Appendix A

Rotherham Metropolitan Borough Council

Internal Audit Progress Report

1st May – 31st July 2025

1. Internal Audit Annual Plan

1.1 Internal Audit produced a risk-based Audit Plan for 2025/26 and presented it to the Audit Committee at its meeting on 11th March 2025. The plan is included at **Appendix B**.

1.2 As the year progresses, changes are made to the plan to reflect emerging risks and changing priorities. Additional work requested is added to the plan and is resourced either through contingency or through the removal or deferral of lower risk audits. The audits from the 2024-25 audit plan that have not yet been finalised have been included in the 2025-26 plan.

2. Audit work undertaken during the period resulting in an assurance opinion

2.1 Internal Audit provides an opinion on the control environment for systems or services which are subject to audit review. These are taken into consideration when forming our overall annual opinion on the Council's control environment. There are four possible levels of assurance for any area under examination, these being "substantial assurance", "reasonable assurance" "partial assurance" and "no assurance". Audit opinions and a brief summary of all audit work concluded since the last Audit Committee are set out in **Appendix C**. 19 audits have been finalised since the last Audit Committee.

3. Details of other Internal Audit activities undertaken not resulting in an assurance opinion

3.1 The table below sets out the work undertaken where audit have not issued an audit report with an opinion. This highlights the range of activities that we have also undertaken in the period.

Audit Work Completed	**Details of Work Undertaken, and Assurance Provided**
Signals grant	Grant claim validation which confirmed the income and expenditure were accurately reflected.
Bus Operators grant	Grant claim validation which gave assurance that the funds were spent in accordance with those intended.
School request for assistance	Internal Audit were requested to investigate financial concerns raised by a maintained school Headteacher following her return to school after a period of absence. The financial and management controls were reviewed and recommendations raised to enhance governance and financial oversight at the school.
Customer Services Liaison meeting	Participation in this regular meeting helps to ensure audit are informed of the latest areas that Customer Services are working on, and where audit may wish to focus on at an early stage before changes to systems or ways of working are implemented.
Audit Queries and Advice	We have received and responded to a number of queries and requests for advice from schools regarding asset inventory controls and general financial controls.

4. Anti-fraud and corruption work and investigations

4.1 In addition to the planned audit assurance work, Internal Audit also carries out unplanned responsive work and investigations into any allegations of fraud, corruption or other irregularity. There are two investigations ongoing.

4.2 The National Fraud Initiative (NFI) is a biannual data matching exercise conducted by the Cabinet Office. Matches were released in late December 2024 and January 2025. 7,418 matches have been released to date. As at 31st July 6,918 matches have been closed. The remainder of the matches will be reviewed during 2025/26.

4.3 The Public Sector Fraud Authority has been working to amend the Local Audit and Accountability Act 2014 and the Public Audit (Wales) Act 2004 through a Legislative Reform Order (LRO). This amendment will enable the NFI to resume the matching and sharing of adult social care data with local authorities. There has been a delay in the legislative commencement process, which relevant Parliamentary teams are actively working to progress. Once this has been resolved, the Council will be able to proceed with recommencing the matching of adult social care data within the NFI, starting with Residential Care Homes and Personal Budget (direct payments) data as set out in the NFI 2024/25 work programme. Once a formal data request is issued Internal Audit will work with the relevant services within the Council to obtain and provide the data.

5. Data analytics

5.1 Internal Audit have commenced the journey with enhanced data analytics. This work will allow the introduction of an agile form of auditing, in conjunction with the audit plan. The potential benefits that data analytics will bring will be a wider scope of assurance within defined audits in the audit plan, use in proactive counter fraud work, and with development, continuous auditing in some areas.

5.2 A menu of approaches and software will be required. The starting point is with a level of skills and expertise on MS Excel which will be enhanced. Detailed specifications will be developed to enable access to data in the most efficient and complete way, following assistance from colleagues in Digital Services. The aim, wherever possible, is to use any existing reports and data sets after the completion of independent verification and quality checks.

5.3 Work will commence on the areas identified in the 2025/26 Data Analytics Strategy over the summer period. The findings from the purchasing card review have been shared with Directorate Leadership Teams, along with a request for services to propose areas suitable for review under this new auditing approach.

6. Internal Audit Performance Indicators, Post Audit Questionnaires and the Quality Improvement and Performance Plan (QAIP)

6.1 The performance indicator results for the period are highlighted in **Appendix D**. These demonstrate good performance over all three indicators. Regarding audit plan completion, the team are finalising audits within the 2024/25 audit plan. The audits from the 2024-25 plan where a final report has not yet been issued have been carried forwards into the 2025-26 plan. Work has also commenced on the 2025/26 audit plan.

6.2 The results from the post audit questionnaires received over the period have been positive (**Appendix E**).

6.3 The updated QAIP Action Plan is attached at **Appendix F**. The major focus during this period was to continue to review our working practices against the new standards, identify appropriate training for the team and develop the Audit Strategy. As a consequence, the work surrounding fraud risk assessment is behind expected timescales.

7. Management Response to Audit Reports

7.1 Following the completion of audit work, draft reports are sent to or discussed with the responsible managers to obtain their agreement to the report and commitment to the implementation of recommendations. This results in the production of agreed action plans, containing details of implementation dates and the officers responsible for delivery. Draft reports are copied to the relevant Head of Service and Assistant Director and final reports are also sent to the Strategic Director, Chief Executive and the Leader.

7.2 Confirmation of implementation of audit recommendations is sought from service managers when the implementation date is reached. This is an automated reminder from the audit system, with alerts being sent out a week before the due date to the responsible manager and Head of Service. Overdue alerts are sent out weekly, copied into the Assistant and Strategic Director. Managers should access the audit system and provide an update on the action – either implemented (with evidence) or deferred.

7.3 Summary reports of outstanding actions are produced monthly and distributed to Strategic Directors. The status of all open recommendations is tabulated below:

	Open Recommendations & Priority			**Total as of 31 July 2025**	**Total Deferred**
Directorate	**High**	**Medium**	**Low**		
Adults, Housing and Public Health		3		3	
Assistant Chief Executive			4	4	
Children and Young People	5	4	4	13	
Finance and Customer Services	2	10	7	19	1

Regeneration and Environment	11	18	13	42	5
Total	**18**	**35**	**28**	**81**	**6**

7.4 The following table shows the movement between periods.

Directorate	Total as of 30 April 2025	Recommendations opened in period	Recommendations closed in period	Total as of 31 July 2025
Adults, Housing & Public Health	3	4	4	3
Assistant Chief Executive	0	4	0	4
Children and Young People	3	12	2	13
Finance and Customer Services	30	14	25	19
Regeneration & Environment	18	40	16	42
Total	**54**	**74**	**47**	**81**

8. Internal Audit Standards Update

8.1 From the 1 April 2025 the requirements of the Global Internal Audit Standards, the Application Note "Global Internal Audit Standards in the UK Public Sector" and the Code of Practice for the Governance of Internal Audit in UK Local Government apply to work on internal audit engagements commenced on or after this date.

8.2 CIPFA (the Relevant Internal Audit Standard Setter for local government) have stated that internal audit teams will not be expected to demonstrate full conformance on this date. They must work in accordance with the new standards from this date and by doing so will build up their conformance.

8.3 The new Internal Audit Standards are a standing item on Internal Audit's fortnightly team meetings. A further self-assessment against the standards will be undertaken once the Chartered Institute of Public Finance and Accountancy releases the document, ahead of the External Quality Assessment. This is currently planned for the 17th – 28th November.

8.4 A Draft Audit Strategy 2025-28 has been developed in accordance with the Global Internal Audit Standards (UK Public Sector) and is attached at **Appendix G**. The strategy sets out the vision, strategic objectives and initiatives and an action plan of how they will be delivered. The strategy should align with the expectations of senior management and the Audit Committee. The Draft Strategy has been discussed with the Senior Leadership Team and is now brought to the Audit Committee for further consideration.

9. Review of Internal Audit performance objectives/indicators

9.1 The audit standards state that there should be a comprehensive set of targets which between them encompass all significant internal audit activities which includes obtaining stakeholder feedback. There are no mandatory performance indicators that internal audit should report upon.

9.2 The Global Internal Audit Standards require that:-

- The Chief Audit Executive (CAE) (the Head of Internal Audit at RMBC) must develop objectives to evaluate the internal audit function's performance. The CAE must consider the input and expectations of the Board (the Audit Committee at RMBC) and senior management (Senior Leadership Team at RMBC) when developing the performance objectives
- The CAE must develop a performance measurement methodology to assess progress toward achieving the functions objectives and to promote the continuous improvement of the internal audit function
- When assessing the internal audit function's performance, the CAE must solicit feedback from the board and senior management as appropriate
- The CAE must develop an action plan to address issues and opportunities for improvement
- The Board (Audit Committee at RMBC) must approve the internal audit function's performance objectives at least annually.

9.3 The Audit Charter which has been discussed at Senior Leadership Team and agreed at Audit Committee, defines the internal audit activity's purpose, authority and responsibility. The Charter also includes the 'Mandate', with Internal Audit being a statutory requirement for local authorities as set out in the Accounts and Audit (England) Regulations 2015 and Section 151 of the Local Government Act 1972. The performance objectives for audit are to:-

- Deliver risk-based and objective assurance on the adequacy and effectiveness of governance, risk management, and internal control systems
- Contribute to the achievement of the council's strategic goals by identifying areas for improvement
- Advise on internal control implications of system or process changes
- Recommend improvements to systems and processes to enhance efficiency, economy, and effectiveness
- Operate independently from management, with direct reporting to the Audit Committee
- Conform to the Global Internal Audit Standards (GIAS) and the CIPFA Code of Practice for internal audit in UK Local Government

9.4 The performance indicators to encompass the above objectives have been reviewed and the following is proposed:-

9.4.1 Draft reports issued within 15 working days of fieldwork being completed (target 90% actual 2024-25 93%)

Retain this indicator. This is considered to be a good indicator of how promptly the audit report has been compiled following the completion of audit testing and is important to ensure that any actions identified are highlighted to management in a timely manner.

9.4.2 Final reports issued within 5 working days of customer response, (target 90% actual 2024-25 97%)

Retain this indicator. This measures the timeliness between receiving final comments from the draft report and the issue of the final report. This is important to ensure that the final report is issued on a timely basis so that audit findings remain relevant and that the service can begin implementation of any action plans promptly.

9.4.3 Audits completed within planned time (target 90% actual 2024-25 79%)

Retain this indicator. This is considered to be a good indicator of performance in completing the audit work to the agreed time budget. Failure to achieve audits to planned timescales will increase the risk of failing to complete the wider assurance plan.

9.4.4 Audit plan progress

Since the review of performance indicators last year**,** a table at **Appendix C** now shows the progress of the internal audit plan delivery analysed by the number of plan assignments by directorate. These are assignments where a report is expected to be produced or where we are certifying grant claims. It does not include any consultative work, such as attending boards, that is reported in the other assurance work at **section 3.1**. It is proposed to retain the table setting out audit plan progress.

9.4.5 Client Satisfaction Survey responses

Value added by the audit is measured through the client satisfaction questionnaires that are issued following every final audit report.
A more detailed information in the form of a graph, rather than a percentage satisfaction figure has been used over the last year. This is more open and transparent and should help to highlight where any improvements in the audit process are required. This is accompanied by any comments where written. Provision of the client satisfaction survey responses in the current format is proposed to be retained.

A questionnaire was developed in quarter 1 of 2025-26 for the Chief Executive, Strategic and Assistant Directors and the Chair of the Audit Committee to feedback their views on the audit service. This will be requested on an annual basis and the results will be included in the Annual Report.

9.4.6 Quality Assurance and Improvement Plan

Following the review of the indicators last year, the action plan and progress against it is included within each quarterly progress report. This includes the annual internal assessment against the audit standards and will include the results of the external assessment.

9.5 From a review of the performance indicators currently in place, and from reviewing those in use at other local authorities, it is considered that no further changes are required. This will be reviewed again next year.

Appendix B

Internal Audit Plan 2025/26

Adult Care, Housing and Public Health				
Total number of days 130				
Risk Register Ref	**Council Plan Theme Ref**	**Title**	**Brief Description**	**Progress/ Qtr planned**
ACHPH-R41 & 50	1	Health and Safety in Council Homes (Smoke and Carbon Monoxide).	Follow up audit of partial opinion.	In progress
	6	Procurement Governance (Contract Management)	Follow up audit of partial opinion.	Q3
ACHPH-R41 & 50	1	Health and Safety in Council Homes - Water Safety (Legionella).	Follow up audit of partial opinion.	Q4
SLT 40 ACHPH-R41 & 50	1	Health and Safety in Council Homes - Review of fire safety compliance	Cyclical review of key areas of health and safety compliance.	Q3
SLT 40 ACHPH-R41 & 50	1	Health and Safety in Council Homes - Review of asbestos compliance.	Cyclical review of key areas of health and safety compliance.	Q3-4
	6	Compliance with statutory tenancy processes.	Review of compliance with policy. A cyclical programme will be established to review granting tenancies, terminations, assignments, successions and mutual exchanges.	In progress
HR29	1	Handover arrangements of new build homes.	Assurance that all areas of H&S have been checked and addressed where appropriate before handing over the property to tenants.	Q3
SLT 38 ACHPH-R21	1, 3	Assistive Technology. (PSTN)	Review progress against the project implementation plan.	Q3
ACHPH-R21	1	Rothercare Follow Up	Follow up of partial opinion and assurance on new service delivery model.	Q2
ACI-R4	1	Safeguarding	(Deferred from 2024/25) A review of the processes for the receipt, triage and investigation of safeguarding enquiries from all sources.	Q2
ACI-R22	1	Community Dols	(Deferred from 2024/25).	Q2

			To provide assurance on the management of Dols cases following the increase in demand.	
	1	Drug and Alcohol	(Deferred from 2024/25). Review of drug and alcohol working partnerships including needs assessment and plans.	Q4
Assistant Chief Executive				
Total number of days 55				
Risk Register Ref	**Council Plan Theme Ref**	**Title**	**Brief Description**	**Progress/ Qtr planned**
HR 16	6	Corporate Health and Safety	TBC following review of arrangements by new Head of Service.	Q3/4
HR 05	6	Agency Staff	TBC, areas for consideration for audit include: • Appointments process • Monitoring and Review • Policy/procedure not being followed for any areas outside of new contract (eg for specialist areas). • Suppliers onboarded only providing IR35 engagements	Q3/4
HR 12	6	Gifts and Hospitality (Employees)	Review to provide assurance that: - • Staff are aware of the Council's Code of Conduct and their responsibility to declare gifts and hospitality. • Monitoring arrangements are in place with appropriate action taken where necessary.	Q4
Childrens and Young People's Services				
Total number of days 70				
Risk Register Ref	**Council Plan Theme Ref**	**Title**	**Brief Description**	**Progress/ Qtr planned**
	2	S17 payments and reduction in cash payments project (2024-25)	Review of the need, authorisation and delivery of the S17 funds to clients and compliance with the policy.	Draft report

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EI 13	2	Crowden Outdoor Education Centre	Assurance regarding the financial management arrangements including that all services are being charged for.	In progress
	2	Schools assurance	Approach to be determined but will include at least one audit visit to a school.	Q3
EI 01 EH 09	2	Elective Home Education	Review the monitoring and reporting arrangements against statutory guidance published In August 2024.	Q3
Finance and Customer Services				
Total number of days 145				
Risk Register Ref	**Council Plan Theme Ref**	**Title**	**Brief Description**	**Progress/ Qtr planned**
FCS 24	6	Water safety (legionella) Follow up	Follow up audit of partial opinion	Q4
FCS 23	6	Building Security Follow up	Follow up audit of partial opinion	Q4
FCS 23	6	Riverside House security and ID cards	A review of the controls in place for ID card issuing/cancelling and Riverside House building security arrangements.	In progress
	3	Asset management estimates & Capital Programme	Follow up audit of partial opinion.	Q2
	6	Procurement Governance (Contract management)	Follow up audit of partial opinion.	Q3
	6	Purchasing Cards	Assurance regarding compliance with the system controls and confirmation regarding appropriateness of expenditure and that this is supported with receipts.	Q4
	6	Cash and banking system and reconciliations	Review the timeliness and accuracy of cash and bank reconciliations and key controls. Review the effectiveness of the project management of the switchover of the banking provider.	Q3
	6	Revenues and Benefits Business Continuity and Disaster Recovery Plan	Review of the robustness of the business continuity arrangements and the disaster recovery plan in the event of an IT failure.	Q2
	6	Treasury Management and Prudential Indicators	Review compliance with CIPFA Treasury Management Code, Prudential Code and authorisation controls for investments & loans.	Q3

FCS16	6	NNDR /Business Rates	Assurance on the arrangements for billing, collection, recovery, enforcement and discretionary reliefs.	Q2
	6	Insurance	To provide assurance that the Insurance Service fulfilling its requirements to the Council. This would include a review of the processes from receipt of requests, to conclusion, including liaison with the relevant services to identify trends in claims and any preventative action.	Q4
Salford IA risk assessment	6	Network access management and active directory administration.	This review will include configuration management, security management (especially around access and authentication), performance management (KPI definition and monitoring), privileged access management and capacity planning/forecasting).	Q4
FCS 24	6	Health and Safety - Review of asbestos compliance	Cyclical review of key areas of health and safety compliance.	Q3/4
Regeneration and Environment				
Total number of days 100				
Risk Register Ref	**Council Plan Theme Ref**	**Title**	**Brief Description**	**Progress/ Qtr planned**
RE51 PRT53	3	Highways structures (2024-25)	Assurance regarding compliance with the inspection regime and a review of the adequacy of the follow up process where issues have been identified.	In progress
	6	Procurement Governance (Contract management)	Follow up audit of partial opinion.	Q3
RE34 CST58 CCoC1-8	2, 5	Children's Capital of Culture	Follow up audit of partial opinion.	Q2

CSS28 & R&E 9	4	Home to School Transport	Follow up audit of partial opinion.	Q2
RE56 & CSS47	1, 5	Hellaby Stores	Review of stock control arrangements following introduction of new stock software system.	Q3
	1	Trading Standards	Unannounced visits	
RE60 PRT55	1	Building Control (Deferred from 2024-25 audit plan)	Provide assurance after changes in regulations around payments and inspection visits.	In progress
RE15 & CSS13	4	Barnsley Doncaster Rotherham PFI Joint Waste Contract	Review of effectiveness of contract management	Q4
	6	Directorate Risk Register review	Seek assurance that risks are being effectively managed.	In progress
	3	Community Infrastructure Levy and Section106	A review of the management and outcomes to ensure that the CIL /S106 process is robust.	Q4
	6	Music Service Follow Up	Follow up audit of partial opinion.	Q3
Corporate/Crosscutting reviews				
Total number of days 270				
Risk Register Ref	**Council Plan Theme Ref**	**Title**	**Brief Description**	**Progress/ Qtr planned**
	6	Sundry Debtors 2024-25	Cross directorate review of implementation of recommendations. This will identify if authority wide debt has reduced and confirm if action is being taken to proactively reduce debt	CYPS draft report. All other directorates reports finalised.
	6	Cash Controls 2024-25	Review to identify the controls in place over the use of cash authority wide, to include the receipting, recording and the value being held, including a review of the safe limits.	Draft report
	6	Social Value and Key Performance Indicators 2024-25	Compliance with the Social Value Policy regarding obtaining quotes from suppliers and a review key performance indicators being measured in contracts.	In progress
	1, 6	Council's arrangements for managing CCTV	Review to confirm compliance with GDPR, RIPA, any other relevant best practice guidance and legislation including the	Q4

			CCTV Policy. This will consider the overall responsibilities for CCTV management and monitoring arrangements.	
Salford IA risk assessment	6	Application review – Liquid logic (ACHPH and possibly CYPS – coverage to be confirmed by IT auditor)	The audit will include maintenance and support controls, including supplier management and roadmap prioritisation; Application access controls assessing controls over both general and privileged level access; Audit trail management covering monitoring of users accessing the system, particularly in relation to users with high level access or processing of 'critical' transactions; System availability and continuity covering system performance management, availability, capacity and continuity management.	In progress
CSC 09	1, 2	16/17 Year Old Homeless Pathway	Approach to meeting the need of 16/17 yr old children whom present as being homeless either to Childrens social care or Housing.	In progress
Follow Ups			Time set aside for the follow up of any partial or no assurance opinions completed within the year.	
Project Boards and groups			Internal Audit attendance at project boards or groups to give advice on internal controls.	
Data analytics development			Time set aside to develop the data analytics workstreams and undertake testing.	
Independent review of grants			Independent examination of accounts and / or assurance that the grant claim has been spent in accordance with the grant determination.	
Contingency			Time set aside for audit review of any new and emerging risks, unplanned work identified as being required during the year.	
Anti-Fraud and Corruption and Anti Money Laundering				
Total number of days 210				
Title			**Brief Description**	**Progress/ Qtr planned**
Investigations			Time set aside for investigation of whistleblowing and other referrals received.	1-4
Anti-Fraud and Corruption Policy Updates			Review and update of Anti Fraud and Corruption Policies • Anti-Fraud and Corruption Policy and strategy and assessment against best practice	2
Anti-Fraud and Corruption Proactive Work			Risk-based work to prevent and detect fraud including:-	1-4

	• Review and investigation of NFI matches • Awareness raising and communication of fraud risks and internal reporting arrangements to employees. This includes liaison with risk champions supporting fraud risk development across the council.	
Anti Money Laundering Assurances	Testing on key systems/controls to gain assurance on Anti Money Laundering arrangements (Land and Property transactions).	Q4
Total number of days 980		

Key:- Council Plan Themes

1- People are Safe, Healthy and Live Well
2- Every Child able to fulfil their potential
3- Expanding economic opportunity
4- A cleaner, greener local environment
5- Every neighbourhood thriving
6- One Council

Appendix C

Summary of reports issued during the period May to July

Audit Area & overall opinion	Assurance Objective	Summary of findings
Adult Care, Housing and Public Health		
Lift Servicing Reasonable	The overall objective of the audit was to review the effectiveness and provide assurance of the Council's compliance with Health & Safety for lift servicing in Council tenanted properties.	Audit checks found discrepancies between asset information held on the housing system (NEC) and that held with the contractor and there was no regular comparison between the information held on the housing system (NEC) and that held with the contractor. Housing Property Services do not perform regular, documented, quality assurance checks on the individual services conducted by the contractor, to ensure they meet RMBC's expected quality standards. Monthly meetings are held between the contractor and Housing Property Services to discuss services carried out and issues encountered. The contractor provides a monthly report at these meetings detailing the service status of all assets installed in council owned properties, under the responsibility of the Contract. Discrepancies were found when comparisons were made between the asset data held on a sample of monthly reports.
Customer pathway Substantial	To ensure that decision making pathways for care package approvals is clear and consistently applied.	The evolution of the Customer Pathway will in the future be assisted by the new generation of data analysis tools that are being introduced including CoPilot, Power Bi and others. As these reporting tools develop further opportunities may be identified for service change. No recommendations were raised.
Sundry Debtors Reasonable	The overall objective of the audit was to review the implementation of previous recommendations to confirm that action is being taken to proactively reduce authority wide debt.	A significant proportion, £337k, 39%, of the £862k outstanding debt at the end of March 2025 was debt outstanding for longer than one year. At the time of audit there were no formal arrangements in place for Senior Management to review Directorate debt and debt recovery which increases the risk of debts becoming uncollectible. Further review is required to provide assurance that where possible services are collecting fees and charges in advance and where this is not possible to provide exemptions for approval by F&CS.

Appendix C

Audit Area & overall opinion	Assurance Objective	Summary of findings
Assistant Chief Executive		
Sundry Debtors Substantial	The overall objective of the audit was to review the implementation of previous recommendations to confirm that action is being taken to proactively reduce authority wide debt.	The amount of outstanding debt on 31 March 2025 (£72k) was low in comparison to the other Directorates. Controls are in place for Senior Management to review outstanding sundry debts based on monthly debt reports provided by F&CS and with support from F&CS colleagues at DLT meetings. The audit did not identify any concerns with service engagement in debt recovery. ACX had reviewed fees and charges following the 2023 audit and provided exemption forms to F&CS in respect of service areas for which there was no alternative to collecting payment in arrears.
Payroll Substantial	The overall objective of the audit was to assess the adequacy of internal control arrangements for the following areas: • Faster Payments • Payments to 3rd Parties • Recovery of Overpayments • Management of Personal Information	There are robust controls in place for managing faster payments, payments to third parties and management of personal information. Two lower priority recommendations were made, regarding compliance with the authorisation of faster payments, and that action be taken on historical overpayments (either write off or recovery).
Childrens and Young People's Services		
SEND sufficiency Substantial	The overall objective of the audit was to provide assurance on the progress achieved with the Special Education Needs (SEND) Sufficiency Strategy.	No recommendations were raised in the audit. There were robust processes in place to manage the risks reviewed which were:- • Safety Valve funding may not have achieved its reported SEND Sufficiency aims. • Identification of the lessons learnt from partnership working in delivering the safety valve project may not be complete and fully reported. • Medium term planning beyond the life of the Safety Valve project may not be evolving to meet longer term needs.

Appendix C

Audit Area & overall opinion	Assurance Objective	Summary of findings
		• Prioritising in borough and out of borough commissioned needs to meet current and future demand may not be taking place.
Joint Funded Care Packages (JFCP) Follow Up Reasonable	The overall objective of the audit was to provide assurance that the agreed actions arising from the previous audit of JFCP have been implemented.	Review of the implementation of the audit recommendations confirmed that all but two recommendations had been implemented. The first recommendation was regarding the integration of the JFCP process into other social care actions. It was agreed that draft process charts will be shared and uploaded to the CYPS learning academy page on the intranet. The Service Manager will also attend the Independent Reviewing Officer (IRO) team meeting to discuss key indicators that may be appropriate. The process will also be covered to support the IROs understanding, alongside the function of the new form. The second recommendation was regarding the audit trail on the system. The evidence provided and reviewed identified that a weakness still exists from the testing of cases on the system. It was agreed that the Service Manager would meet with Head of All Age Continuing Care in the ICB to agree a process for information sharing. It would be explored whether the draft Continuing Health Care checklist on the system could be developed to capture the full process. If this is possible, this would allow for a performance report to be generated automatically.
Unaccompanied Asylum Seeking Children (UASC) Follow Up Substantial	The overall objective of the audit was to provide assurance that the agreed actions arising from the previous audit of 'Unaccompanied Asylum-Seeking Children' have been implemented.	Of the five recommendations included in the previous audit report, four have been implemented, and one is no longer required. The original audit was undertaken at a time of transition for UASC services which have since been re-established with new procedures and more effective working with Legal Services.
Schools assurance Partial	To provide assurance that the financial and management controls are robust and meet the	The establishment has not submitted a 3-year financial forecast in regard to the expected overspend or a deficit recovery plan. Any proposed deficit would need formal approval by the Council supported by a sustainable budget recovery plan. The audit recommended that a three-year plan or, if necessary, a deficit recovery plan is in place

Audit Area & overall opinion	Assurance Objective	Summary of findings
	requirements outlined in the various Council and statutory and operational (financial) guidance.	as required by the Rotherham Scheme for Financing Schools. It is recognised that the School's Finance Team are in discussions with the Management Committee to look into ways to reduce the expected overspend and maintain a balanced budget while taking into account the specialised circumstances in this establishment. There was no 'Scheme of Delegation' in place to confirm delegation of spending powers, debt write off limits and staff recruitment. The approval of the Scheme of Delegation should be an annual recurring Management Committee agenda item. The Financial Procedures manual was not up to date nor shared with key finance and administration staff. An up to date, annually reviewed Financial Procedures Manual is an essential document that should be shared with staff so that they are aware of correct procedures. Many of the issues identified throughout the audit relate to missing or incorrect procedures being used by finance and administration staff. Once the Financial Procedures Manual has been updated, training in key areas should be provided to staff to ensure robust controls are documented and processes used are in line with the guidance provided. BitLocker encryption was not routinely activated for staff equipment that is regularly removed from site. Staff who regularly remove electronic devices from the establishment should have their BitLocker encryption enabled on all electronic devices to further protect school data in the event of loss or theft.
Finance and Customer Services		
Capital Programme Reasonable	Review the capital programme procedures and provide assurance that they are being complied with and that	The procedures followed for the approval of capital projects, capital budget virements and capital grants differ in several respects from the documented procedures set out in the Capital Governance Principles document.

Appendix C

Audit Area & overall opinion	Assurance Objective	Summary of findings
	expenditure is appropriately approved, controlled and monitored.	Annual allocations of CYPS capital grants to specific projects are not approved in accordance with Capital Governance Principles guidance (schools maintenance and schools growth). Recommendations were raised to provide Cabinet for information and approval, a cyclical capital works programme and school capital sufficiency programme at the start of each financial year.
Lift Servicing Compliance Substantial	The overall objective of the audit was to assess the adequacy of the internal control arrangements and give assurance that the corporate landlord estates, including any Housing communal area lifts, complies with Health and Safety Regulations relating to lift servicing.	The review has provided assurance that robust controls and procedures are in place to ensure the Council meets its health and safety obligations in relation to passenger lifts managed by Facilities Management. The current servicing and inspection arrangements, delivered by two contractors are effective, with evidence confirming timely maintenance, qualified personnel, and appropriate documentation. Monitoring and oversight mechanisms, including regular contractor meetings and KPI reporting to senior leadership, further reinforce compliance and accountability.
Sundry Debtors Reasonable	The overall objective of the audit was to review the implementation of previous recommendations to confirm that action is being taken to proactively reduce authority wide debt.	The amount of longstanding outstanding debt is low (just under £200k over one year old on 31 March 2025) relative to the value of sundry debts raised during the year – and this largely relates to debt inherited from R&E when services were transferred to F&CS last year. Robust controls are in place for Senior Management to review outstanding sundry debts on a monthly basis at DLT. Further work is needed to ensure compliance with FPPR 14.7 to ensure that all services within F&CS are reviewed to either move to upfront payments or for exemptions to be approved where this is not possible. The audit found examples of non-compliance with Section 15.7 of the Sundry Debtor Billing and Collection Guide which states that 'If the Service requests the Account Management Team to withhold action on any invoice for a period exceeding 14 days then the Service must seek the approval of their Assistant Director'. Invoices had been put on hold at the request of Estates for which AD approval had been requested but not received.

Appendix C

Audit Area & overall opinion	Assurance Objective	Summary of findings
Record of Processing Activities Reasonable	The overall objective of the audit was to give assurance on the arrangements for information security and management, specifically ROPA.	This audit reviewed action taken migrating from a decentralised to centralised ROPA following an observation from the ICO. The overall objective of the centralised ROPA is to have a robust, resilient and ICO compliant Record Of Processing Activity and supporting processes. The key issues identified are: • Uncertainty over the completeness of the decentralised ROPA, therefore caveats and guarantees are required from the previous directorate ROPA managers. • Directorates limited progress in providing the required information to the Information Governance Service to complete the centralised ROPA. • Data Mapping should be completed. Data mapping is a key ICO requirement for a ROPA.
Regeneration and Environment		
Waste Operations Reasonable	To review the compliance of vehicle crews with health and safety requirements.	During sample checking, the audit identified vehicles where no records of the daily vehicle log out checks were available (either on the MVA app or paper based system). It was unclear whether this was a recording issue or if the daily vehicle checks had not been conducted. Some daily vehicle checks that are recorded on the Key 2 Jaama system did not appear on the daily system-generated report sent to waste services from fleet services. There is a known system synchronisation issue that has occasionally prevented/ delayed some vehicles check data uploading to the Key 2 Jaama system at the time of the check. We were informed that some crews have reported Wi-Fi connectivity issues in the vicinity of the salt barn, and it is possible system synchronisation delays combined with data volumes could be the cause. These issues will be investigated and resolved. The Fleet Transport Policy states that "All driving licenses, including Tachographs and driver qualification cards, are to be checked and recorded on the central licence register maintained at Fleet Services." Currently there is no central register of driver qualifications/CPC cards.

Audit Area & overall opinion	Assurance Objective	Summary of findings
		The audit identified that all the 4 Risk Assessments (RAs) and 4 Method Statements (MSs) were due for review in January 2022. Following a 'near miss' report in September 2024 the Emergency & Safety team identified that the length of time that had elapsed since the last Risk Assessment review did not represent suitable and sufficient risk assessment processes. At the close of the audit we were informed that a review of Risk Assessments and Method Statements had begun.
Home to School Transport Partial	The overall objective of the audit was to provide assurance on the effectiveness of the Home to School Transport Service.	There is no current contract/framework in place with the operators providing transport for the service. Contract extensions have been approved via exemptions in order to continue operating the service out of contract. The latest approved exemption expired in March 2024. The Council's delivery specifications with the operators are detailed in an "Agreement", distributed to the operator and signed as part of the original tender process. This Agreement outlines the Council's expectations of the operator and the operator's expectations of the Council. Six operators have been onboarded outside of the original tendering process. These new operators were not required to sign and return a copy of the Agreement, which serves as proof of their understanding of their responsibilities. Contracts are monitored through annual operator audits and quarterly desktop questionnaire audits. At the time of the audit there were 31 operators. Two operators had been audited in September 2024, however none of the planned audits for October and November had been carried out. Compliance spot checks are conducted to ensure the safety of the children transported and that transport is in accordance with the Agreement. These spot checks are performed to ensure adherence to these regulations, as well as to ensure the correct and authorised driver and passenger assistant are present. Each route should undergo a spot check twice a year. Audit testing found that there was an inconsistent distribution of spot checks, with some routes undergoing multiple checks over the two years while others had none.

Audit Area & overall opinion	Assurance Objective	Summary of findings
		Audit reviewed the procedures related to incident reporting and monitoring. It was found that incident reports are not recorded immediately on the monitoring record upon receipt, increasing the risk of incident reports going missing. There was a delay in uploading incident reports to the One System, due to staff preferring to wait for the receipt of the incident outcome report to upload both documents together. The current methods used to record the online DBS checks do not provide a clear indication of when the check has been successfully completed, if all passenger assistants and drivers have been included in this check, or if there is a valid DBS held. Sample testing on the Passenger Assistants found that all DBS were in place, however some DBS consent forms were missing and some checks against the online service had not taken place within the prescribed 6 months. There were discrepancies between the online DBS check date recorded on the One System and the physical consent form and over half of the consent forms were not signed by the PA. Private hire drivers fall under Licensing's DBS application and monitoring procedures. Out of the small sample of (non private hire) drivers that required an online DBS check every 6 months, audit found that all DBS were in place, however one DBS consent form was missing from the file. There were discrepancies between the online DBS check date recorded on the One System and the physical consent form. A report is run once a month from the One System that details all DBS's that are due to expire in the next 60 days or have already expired. This process is in place to ensure the integrity of the safeguarding information held on the One System. However, this had not been completed since June 2024 due to staff sickness. There is no process in place to ensure training details held on the One System are up to date and accurate. Testing found that drivers and passenger assistants had expired safeguarding training recorded on the system.

Appendix C

Audit Area & overall opinion	Assurance Objective	Summary of findings
Tree Service Substantial	Review of the implementation of the agreed actions following the 22-23 and 23-24 audits of the Tree Service to ensure that controls are embedded and that they are being complied with.	Two low priority recommendations were raised, one related to the documentation of key processes and controls as although triaging of service requests and the monthly checking of requests for payments is working well in practice, these processes are not formally documented. There is a risk of operational disruption if the Business Support Assistant was unavailable for any reason. The second recommendation related to implementing a formalised system of spot checks of Tree Officer work. The Tree Service Manager does some ad hoc quality checks such as site visits and discussion at weekly team meetings, however there is not a formalised system in place for quality checks by the Tree Service Manager of work done by the Tree Officers.
Sundry Debtors Reasonable	The overall objective of the audit was to review the implementation of previous recommendations to confirm that action is being taken to proactively reduce authority wide debt.	Of the £4.3m total outstanding debt at the end of March 2025, £413k was debt outstanding for longer than one year. At the time of audit there were no formal arrangements in place for Senior Management to review Directorate debt and debt recovery which increases the risk of debts becoming uncollectible. No evidence could be provided to demonstrate that a plan had been put in place after the previous audit in November 2023 to identify fees and charges which could be collected in advance rather than arrears or to provide any evidence that exemptions to this had been agreed with F&CS. At the time of the current audit, around half of the more than 1200 different types of fees and charges used by R&E across all Services, are being collected in arrears.
Cross cutting audits		
Anti Money Laundering and anti fraud controls – Right to buy Substantial	The overall objective of the audit was to ensure that appropriate and proportionate arrangements are in place to prevent fraudulent and money laundering activities	A review of the Right to Buy application processes was undertaken to ensure suspicious and fraudulent behaviour is identified and dealt with appropriately. All applications had been processed in line with the procedures with evidence of all due diligence on file supporting the decisions made and escalated where appropriate. Where concerns were identified these were escalated to either the Tenancy Fraud Officer, Internal Audit and/or Legal Services.

Appendix C

Audit Area & overall opinion	Assurance Objective	Summary of findings
	taking place regarding Right to Buy transactions.	The Housing Service has effective measures in place to identify and address suspicious and fraudulent behaviour. No recommendations were raised.
Salford IT audit ITrent (HR) IT application review Substantial	The audit reviewed Maintenance and Support Controls, Access Control Management, Audit Trail Management, and System Availability.	The review of the administration of the iTrent application concluded that, in the main, the key risks are being mitigated to a high level. Improvements could be made to the verification of controls operated by MHR ITrent (see below, recommendation raised), and the management of data and information used on test and training versions of the application (advisory points raised). The supplier carries out various IT-related processes on behalf of the Council as part of both application support and the wider cloud service. The processes include program change and version management, back-up and recovery procedures, patching and hardening and privileged access management at operating system and database level. However, the Council does not receive verification from MHR that the processes are operating as expected. Typically, assurance would be provided by a Service Organisation Controls (SOC) 'Type 2' report, other independent assurance reports provided by the supplier or by the customer reviewing the processes themselves. Conclusion: There is an undue risk that IT processes are not being carried out either in line with the contract, or best practice without the knowledge of RMBC and a recommendation was raised. Two advisory points were included, that if implemented should enhance the current control environment.

Rating	Definition
Substantial Assurance	Substantial assurance that the system of internal control is designed to achieve the service's objectives and this minimises risk. The controls tested are being consistently and effectively applied. Recommendations, if any, are of an advisory nature to further strengthen control arrangements.

Appendix C

Rating	Definition
Reasonable Assurance	Reasonable assurance that the system of internal control is designed to achieve the service's objectives and minimise risk. However, some weaknesses in the design or inconsistent application of controls put the achievement of some objectives at low risk. There are some areas where controls are not consistently and effectively applied and / or are not sufficiently developed. Recommendations are no greater than medium priority.
Partial Assurance	Partial assurance where weaknesses in the design or application of controls put the achievement of the service's objectives at a medium risk in a significant proportion of the areas reviewed. There are significant numbers of areas where controls are not consistently and effectively applied and / or are not sufficiently developed. Recommendations may include high priority and medium priority matters.
No Assurance	Fundamental weaknesses have been identified in the system of internal control resulting in the control environment being unacceptably weak and this exposes service objectives to an unacceptable high level of risk. There is significant non-compliance with basic controls which leaves the system open to error and / or abuse. Recommendations will include high priority matters and may also include medium priority matters.

Appendix D

Internal Audit Performance Dashboard

Key Performance Indicators

Performance Indicator	Target	April - July	Aug - Oct	Nov - Jan	Feb - Mar
Draft reports issued within 15 working days of field work being completed	90%	96%			
Final reports issued within 5 working days of customer response to the draft report	90%	100%			
Audits completed within planned time	90%	95%			

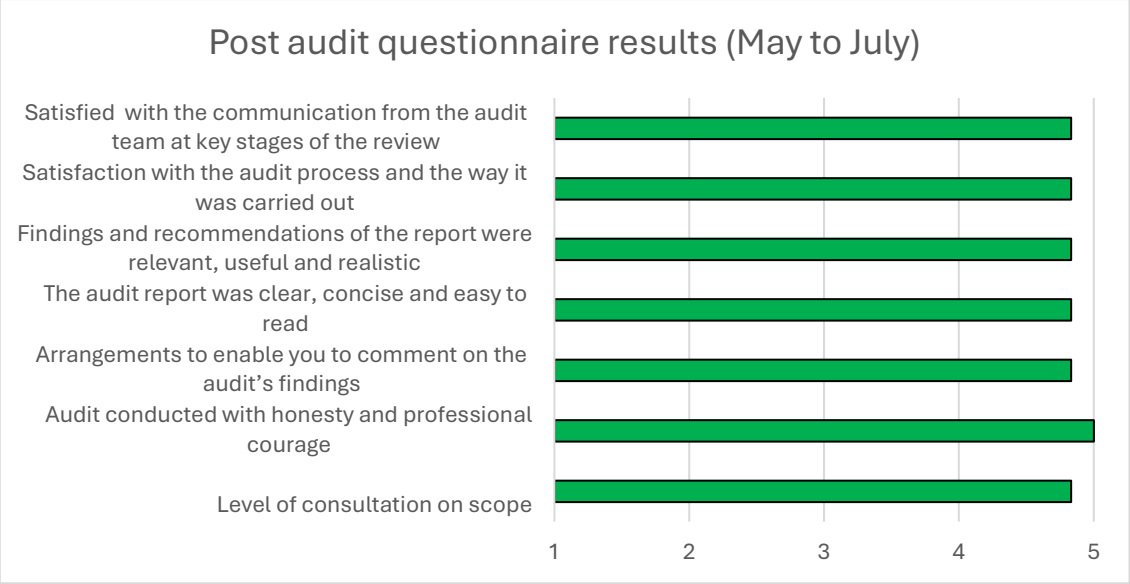
Audit Plan Progress

Assurance Type/ Directorate	2025/26 Plan	Completed	In progress	Not started
Adult Care, Housing and Public Health	12	0	2	10
Assistant Chief Executive	3	0	0	3
Childrens and Young People	3	0	1	2
Finance, Customer Services	13	0	1	12
Regeneration and Environment	10	0	2	8
Crosscutting	3	0	2	1
Grants	8	3	1	4

Appendix E

Post Audit Questionnaires

6 questionnaires were received during the period. The graph below illustrates the average responses to each question on a scale of 1-5, 5 being the highest level of satisfaction.



"Kept informed of developments"

"Knowledgeable and friendly staff, great communication

"Auditor was extremely supportive and understanding given the situation in school with key staff absent to help locate information required for the audit."

"Attention to detail"

"The review was clear in its scope with time for the required

Appendix F

Quality Assurance and Improvement Programme Action Plan		
Action	**Position statement**	**Target completion date**
Review the need for assurance mapping, to improve audit planning.	Cipfa's detailed assurance framework guide will be used to take forwards this development. The assurance framework guide has not yet been issued by Cipfa but will be used to strengthen assurance mapping once it has been issued. The audit planning process has continued to evolve including the documentation of other sources of assurance. However it is not possible or practical to coordinate with other providers of assurance (for example CQC and Ofsted) due to the nature of their work. This area has been included in the Draft Audit Strategy as an area for future development.	Further work will be undertaken on assurance mapping for March 2026 audit plan submission, but it is recognised that this is a longer term ambition.
Action from the self assessment against fraud checklist. Update the directorate and corporate wide fraud risk assessment and examine the results as part of the annual internal audit planning exercise.	The directorate and corporate fraud risks have been reviewed by Internal Audit. The Finance and Customer Service Directorate has been selected as the starting point for a broader fraud risk assessment. This approach will be further developed and reviewed at the Risk Champions meeting. Best practice from central government will be considered in the approach to fraud risk management and once the approach is agreed it will be rolled out to the remaining directorates. An enhanced report to the Audit Committee setting out the key fraud risk areas and mitigating actions will be developed.	September 2026.
Action from the self-assessment against fraud checklist. Conduct an annual comparison against the checklist and where	This will be undertaken alongside the review of the Anti Fraud and Corruption Policy and Strategy on an annual basis, and will therefore be removed from this action plan.	September 2025. Complete.

necessary, implement actions to ensure compliance with it.		
Action from the self assessment against fraud checklist The reporting of the fraud risks and mitigation will be strengthened over the year and a more comprehensive report will be brought to the Audit Committee.	This reporting of fraud risks and mitigations has been considered and an enhanced report will be brought to the Audit Committee once a robust Council wide fraud risk assessment has been undertaken.	September 2026.
Global Internal Audit Standards (UK public sector) review of actions required		
Update the Audit Manual and associated documentation.	Documentation supporting the audit process has been updated in accordance with the standards. The Audit manual will require further review. This is expected to be complete by 30 September 2025.	30 September 2025
Develop an Internal Audit Strategy	This is a new requirement. This should build on a strategic statement of how the service will be delivered and developed. A Draft Strategy has been prepared.	September 2025 Audit Committee Complete
Update the Audit Report	To include details of root cause analysis and reference to GIAS (UK Public Sector) rather than PSIAS. The format of the audit report has been slightly amended to include an enhanced report and action plan which identify root causes. The audit report template has been amended.	Complete
Quality Assessment	To undertake an assessment of conformance against GIAS (UK public sector) and update the Audit Committee. An initial self-assessment has already been completed. A further self-assessment will be undertaken utilising material that will be produced by CIPFA and will help inform the EQA.	To tie in with External assessment (Q3/4) 2025/26.
Quality Assessment Improvement Programme	The results need to be reported annually including progress against action plans to address instances of non-conformance.	March 2026

	This is already in place and the results of the external assessment will be included in the action plan.	
Head of Internal Audit performance review	The Audit Committee Chair should contribute to the Head of Internal Audit's performance assessment. Feedback from the previous Chair has been received and will be discussed in the Year Ahead Development Plan meeting.	September 2025
Review of Internal Audit performance and effectiveness	Audit Committee to undertake a review. The conclusions should be reported to those charged with governance (eg in the Audit Committee's Annual Report). This will be included in the 2025-26 Audit Committee Annual Report. The performance information for the year, customer feedback and progress against the plan was reported to the June Audit Committee within the Internal Audit Annual Report.	Complete To note that the outcome will be reported in the 2025-26 Audit Committee Annual Report
Staff training	Training is a common theme throughout the standards and should be evidenced in a training log. Annual/rolling training plan and log in place. CPD template has been updated. As this is an ongoing action and template documents are now in place, this will be removed from the action plan.	Complete