London Borough of Hammersmith & Fulham

Report to: Audit Committee

Date: 9 June 2025

Subject: Head of Internal Audit Annual Report 2024/25

Report of: David Hughes, Director for Audit, Fraud, Risk and Insurance

Responsible Director: Director for Audit, Fraud, Risk and Insurance

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Summary

This report summarises the work of Internal Audit in 2024/25 and provides the opinion of the Director of Audit, Fraud, Risk and Insurance on the adequacy and effectiveness of the Council's framework of governance, risk management and control. This opinion is provided for the use of the London Borough of Hammersmith and Fulham and is used to support its Annual Governance Statement.

The report sets out a consistent level of assurance being obtained and provided for 2024/25 through the work of internal audit. This reflects the commitment to a robust assurance framework being led by the Chief Executive, through monthly SLT Assurance meetings, and through the delivery of the Ruthlessly Financially Efficient programme of the Council.

Recommendation

For the Committee to note the Head of Internal Audit's opinion on the adequacy and effectiveness of the Council's framework of governance, risk management and control environment (para 11) and to consider whether there are any areas the Committee would like to explore further.

Wards Affected: None

H&F Values

Our Values	Summary of how this report aligns to the H&F Priorities
Building a shared prosperity	Internal audit work covers a wide range of services including those which are delivered in partnership with local and national companies. Assurance may be required over governance arrangements to demonstrate the benefit to residents of co-delivered services.
Creating a compassionate council	Internal audit provides assurance that the Council's resources are managed appropriately to provide the most effective support to the most vulnerable residents.

Our Values	Summary of how this report aligns to the H&F Priorities
Doing things with residents, not to them	Where engagement with residents is part of service development, internal audit will consider how well co-production and resident access is embedded in a process.
Being ruthlessly financially efficient	The work undertaken by Internal Audit helps to ensure that management have robust controls and practices in place to safeguard the Council's assets, controlling expenditure and maximising potential income to protect and invest in essential frontline services which are in place to meet the Council's priorities.
Taking pride in H&F	Investment in public realm services such as waste collection, street cleaning and open/park spaces is significant. The internal audit strategy identifies services for cyclical review, including contract management for outsourced services and performance delivery for in-house services.
Rising to the challenge of the climate and ecological emergency	Internal Audit consider the impact of strategies, including, the Climate and Ecology Strategy, in a number of different reviews that form part of the Internal Audit Plan.

Contact Officers:

Name: David Hughes
Position: Director for Audit, Fraud, Risk and Assurance
Telephone: 07817 507 695
Email: David.HughesAudit@lbhf.gov.uk

Name: Moira Mackie
Position: Head of Audit
Telephone: 07800 513 192
Email: Moira.Mackie@rbkc.gov.uk

Background Papers Used in Preparing This Report

None.

DETAILED ANALYSIS

1. From the Internal Audit work undertaken in the financial year 2024/25, reasonable assurance can be provided that the systems of internal control are effective with 91% of the audits undertaken receiving a positive assurance opinion, with four Substantial Assurance audits issued. No Nil Assurance audits have been reported for the ninth consecutive year Given the way in which the Audit Plan is constructed, it is not unusual for some reviews to be given a Limited Assurance rating and this does not indicate that there are pervasive issues with the Council's control environment but that there are actions required in specific areas to improve controls (Appendix 1).

2. There are some areas where control improvements are required and compliance with agreed systems could be improved. In each case, action plans are either in place, or have already been implemented, to remedy the weaknesses identified. These will be followed up by the internal audit team until they are completed.

3. The Council was found to be effective, in most areas, at implementing recommendations where concerns in respect of controls were identified.

4. The report is a key element of the evidence supporting the Annual Governance Statement (AGS), which will be presented separately to the Committee with the Annual Accounts.

Internal Audit Work 2024/25

5. The Audit and Accounts Regulations 2015 require the Council to conduct a review of effectiveness of the system of internal control. This contributes to the Council priority of being Ruthlessly Financially Efficient. Detailed reports on the performance and outcomes of the internal audit work undertaken, have been presented regularly to the Council's Section 151 Officer and at each meeting of the Audit Committee.

6. Wherever possible, when planned audits are postponed, alternative work is identified or alternative sources of assurance are sought. Three audits are shown as in progress in Appendix 1 and five audits were deferred until 2025/26, by agreement with the service (Appendix 2). The Internal Audit service has also liaised closely with the Council's senior managers to prioritise the audit work undertaken and to assist them in identifying other sources of assurance including the Directors' Assurance Statements which were completed at the end of the financial year.

7. The internal audit service has been provided in accordance with the UK Public Sector Internal Audit Standards (PSIAS). One of the requirements of the PSIAS is that the Head of Audit confirms to the Committee, at least annually, the organisational independence of the internal audit activity. The Internal Audit Charter reinforces this requirement.

Declaration of independence and objectivity

The reporting and management arrangements in place are appropriate to ensure the organisational independence of the Internal Audit activity. Robust arrangements are in place to ensure that any threats to objectivity are managed at the individual auditor, engagement, functional and organisational levels. Nothing has occurred during the year that has impaired my personal independence or objectivity.

Head of Internal Audit

8. A self-assessment has confirmed that the Internal Audit Service has been delivered in compliance with the expectations of the Public Sector Internal Audit Standards (PSIAS).

9. The Institute of Internal Auditors (IIA) published new Global Internal Auditing Standards (GIAS) in January 2024 with the Internal Audit Standards Advisory Board (IASAB) and CIPFA publishing the Global Internal Audit Standards in the UK Public Sector Application Note, in December 2024. During 2024/25, the existing Internal Audit Strategy and Charter were reviewed and updated to take into account the requirements of the new Standards. The updated Internal Audit Strategy and Charter were presented to the Audit Committee in March 2025.

Internal Audit Opinion

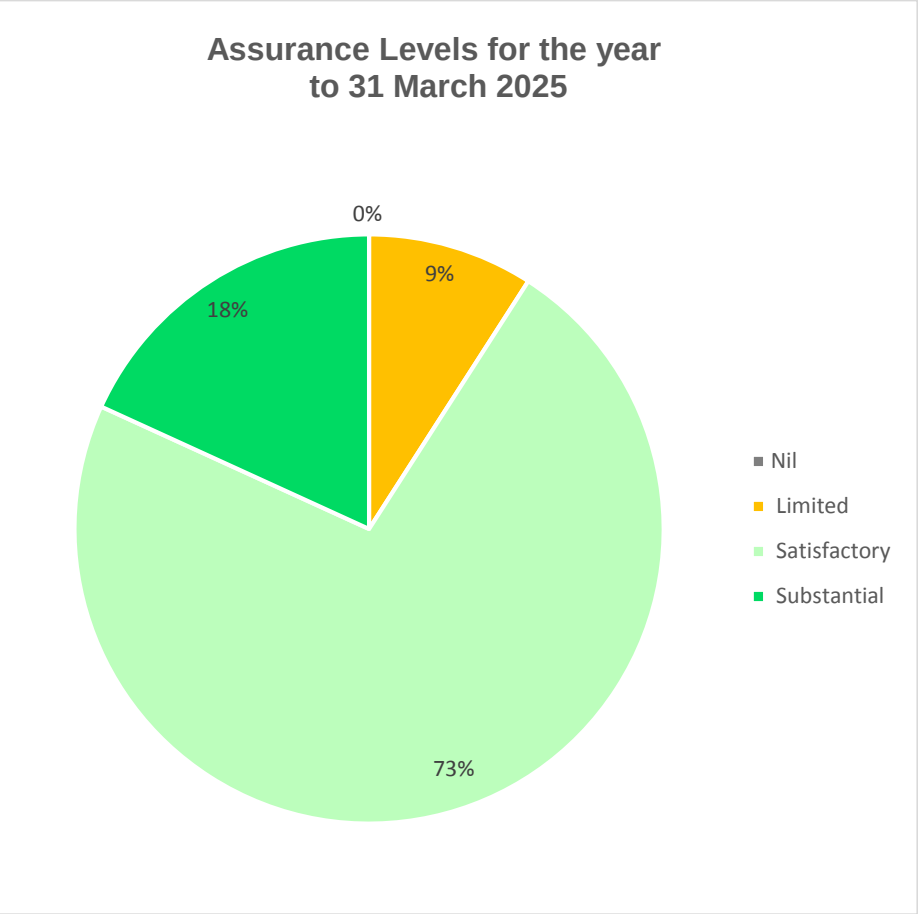
10. As the provider of the internal audit service to the London Borough of Hammersmith and Fulham, the Director of Audit, Fraud, Risk and Insurance is required to provide the Section 151 Officer and the Audit Committee with an opinion on the adequacy and effectiveness of the Council's governance, risk management and control arrangements. In giving this opinion, it should be noted that assurance can never be absolute. Even sound systems of internal control can only provide reasonable and not absolute assurance.

11. The opinion is that, at the time of preparing this report and based upon the work completed this year, the Council's governance, risk management and internal control systems in the areas audited were adequate with the exception of those areas detailed as Limited Assurance (see paragraph 14 below and Appendix 3). This is a positive opinion which means that the Council generally has effective internal control systems with 91% of audits receiving a positive assurance opinion (89% in 2023/24). No Nil Assurance reports have been issued again this year.

12. In the above context it should be noted that:
    - This opinion is based solely upon the areas reviewed and the progress made by the Council to action internal audit recommendations.
    - Assurance can never be absolute neither can internal audit work be designed to identify or address all weaknesses that might exist.
    - Responsibility for maintaining adequate and appropriate systems of internal control resides with Council management, not internal audit.

13. Issues arising from Internal Audit work which have significant implications for the Council's assurance framework, will be included in the Annual Governance Statement which is reported separately to this Committee. The Annual Governance Statement also ensures that follow up action is taken to remedy the key control weaknesses found.

Chart showing assurance levels



Limited Assurance Reviews

14. There were a few areas where improvements in compliance with controls were needed with a total of two audits being designated as limited assurance as set out in the table below:

Service Area	Audited Area	Reported to Audit Committee
People: Children's	No Recourse to Public Funds	June 2025
People: Adult Social Care	Client Affairs (Draft)	June 2025

Substantial Assurance Reviews

15. As identified earlier in the report, four Substantial Assurance reviews were issued in 2024/25 in respect of:
    - NNDR;
    - Elections Readiness;
    - Revenues & Benefits Application Review; and
    - Housing Health & Safety – Water Hygiene.

Managed Services – Finance, HR and Payroll Systems

16. The Council's Finance, HR and Payroll systems are provided by the Integrated Business Centre (IBC) within Hampshire County Council (HCC).

17. In addition to the assurances provided by HCC, the Council is required to apply complementary controls, with Internal Audit carrying out reviews.

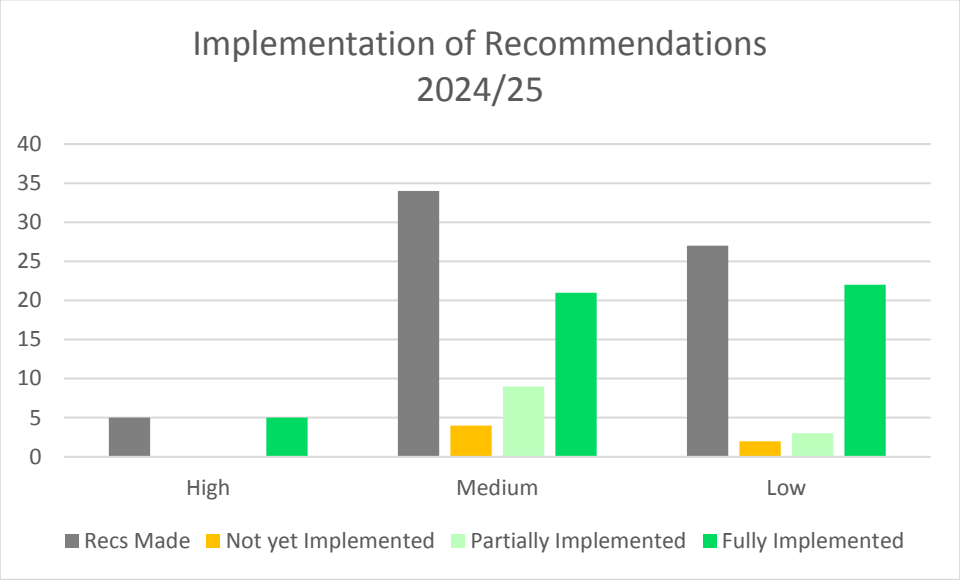
Follow up Audits

18. The implementation of audit recommendations is reported regularly to SLT Assurance and to the Audit Committee.

19. Follow up work is undertaken when most of the recommendations made are expected to have been implemented as indicated in an agreed management action plan. Sometimes recommendations cannot be fully implemented in the anticipated timescales. In these cases, where appropriate progress is being made to implement the recommendations, these are identified as partly implemented. Recommendations will be followed up until all high and medium priority recommendations are implemented or good progress in implementing them can be demonstrated. Where appropriate, the follow up is included in the next full audit of the area.

20. Sixty-six (66) recommendations were followed up in 2024/25 and the implementation of medium and high priority recommendations had been consistently effective with 91% of all recommendations fully or partially implemented. Six recommendations had not been implemented at the time of the follow up (4 medium and 2 low priority recommendations).

Chart showing implementation of recommendations



21. Details of the recommendations not yet fully implemented are contained in Appendix 4.

Additional Sources of Assurance

22. In addition to assurance audits undertaken during the year, the service has provided support and guidance in several areas including:

- Business Continuity Planning
- Pensions Administration

This type of engagement with the services is considered when determining the overall opinion of the Council's governance, risk management and internal control systems together with outcomes provided from internal compliance and quality assurance checks, peer reviews and assessments from external bodies such Ofsted and the Care Quality Commission.

23. In respect of Pensions Administration, the Council receives assurances both through the work carried out by the Local Pensions Partnership Administration (LPPA) Internal Audit Team and the formal annual review of controls carried out by LPPA's external auditor, which takes the form of an Audit and Assurance Faculty (AAF) Type 2 report, which is due to be received shortly from LPPA. An AAF Type 2 report provides assurance both on the design and operation of controls over the specified period (financial year).

24. The Director of Audit, Fraud, Risk and Insurance, the Head of Internal Audit and the Risk and Assurance Manager, also attend meetings of groups across the Council where they contribute and provide advice and challenge where appropriate. During 2024/25, the following were attended:

- SLT Assurance, which is chaired by the Director of Audit, Fraud, Risk and Insurance
- Civic Campus Assurance Board, which is chaired by the Director of Audit, Fraud, Risk and Insurance)
- Contracts Assurance Board, of which the Risk and Assurance Manager is a core member
- Directorate Leadership Teams for regular discussions regarding Internal Audit work and directorate risk registers
- Housing Residents and Building Safety Board
- Cyber Security group, chaired by the Chief Executive
- Procurement Act working group
- Fraud, Error, Recovery Hub Steering Group
- Health and Safety Board
- Service Resilience Group

Assurance on Risk Management

25. As an organisation the Council must ensure that it is delivering against priorities and requirements (political, community and statutory), that it is managing its processes effectively (finance, procurement, governance) and making best use of its resources (money, assets, people). This requires the Council to look both inwardly (to ensure we have effective governance and controls) but also outwardly at risk (e.g., to the risk to citizens, to protect citizens and build resilience).

26. The Senior Leadership Team (SLT) is responsible for providing sufficient assurance against risks and opportunities that affect (or impact upon) the Council and its citizens and communities. It sets the standards and ensures the Council has the right policies, practices and behaviours in place for effective assurance and risk management and is responsible for ensuring that new and emerging risks are identified, captured and appropriate mitigations are put in place.

27. The Council's Corporate Risk Register is reviewed by the Senior Leadership Team at least four times a year and the Register is reported at regular intervals to the Audit Committee for review and comment. SLT Assurance also undertakes deep dives into departmental risks registers, both to give assurance around departmental risk management arrangements and to identify potential additions to the Corporate Risk Register.

28. A new Risk Management Strategy was developed during 2024/25 which was approved by the Audit Committee in March 2025.

29. During 2024/25 an audit of the Council's Risk Management arrangements was undertaken and the Council's approach to identifying and managing risks was provided with Satisfactory Assurance. Two medium priority recommendations were made in respect of the following:
    - Increasing awareness and application of the Risk Management Strategy and supporting procedures and identifying who requires specific risk management training and implementing the training.

- There was a lack of a uniform and consistent approach to escalating risks from the Department Risk Registers to the Corporate Risk Register.

The implementation of the recommendations made in the audit will be discussed with the Council's Senior Leadership Team during 2025/26.

Assurance on Corporate Governance

30. Officers have undertaken an internal review to support the preparation of the draft Annual Governance Statement which will be reported to the Committee alongside the Council's draft Annual Accounts 2024/25 at its July 2025 meeting.

31. Each year, the Council's Directors complete an Assurance Statement which is an opportunity for them to assess the governance arrangements and sources of assurance within their department. Any significant issues should be identified and would feed into the Council's Annual Governance Statement. Internal Audit periodically test the content of Directors Assurance Statements, both to confirm their accuracy and to build upon our own picture of assurance across the Council.

32. The Council's corporate governance framework is considered to comply with the best practice guidance on corporate governance issued by CIPFA/SOLACE.

Consultation

33. The Director of Audit, Fraud, Risk and Insurance is required to provide an annual report and opinion on the Council's system of internal control under the Public Sector Internal Audit Standards. To enable this, an Internal Audit Plan covering the Council's key risks is devised in consultation with the Strategic Leadership Team and the work performed through this plan forms the basis of the annual opinion.

Legal Implications

34. Regulation 3 of the Accounts and Audit Regulations 2015 sets out the Council's responsibility for ensuring that it has a sound system of internal control which:
    a. Facilitates the effective exercise of its functions and the achievement of its aims and objectives.
    b. Ensures that the financial and operational management of the authority is effective, and
    c. Includes effective arrangements for the management of risk.

35. Regulation 5 requires the Council to ensure that it undertakes an effective internal audit to evaluate the effectiveness of its risk management, control and governance processes, taking into account public sector internal auditing standards or guidance.

36. The Constitution gives the Strategic Director of Finance responsibility for complying with the Regulations. The Audit Committee has responsibility for advising on strategic processes for risk, control and governance and the

Statement on Internal Control. This report fulfils the obligations in the Regulations and the Constitution.

37. There are no particular legal implications arising from this report.

Implications verified by Grant Deg, Director of Legal Services on 23 May 2025.

Financial Implications

38. The internal audit plan was delivered within the approved revenue budget for the service for 2024/25. Actions required as a result of audit work, and any associated costs, are the responsibility of the service managers and directors responsible for the areas which are reviewed.

39. Any resource implications from the implementation of the recommendations by services have to be contained within the relevant Directorate approved budgets.

Implications verified by Sukvinder Kalsi, Executive Director of Finance on 23 May 2025.

Risk Management

40. The internal audit plan is developed and delivered to cover the key risks faced by the Council, to provide assurance on the key controls in operation and the effective management of key risks.

Implications verified by Moira Mackie, Head of Internal Audit, on 22 May 2025.

List of Appendices:

Appendix 1 Audits completed in 2024/25 and work in progress
Appendix 2 Changes to the 2024/25 Audit Plan
Appendix 3 Internal Audit Plan 2024/25 – Final Progress Report
Appendix 4 Follow up of Implementation of Recommendations

Appendix 1

Audit work completed in 2024/25

Plan Area	Auditable Area	Issued	Assurance level given	High Priority Recs	Medium Priority Recs	Low Priority Recs
Cross cutting	Business Continuity Planning (2023/24)	Apr-25	Advisory	1	3	1
Cross cutting	Risk Management	May-25	Satisfactory	0	2	1
Corporate Services	NNDR (2023/24)	Jan-25	**Substantial**	0	1	0
Corporate Services	Elections Readiness	-	**Substantial**	0	0	0
Corporate Services	FOIs, SARs & Member Enquiries	Jan-25	Satisfactory	0	2	1
Corporate Services	Digital Services Resilience	Mar-25	Satisfactory	0	0	5
Corporate Services	Integrated Housing Management System (IHMS)	May-25	Satisfactory	0	2	1
Corporate Services	Revenues & Benefits Application	May-25	**Substantial**	0	0	1
Finance	Treasury Management	Feb-25	Satisfactory	0	1	2
People	Local Safeguarding Children's Partnership (2023/24)	Jun-24	Satisfactory	0	2	2
People	Public Health Substance Misuse Procurement (2023/24)	Apr-25	Satisfactory	0	3	3
People	Supporting Families – Claims Compliance	Mar-25	Satisfactory	0	0	0
People	No Recourse to Public Funds	May-25	**Limited**	1	3	0
People	Compliments & Complaints (2023/24)	Aug-24	Satisfactory	0	3	2

Plan Area	Auditable Area	Issued	Assurance level given	High Priority Recs	Medium Priority Recs	Low Priority Recs
People	Client Affairs DRAFT	May-25	**Limited**	2	5	2
Schools	All Saints CE Primary	Oct-24	Satisfactory	1	6	5
Schools	Kenmont Primary	Nov-24	Satisfactory	1	5	7
Housing	Health & Safety – Asbestos	Jan-25	Satisfactory	0	1	1
Housing	Health & Safety – Water Hygiene	May-25	**Substantial**	0	0	2
Place	Trading Standards (2023/24)	Jun-24	Satisfactory	0	2	8
Place	Licensing (2023/24)	Jul-24	Satisfactory	0	3	4
Place	Waste Contract - Monitoring	Apr-25	Satisfactory	0	3	1
Place	Emergency Planning DRAFT	Mar-25	Satisfactory	0	1	2

2024/25 Audit work in progress

Plan Area	Auditable Area	Status
Finance	Housing Rents	Review of additional testing in progress.
Housing	Health & Safety – Electrical	Draft report due.
Place	FM Health & Safety Compliance	Draft report due.

Appendix 2

Changes to the 2024/25 Internal Audit Plan

Some audits originally included in the 2024/25 plan were re-scheduled as the timing of the audits wasn't appropriate. The following audits are now scheduled for inclusion in the 2025/26 plan:

- Coroner's Service
- Adults Direct Payments
- Home Care Contract Management
- Housing Allocations
- Leaseholder Charges Debt Management

APPENDIX 3

Internal Audit Plan 2024/25 – Final Progress Report

1. Audit Outcomes

1.1 Four assurance levels are used and when an audit is completed, an assurance opinion is provided. A description of each of the assurance levels is summarised below:

Assurance Level	Description
Substantial Assurance:	There is a sound system of internal control designed to achieve their objectives and the control processes tested are being consistently applied.
Satisfactory Assurance:	While there is generally a sound system of internal control, there are weaknesses which put some of the objectives at risk; and/or there is evidence that the level of non-compliance with some of the control processes may put some of the objectives at risk.
Limited Assurance:	Weaknesses in the system of internal control are such as to put the objectives at risk; and/or the level of non-compliance puts the objectives at risk.
Nil Assurance:	Control processes are generally weak, leaving the processes/systems open to significant error or abuse; and/or Significant non-compliance with basic control processes/systems open to error or abuse.

1.2 Recommendations are categorised according to the table below:

Priority	Description
High (Fundamental)	Recommendations represent fundamental control weaknesses, which expose the organisation to a high degree of unnecessary risk.
Medium (Significant)	Recommendations represent significant control weaknesses which expose the organisation to a moderate degree of unnecessary risk
Low (Housekeeping)	Recommendations show areas where we have highlighted opportunities to implement a good or better practice, to improve efficiency or further reduce exposure to risk.

2. Limited Assurance Audits

Details from the two Limited Assurance audits are summarised in the table below:

Ref	Audit	Details
1	No Recourse to Public Funds	The Council is committed to supporting refugees, asylum seekers, and people from abroad. Families who are found to be eligible for NRPF are paid according to the composition of their family and minimum rates are set by the government, known as National Asylum Support Services (NASS). Those rates represent a minimum payment, and the Council pays cases in the borough at a higher rate, in acknowledgment of the high cost of living in London. Testing identified: • Cases where relevant documents demonstrating eligibility were not stored on the case management system (Mosaic). A **high** priority recommendation was made, and the service confirmed that all cases identified were reviewed and confirmed as eligible for payment. The service has also reviewed their Protocol to include detailed checklists for the documentation required to support cases and a new tracker* has been developed to ensure compliance with timeframes. • A lack of formal performance indicators by which the NRPF Review Panel can measure performance and no reporting on the time-bound tasks within the NRPF Protocol. A **medium** priority recommendation was made, and the service confirmed that the new tracker* incorporates all of the required performance indicators. • Training is undertaken intermittently, and attendance records were not kept, nor are training materials shared or retained. We were informed that the last training took place in 2022 and additional training was due to be delivered in October 2024. A **medium** priority recommendation was made, and the service has confirmed that a number of staff attended a refresher introductory training in March 2025 and social services specific training at the beginning of April 2025. Training will be recorded and monitored to ensure that attendance and content are kept up to date and will be reviewed at the quarterly NRPF Panel meetings. • The Council's NRPF Protocol was out of date and did not include all the required details, such as process changes due to remote working and budget monitoring. While the Protocol was out of date and was not version controlled to indicate its review and approval schedule, it was confirmed that the processes contained do represent the current processes for obtaining, approving, and retaining evidence. A **medium** priority recommendation was made, and the service has confirmed that they have reviewed the Protocol and updated it against best practice. A checklist of required documentation has been included in the refreshed Protocol and team meetings will be attended to reinforce the importance of maintaining records and working in line with the updated Protocol. The updated Protocol has been placed on Trix, the Children's Procedures Manual and it will be version controlled and reviewed annually. * The tracker will be monitored in the Early Help Service and overseen by the NRPF Panel, chaired by the Head of Service for Early Help. The Early Help duty managers will monitor /audit cases and report to the Panel. Oversight and scrutiny on performance will be provided to the Early Help Practice Board, chaired by the AD Performance and Improvement and will oversee any necessary action plan.

Ref	Audit	Details
2	Client Affairs – Draft	When a resident of the Borough lacks physical and/or mental capacity to manage their own financial affairs, the Council has a discretionary duty to deal with their financial affairs. The Adult Social Care department can apply to become a Corporate Appointee to manage the person's Department of Works and Pensions (DWP) benefits. This could include the payment of utility bills and the release of funds for personal needs. If a resident lacks the capacity to manage their own affairs under the Mental Capacity Act 2005, the Client Affairs team submits applications to the Court of Protection (on behalf of the Director of Adult Social Care) to be appointed as a Deputy to manage the property and affairs of people who lack the capacity. Sample testing confirmed in all cases reviewed, a Mental Capacity Assessment was provided by the Social Workers and saved onto Mosaic. In addition, the property storage companies used to store clients' physical possessions were approved suppliers on the Council's Financial Management. In all cases tested in respect of client deaths confirmed that the DWP were notified within seven days of the death. Some weaknesses in controls were identified with two high, five medium and two low priority recommendations made. The high and medium priority recommendations were made in respect of the following: • There was no regular performance monitoring or reporting on the Client Affairs Service overall performance and the management of Client Affairs cases **(high priority)**. • Deputyships should be set up promptly upon receipt of a Mental Capacity Assessment referral from the relevant Social Worker. Examination of the Standard Operating Procedures for Functions of the Client Affairs team identified that there was no defined timescale for setting up Appointeeship and Deputyship Applications. We were informed that Client Affairs Officers were expected to complete an Appointeeship application within two weeks of a referral, and a Deputyship application within four weeks of a referral. Sample testing identified Deputyship cases where the Application was significantly over the four weeks target **(high priority)**. • There was no evidence of a formal process for conducting regular reconciliations between the bank accounts and the expected entitlements and bills paid. **(medium priority)**. • Compliance with the Standard Operating Procedures could not be evidenced as documentation of supervision sessions within the Client Affairs team was inadequate **(medium priority)**. • No evidence was provided of specific training content which outlined responsibilities and expectations for Social Workers or Client Affairs Officers when dealing with clients' affairs **(medium priority)**. • Client Affairs' procedures had not been followed consistently with testing identifying cases where the evidence provided did not demonstrate that the client bank account was set up promptly and where the appropriate documentation was not saved within the case management system, Mosaic **(medium priority)**. • There was no established process to charge Deputyship fees. Sample testing identified cases where a Deputyship fee should have been charged **(medium priority)**. **The findings and recommendations from this audit have been discussed with the service who are preparing their response on actions required to address the recommendations made. An update on this audit will be provided to the Committee in September 2025, along with progress being made to implement the agreed actions.**

APPENDIX 4

Implementation of Recommendations 2024/25

The 13 medium priority recommendations not fully implemented at the time of the follow up are summarised in the table below and further follow up will be undertaken to confirm implementation.

Ref	Audit	High Priority	Medium Priority	Recommendation(s) in progress/ not implemented and original implemented date	Status	Revised Implementation Date
1	ASC Supervision (Satisfactory) Audit Issued: August 2021 Initial follow up: September 2023 Next follow up: In progress (Oct 2024 but delayed accommodating the CQC inspection)	0	2	1) Line managers should be reminded of the importance of completing and submitting their supervision monitoring form (due Nov-2021). 2) The Council should seek to undertake reporting of supervision to senior management monthly. KPIs should be introduced, which can be used to measure current performance (due Oct 2021).	1) Plan to complete and submit monitoring forms was instigated, however put on hold due to the Principal Social Worker (PSW) post being vacant. Now a Principal Social Worker is in post the recommendation is due to be implemented. 2) Plan for KPIs to build into monitoring & reporting systems was put on hold due the PSW vacancy. Now that a PSW is in post the recommendation is due to be implemented.	1) October 2023 2) November 2023
2	Community Safety Anti-Social Behaviour (Satisfactory) Audit Issued: November 2023 Initial follow up: September 2024 Next follow up: Due Q2 2025/26	0	2	1) The Service should review their ASB and Community Trigger policies and procedures to ensure that they reflect updates to the Anti-Social Behaviour, Crime and Policing Act where necessary, and to ensure that they reflect best practice (due Apr 2024). 2) The Council should review their Community Trigger Procedure and decide if they wish to keep the timescales as currently written and if they are feasible or adjust the Procedure so that it aligns with their current process. The Service should introduce a mechanism to monitor steps taken in community trigger review to provide an opportunity to the team to identify potential delays prior to occurring (due Oct 2023).	1) ASB Policy and Hate Crime Policy has been drafted and is awaiting sign-off on 24 July by Lead Members to allow for resident consultation. Current ASB Case Review Policy and process is being reviewed and updated. 2) This work is scheduled as part of the overhaul of the ASB and Hate Crime procedures. There is a project manager in place to assist with the development of the ASB policies and procedures, of which this work is a feature.	1) October 2024 2) September 2024

Ref	Audit	High Priority	Medium Priority	Recommendation(s) in progress/ not implemented and original implemented date	Status	Revised Implementation Date
3	Children's Services Direct Payments (Satisfactory) Audit Issued: November 2023 Initial follow up: July 2024 Next follow up: In progress (May 2025)	0	2	1) The Service should review the Direct Payment Policy to reflect that a specific 'care plan' does not exist, and it should reflect the actual process in practice. Furthermore, the Service should consider reviewing the defined requirement of parent/carer approval of the 'care plan' and consider whether the Policy should be amended to reflect the process in practice. Where the Service decides to keep the requirement of approval, the Service should ensure that they receive approval of the finalised care package from the parent/carer by undertaking a check prior to processing the payment to confirm this has taken place. Where agreement is outstanding, the Service should take proactive steps to engage with parent/ carer to receive this (due Mar 2024). 2) The Council should consider formulating an action plan documenting and scheduling the reviews for all direct payments. Timeliness of the six-month monitoring reviews should be monitored to provide opportunity to identify where further resourcing may be needed to complete the reviews (due Dec 2023)	1) The direct policy and guidance have been updated to reflect that there is no longer a requirement for a specific 'care plan' document to be in place. The policy instead notes the need for agreed outcomes. However, this amended policy is not yet implemented, partly due to the general election, but is going through appropriate governance steps for approval prior to sharing with families. It is expected that the new policy will be implemented by end December 2024. The policy and guidance have been shared with Internal Audit. 2) An audit started in October and individual casework actions were completed, no action plan was required. The April audit of 149 families is on-going. All 149 have been reviewed with actions for 84 completed. 22 have on-going significant actions mostly recovery of funds. The other 43 have minor issues which are in the process of being resolved (mostly explaining minor underusage). Some of the actions identified from the audit will be implemented alongside the new policy later this year.	1) December 2024 2) December 2024

Ref	Audit	High Priority	Medium Priority	Recommendation(s) in progress/ not implemented and original implemented date	Status	Revised Implementation Date
4	Cambridge School (Satisfactory) Audit Issued: June 2024 Initial follow up: April 2025 Next follow up: September 2025	0	2	1) The school needs to improve on raising POs in advance of purchases. 2) The leavers overpayment had not been recouped and actions required to reduce the risk of a re-occurrence.	1) The school is increasing the number of orders raised in advance of purchases and approval is obtained before all purchases. 2) Governors have been informed and a plan for recouping overpayments is to be agreed and improvements still being made to the process to avoid future instances.	July 2025
5	Climate Action Plan (Satisfactory) Audit Issued: February 2024 Initial follow up: April 2025 Next follow up: September 2025	0	5	1) Roles and Responsibilities across Departments assessed as not implemented. 2) Monitoring Departmental Progress against the Action Plan assessed as partly implemented. 3) Budget Process assessed as not implemented. 4) Clarity of Leadership Roles assessed as partly implemented. 5) Key Performance Indicators (KPIs) for Cabinet and SLT assessed as not implemented.	1) Monthly meetings with key services to be formalised and responsibilities for actions laid out in the Climate Action Plan to be delegated. 2) The service will quantify their progress against the Climate Action Plan in addition to using new and existing KPIs and qualitative updates. The revised implementation date is 31st May 2025 3) The service will measure the impact of existing governance mechanisms to incorporate climate considerations into day-to-day spending of the Council. This will be used to identify further measures, and/or support, required. 4) There will be further engagement with political members. 5) Reviews of the KPIs and their coverage of the Climate Action Plan will continue, including opportunities to better reflect action / inaction in key areas. Development of SMART targets beyond Net Zero 2030 has been proposed.	June 2025 June 2025 June 2025 June 2025 June 2025

Previously reported outstanding recommendations now implemented:

Ref	Audit	High Priority	Medium Priority	Recommendation(s) previously outstanding	Confirmed as implemented
1	William Morris Sixth Form (Limited) Audit Issued: October 2022 Initial follow up: February 2024 Next follow up: In progress (Oct 2024)	1	0	The Voluntary Fund Account(s) should be reconciled monthly with the reconciliation signed and dated by the appropriate officer. The reconciliation should be reviewed, by a second officer with this review evidenced. Voluntary Fund Accounts should be audited by a registered auditor on an annual basis and presented to the FGB for review and approval (due Feb 2023). The reconciliation was implemented in Feb-2022 when the new SBM joined. The 19-20 accounts were presented to the Finance Staffing and Resources Committee in May 2021. The accounts for 21-22 and 22-23 are still with the external auditor as the school had trouble finding paperwork for the 21-22 accounts which delayed the audit. Revised implementation date: May 2024	December 2024