also have a role in monitoring and overseeing capital grant income and spend as part of the processes relating to the management of the Council's capital programme. However, whilst Corporate Finance and Finance Business Partnering have records detailing grants received, there is currently no single, overarching corporate register with more detailed information, for example on accountabilities, certification requirements and deadlines. A grants register would support improved governance and oversight by enabling clearer accountability for grant ownership, enhanced oversight of reporting requirements, improved financial assurance, better visibility of delivery timelines and dependencies, and more effective management of funding risks, including clawback and underspends. It could also facilitate corporate-level reporting, transparency, and the sharing of good practice across services.

It was also noted that there is no overarching corporate guidance to provide support to services and promote consistency of approach, particularly in relation to more complex grant administration arrangements, across services in the management of grants received. Examples were noted where documented local procedures would reasonably be expected but were not in place. Additionally, whilst there are strong processes in place within Corporate Finance to oversee capital grant income and expenditure, these are reliant on one member of staff with no documented procedures in place.

Grant Monitoring The audit noted, for the sample of grants reviewed, that there were appropriate processes in place to monitor activity and delivery of the project, service or initiative being funded by the grant and on grant income and expenditure. As noted previously, there are also clear processes in place within Corporate Finance for the oversight and monitoring grants received.

Grant Reporting and Returns There were also found to be appropriate reporting mechanisms in place to provide assurance to both external funding providers and senior management within the service area over delivery of the requirements of the grant and on grant expenditure. It is noted that for the grants where Internal Audit certification and sign off of compliance with grant conditions has been required during 2025/26, it has been possible to evidence and confirm compliance with grant conditions. However, improvements were noted as being required in relation to the coordination and management of grant certification and sign off arrangements by the lead officers within service areas, to ensure that these processes can be completed on a timely basis.

Bridge Management 2025/26

Overall conclusion on the system of internal control being maintained	R
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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 and Strategy	R	1	1	-	-	-	-	-	-	1	1
Asset Management	R	0	3	-	-	-	-	-	-	-	3
Inspection, Maintenance and Repairs (including Risk Management)	R	1	7	-	-	-	-	-	-	1	7
Contract Management	R	0	1	-	-	-	-	-	-	-	1
Budget Monitoring	R*	1	0	-	-	-	-	-	-	1	-
Management Oversight and Performance Monitoring	R	1	0	-	-	-	-	-	-	1	-
TOTAL		4	12								

Under the Highways Act 1980, Local Authorities have a duty to maintain highways, including structures such as bridges, in a safe condition. Additionally, technical standards and guidance, including the Design of Manual for Roads and Bridges (DMRB) and the Code of Practice: Well-managed Highway Infrastructure (2016) place duties on Local Authorities for ensuring that structures are fit for purpose and all risks are appropriately managed by setting out recommended practices for inspection, assessment, maintenance and record keeping.

The audit identified several weaknesses across the reviewed risk areas, including gaps in governance arrangements, weaknesses in contract management oversight and escalation, and limitations in the quality and completeness of structures asset information. Collectively, these issues reduce assurance that roles, responsibilities and decision-making expectations are clearly defined and consistently applied, and that management has a complete and reliable view of the Council's bridges and structures portfolio.

The audit also identified under-delivery and weak quality assurance across inspection, maintenance and repairs, with a longstanding backlog in inspections and an inconsistent approach to the recording of follow-up activity and remedial actions.

These weaknesses are combined with the absence of bridge-specific performance monitoring, and reported material underspend in the 2025/26 Bridges Capital Programme.

Governance and Strategy

The audit identified weaknesses in governance arrangements for bridge management, including gaps in contract management oversight, performance monitoring and asset data quality. While a proposal is being developed to move delivery of the capital structures programme fully to the contractor, arrangements were not yet formally approved or fully documented at the time of audit fieldwork (April 2026), with roles, responsibilities, governance expectations and timescales still to be agreed.

A separate audit of Highways Contract Management was carried out in 2025/26. This reviewed the governance arrangements in place for the oversight of the contract, and reports on the areas for improvement in more detail.

A review of procedural guidance in relation to structures found the Structures Asset Management Strategy (SAMS) and Structures Asset Management Plan (SAMP) are being used operationally, although it was noted that the documents are still at draft, and have not been formally adopted through the Council's governance process.

Asset Management

The audit identified gaps and errors in key asset information held in the asset management system, BridgeStation, including duplicate structure records, incorrect coordinates, and widespread missing or inconsistent fields for ownership, maintaining authority, and inspection history. These weaknesses, driven by factors such as unclear asset assignment across teams, historic data migration issues, and information being held offline, reduce assurance that the Council has a complete and reliable view of its structures.

The integrity of the data held is a known issue to management, who acknowledged the data on BridgeStation is in its infancy, with much of the relevant asset data being held offline. It was reported it is an aim within the service to better record this information, ensuring consistency with BridgeStation, as well as improve the currently limited data validation activity.

In addition to the inconsistent ownership and maintenance records, the audit found weaknesses in the availability and consistent recording of moiety agreements needed to define ownership boundaries and inspection/maintenance responsibilities for jointly owned structures, including cases where no sufficient agreement was in place.

Inspection, Maintenance and Repairs (including Risk Management)

The audit identified under-delivery of the Principal Inspection (PI) programme, which is delivered by the contractor, with a longstanding backlog, reducing assurance over bridge condition and safety. The audit also found limited independent oversight in relation to completed PIs.

General Inspections (GIs), delivered internally, were found to be overdue, and a backlog has also developed in the review and approval of the completed GI reports, weakening quality assurance over inspection content and follow-up actions.

The audit found that inspection outcomes and follow-up actions are not consistently recorded, reviewed, or closed within BridgeStation

Recording of follow-up activity (post-inspection reviews, photographs and re-inspections where required) was not clearly defined, leading to inconsistencies and limited evidence that defects are being assessed, mitigated, and closed.

Bridge-related reports raised via FixMyStreet are not efficiently managed by the bridges team with duplication and manual intervention taking place.

Contract Management

The audit found that oversight and escalation arrangements for the contract are not providing clear, timely assurance over delivery. Instances were noted in which monthly escalation reports to the Highways Operations Board (HOB) from the various governance groups were not updated month to month to reflect current position or progress, instead repeating the same information.

Meeting minutes, particularly from the Contract Management Group (CMG) and HOB, recorded limited scrutiny and follow-up on key bridges/structures issues. This reduces visibility of whether escalated matters are being progressed and resolved.

The audit found that governance oversight and escalation arrangements are not providing clear, timely assurance over delivery of the highways maintenance contract, particularly in relation to bridges and structures. Monthly escalation reporting to the Highways Operations Board (HOB) were often repetitive and not consistently updated to reflect the current position (for example, Project Management Group (PMG) escalation reports contained identical narrative repeated across multiple months), and several escalated bridge items showed limited evidence of progression (including items carried over for months with responsible leads recorded as "TBC" and escalation narrative remaining unchanged), limiting the effectiveness of escalation.

In addition, the audit found limited evidence that bridges/structures delivery issues were routinely scrutinised through the Contract Management Group (CMG) or effectively progressed via HOB, with minimal references within minutes. Where references did exist, there were typically recording acknowledgement rather than challenge, decisions, agreed actions, or subsequent follow-up. These weaknesses reduce transparency of issue ownership, status and resolution, limit the effectiveness of escalation, and increase the risk that contract risks are not actively managed, decisions are delayed, and senior leadership has reduced assurance over delivery and value for money.

Wider contract management areas for improvement, such as contract risk management processes, have been identified and reported separately within the Highways Contract Management Audit 2025/26.

Budget Monitoring

The audit noted material underspend against the 2025/26 bridges capital programme, which was reported as slippage in delivering planned schemes. Schemes have been reprogrammed, partially completed, deferred, and carried forward. Management have reported that it is intended that the move to commission the contractor to deliver the bridge capital programme in full will address the current issues and delays.

Detailed testing was not undertaken as part of the audit regarding the accuracy of quotes and payment applications, but have been separately reviewed as part of the Highways Contract Management Audit 2025/26.

Management Oversight and Performance Monitoring

The audit identified significant weaknesses in the performance monitoring arrangements for bridge management activities, which limits management's ability to oversee delivery and challenge underperformance. Although the highways maintenance contract has been in place since April 2025, bridge-specific performance indicators have not been implemented or monitored, and there is no established performance baseline for inspections, asset data quality, and structural maintenance.

The audit also found that performance information relating to bridge related activity that is delivered internally is not routinely monitored or reported.

Key Themes and Root Causes

The issues highlighted in this report identify underlying root causes in **People, Processes, and Management/Governance**. Specifically, a lack of formalised guidance, poor data governance, and weak oversight, escalation, and performance monitoring arrangements.

Highways Contract Management 2025/26

Overall conclusion on the system of internal control being maintained	A
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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	A	0	5	-	-	-	-	-	-	-	5
Contract Management	A	1	5	-	-	-	-	-	-	1	5
Accuracy of Payments	A	1	3	-	-	-	-	-	-	1	3
TOTAL		2	13								

In April 2025, following a mobilisation period, a new contract commenced to deliver the Council's highways maintenance contract. The contract is for an initial 8 year period, with options for two 3-year extensions. The total value of the contract, excluding VAT, is £840 million.

The audit has identified several weaknesses across the reviewed risk areas. These include insufficiently clear and embedded governance arrangements, such as incomplete and inconsistent Terms of Reference documents and meeting records/minutes. The audit also identified weaknesses in contract management controls, including ineffective contract risk management and inconsistent performance monitoring. In addition, the audit found gaps in payment assurance arrangements, particularly in the transparency of payment application approvals and in the management of abortive costs.

Governance

The audit found that governance arrangements for managing the highways contract are not sufficiently clear, formally approved, or consistently evidenced in practice. Although governance structures and roles are described within the Contract and a separate Relationship Management Plan, there was no evidence that the latter had been formally approved, and the audit could not confirm the arrangements are fully embedded and operating consistently. Evidence that the Contract Management Group (CMG) has met regularly, for example through meeting minutes, was limited, and documentation held in the designated central repository was incomplete.

Terms of Reference documents for the key governance bodies were found to be inconsistent with insufficient clarity on decision-making authority, escalation routes, and expectations for risk, performance and financial oversight. Meeting minutes and action tracking across the Strategic Partnership Board, Highways Operations Board and Contract Management Group were variable and often lacked the detail required to evidence decisions, follow-up and ownership, and in some cases could not substantiate decisions reported to have been made. Several instances were noted throughout the audit in which it was reported discussions and decisions had been made at the CMG meetings; however, minutes were either unavailable or insufficiently detailed to support this.

The audit also found non-compliance with the Council's conflicts of interest and secondary employment requirements, with an instance of undeclared paid work for the contractor, increasing the risk of actual or perceived conflicts and undermining transparency and confidence in governance.

Contract Management

The audit found that contract risk management arrangements are not operating effectively, with no current Contract Risk Register in place and no evidence that contract-related risks are being routinely identified, assessed, owned, monitored or escalated under the current contractual arrangements. Risk management is not clearly embedded within governance documentation, with limited reference to risk responsibilities in Terms of Reference and no evidence that actions to review the risk register (recorded in Contract Management Group minutes) were completed. This reduces assurance that emerging issues will be identified and escalated in a timely way to support effective oversight and informed decision making.

The audit found that key contract management controls intended to provide performance assurance have not been applied consistently since mobilisation. The monitoring of Operational Performance Indicators under the contract's Performance Management Framework has been paused for an extended period without adequate documented approval or rationale, with limited evidence of formal performance review, escalation through contractual improvement mechanisms, or application of performance deductions, weakening value for money and assurance over service delivery.

There has been a separate audit of Bridge Management in 2025/26 which identified required areas for improvement in relation to the oversight and contract management of bridge/structure related activity.

Accuracy of Payments

Testing of a sample of Applications for Payment identified weaknesses in payment approval controls and a lack of transparency where Budget Holder rejections were subsequently approved by the Contract Manager. In most cases, the rationale for

overriding decisions was not recorded and Budget Holders were not sighted on the final approvals.

Budget Holders also reported they were unclear as to whether certain costs were included within the contract terms or should be charged separately, creating uncertainty around the approval of applications, and inconsistency across work orders. It was reported these charges have now been clarified with the contractor, with plans in place for notification to Budget Holders.

The audit found limited controls in place for the management, agreement and payment of abortive costs (where a defect repair cannot be carried out at the time of the visit). Abortive costs are understood to be claimed at 60% of the scheduled repair value, however no evidence was provided to demonstrate how this rate was agreed and communicated, and governance records (including CMG minutes) did not provide a complete trail of eligibility decisions or the intended approach to compensation events.

It was found that the current approach does not always provide value for money as charging a percentage of the scheduled repair value with no cap can produce disproportionate costs. This methodology also does not prevent multiple charges where duplicate work orders or neighbouring defects are recorded for the same location/visit.

The contractor has so far submitted two compensation events for abortive costs. Due to data accuracy concerns, revised quotations were requested, however were not submitted within contractual timescales (due December 2025), meaning the Council can now make an assessment to determine the payment amount, however a decision regarding this has not yet been made.

During 2025, Internal Audit and Counter Fraud reviewed concerns relating to the potential submission of duplicate job instructions to the contractor under the previous contract. Investigative work was undertaken in collaboration with the service, resulting in the identification of control weaknesses and the implementation of strengthened processes and oversight arrangements. Any instances where overcharging was identified were addressed with the contractor and a payment adjustment made. As part of this audit, Internal Audit has undertaken follow-up work to assess the effectiveness of the revised controls now in operation. Some matters arising from internal audit testing remain under active consideration and are subject to a separate, ongoing review by Internal Audit and Counter Fraud.

Key Themes and Root Causes

The issues highlighted in this report identify underlying root causes in **People and Management/Governance**. Specifically, incomplete governance documentation, weak contract management oversight due to the lack of robust risk management and performance monitoring arrangements, and insufficient documentation and transparency to support payment decisions.

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.