SUBJECT:	**INTERNAL AUDIT** **Progress Report for Quarter 2 (2025/26)**
DIRECTORATE:	**Resources**
MEETING:	**Governance & Audit Committee**
DATE:	**October 2025**
DIVISION/WARDS AFFECTED:	**All**

1. PURPOSE

To consider the adequacy of the internal control environment within the Council based on the outcomes of audit reviews and subsequent opinions issued to the 30th September 2025.

To consider the performance of the Internal Audit Section over the first 3 months of the current financial year.

2. RECOMMENDATION(S)

That the Committee note the audit opinions issued.

That the Committee note the progress made by the Section towards meeting the 2025/26 Operational Audit Plan and the Section's performance indicators at the 6 month stage of the financial year which are currently meeting the profiled target.

3. KEY ISSUES

3.1 Audit work has started in line with the 2025/26 agreed draft audit plan, considered by the Governance & Audit Committee in June 2025.

3.2 This report gives brief details of the work undertaken in the year to date. The report also gives details of the Section's performance indicators for the 6 months to 30th September 2025.

3.3 The Global Internal Audit Standards (GIAS) came into force for the UK public sector in April 2025 replacing the Public Sector Internal Audit Standards. A self-assessment and gap analysis of compliance to the new standards has been completed and an action plan is in place to ensure the team fully meet the requirements. A separate report is to be considered by the October 2025 G&AC meeting regarding this.

3.4 The year end opinion for 2025/26 will be based on the audit work undertaken during the year, cumulative audit knowledge from previous

years on key financial systems along with any assurance gained from other parties where relevant.

4. REASONS

4.1 Since the start of the financial year, the Internal Audit Section has completed 20 audit jobs to draft stage from its 2025/26 draft Operational Audit Plan; 10 of these being opinion related and are shown in the table at Appendix 1.

4.2 In relation to audit opinion related reports, the following have been issued during the second quarter;

1. Education Welfare Service – Substantial Assurance
2. Digital Projects – Reasonable Assurance
3. Museum Service – Reasonable Assurance
4. Housing Support Grant – Unqualified
5. Health & Safety Building Compliance – Limited Assurance

4.3 One audit opinion was subject to an unfavourable opinion which was issued during Quarter 2 – Health & Safety Building Compliance. The findings from this review are included as Appendix 4 to this report.

4.4 Other audit work in line with the plan has started and site visits have been undertaken to a number of establishments. At the end of Quarter 2, 52% of the agreed audit plan has been deemed as being started or in progress.

4.5 5 special investigations / reactive pieces of work commenced during Quarter 2. At the end of the quarter these all remain under investigation.

1. Infrastructure – Bribery Allegation
2. Learning Skills & Economy – Employee investigation
3. Social Care, Safeguarding & Health – Employee investigation
4. Infrastructure – Employee investigation
5. Cross-Cutting – Proactive review of overtime paid across MCC

4.6 In addition 1 investigation was open from the 2024/25 financial year. This was within the Social Care, Safeguarding & Health directorate and has now been completed with a disciplinary hearing held.

4.7 Appendix 3 of the report gives details of the Section's performance indicators as at the 30th September 2025.

4.8 As of 30th September 2025, 30% of the 2025/26 Audit Plan has been completed. This meets the profiled target of 30% for the second quarter.

5. SERVICE MANAGEMENT RESPONSIBILITIES

5.1 Heads of Service and service managers are responsible for addressing any weaknesses identified in internal systems and demonstrate this by including their management responses within the audit reports. When management agree the audit action plans, they are accepting responsibility for addressing the issues identified within the agreed timescales.

5.2 Ultimately, managers within MCC are responsible for maintaining adequate internal controls within the systems they operate and for ensuring compliance with Council policies and procedures. All reports, once finalised, are sent to the respective Chief Officers and Heads of Service for information and appropriate action where necessary.

6. FOLLOW UP AUDIT REVIEWS

6.1 Where 'unfavourable' (Limited Assurance / No Assurance) audit opinions are issued, they are followed up within a twelve month timescale to ensure that the agreed actions have been taken by management and that the internal control systems are improved.

6.2 No follow-up reviews have commenced during the first quarter of the financial year. The following reviews were subject to unfavourable audit opinions issued during previous financial years and the table below indicates when the follow-up work will be conducted by the Internal Audit team. The original findings from each of these reviews have already been presented to the Committee.

Year	Assignment	Opinion	Status
2023/24	Mileage	Limited	Fieldwork
	General Expenses	Limited	2025/26 – Q3
	Children Looked After Savings	Limited	2025/26 – Q3
2024/25	Job Evaluation	Limited	Fieldwork
	Procurement Cards	Limited	Fieldwork
	Mardy Park Residential	Limited	2025/26 – Q4
	Facilities & Building Cleaning	Limited	2025/26 – Q4
	Bank Imprest - Severn View Residential	Limited	2025/26 – Q3
	Caldicot School	Limited	2025/26 – Q4
	Supply Staff at Schools	Limited	2026/27

	Contract Management	Limited	2026/27
	Pupil Referral Service	Limited	2026/27
2025/26	My Mates	Limited	2026/27
	H&S Building Compliance	Limited	2026/27

6.3 The timing of a follow-up review is based on when the previous final report was issued plus enough time for management to successfully implement their management actions along with sufficient time to pass to ensure the changes are fully embedded within the service. Chief Officers and Senior Managers are given appropriate notice of follow-up audit reviews to so that proactive steps are being taken by management to act on the recommendations issued. As the table details, this is a challenging programme to ensure all these reviews are completed during quarter 3 and especially quarter 4 of the year. The Audit Management team are planning workloads to ensure as much of these can be completed within the year as possible.

7. RESOURCE IMPLICATIONS

None.

8. CONSULTEES

Deputy Chief Executive / Chief Officer Resources
Chair of Governance & Audit Committee

Results of Consultation:

N/A

9. BACKGROUND PAPERS

Draft Operational Audit Plan 2025/26

10. AUTHORS AND CONTACT DETAILS

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AUDIT COMMITTEE OCTOBER 2025

INTERNAL AUDIT SECTION PROGRESS REPORT
2025/26 – 6 MONTHS

APPENDIX 1

Internal Audit reviews from the 2025/26 Operational Audit Plan where fieldwork has been completed and/or final reports issued since 01/04/25 are listed in the table below.

Internal Control Opinions give the auditor's overall conclusion on the control environment operating in each system/establishment under review. Opinions range from Substantial Assurance through to No Assurance (Appendix 2).

Draft issued indicates that a draft report has been issued and a response is awaited from the client before the report can be finalised.

Status of reports as at 30th September 2025

Internal Audit Services - Management Information for 2025/26 – Quarter 2

Opinion Summary	Number
Substantial Assurance	2
Reasonable Assurance	5
Limited Assurance	2
No Assurance	0
Unqualified (Grant Claim)	1
Qualified (Grant Claim)	0
Total	**10**

Job number	Directorate	Service	Job Name	Risk Rating / Priority	Final / Draft	Conclusion given (Assurance)
P2526-09	Law & Governance	Legal	Welfare & Family Law	Medium	Draft	Substantial
P2526-13	Learning, Skills & Economy	Achievement & Attainment	Education Welfare Service	Medium	Draft	Substantial
P2526-03	Resources	Digital Design & Innovation	Digital Projects	Medium	Draft	Reasonable
P2526-19	Learning, Skills & Economy	Primary Schools	Thornwell Primary	Medium	Draft	Reasonable
P2526-51	Customer, Culture and Wellbeing - Mon Life	Leisure Services	Monmouth Leisure Centre	Medium	Draft	Reasonable
P2526-52	Customer, Culture and Wellbeing - Mon Life	Visitor Attractions	Museum Service	Medium	Final	Reasonable

Job number	Directorate	Service	Job Name	Risk Rating / Priority	Final / Draft	Conclusion given (Assurance)
P2526-54	Customer, Culture and Wellbeing - Mon Life	Environment & Culture	Markets	High	Final	Reasonable
P2526-04	Resources	Landlord & Commercial Services	Building Compliance	High	Draft	Limited
P2526-27	Social Care, Safeguarding & Health	Adult Services	My Mates	Medium	Final	Limited
P2526-47	Chief Executives – Housing, Rural Development & Strategic Partnerships	Housing Support Grant	Housing Support Grant	Medium	Final	Unqualified

Non – opinion / Added Value Audit Work

Job number	Directorate	Service	Job Name
P2526-07	Resources	Resources General	Audit Advice
P2526-10	Law & Governance	Law & Governance General	Audit Advice
P2526-25	Learning, Skills & Economy	Learning, Skills & Economy General	Audit Advice
P2526-34	Social Care, Safeguarding & Health	Social Care, Safeguarding & Health General	Audit Advice
P2526-40	Infrastructure	Infrastructure General	Audit Advice
P2526-45	Place	Place General	Audit Advice
P2526-49	Chief Executives – Housing, Rural Development & Strategic Partnerships	Chief Executives – Housing, Rural Development & Strategic Partnerships General	Audit Advice
P2526-56	Customer, Culture and Wellbeing - Mon Life	Customer, Culture and Wellbeing - MonLife - General	Audit Advice
P2526-63	People, Performance and Partnerships	People, Performance & Partnerships	Audit Advice

Job number	Directorate	Service	Job Name
		General	
P2526-65	Corporate	Corporate	Annual Governance Statement

APPENDIX 2

Internal Audit Opinions

Each report contains an opinion which is an overall assessment of the control environment reviewed.

OPINION	DESCRIPTION
SUBSTANTIAL ASSURANCE	A sound system of governance, risk management and control exists, with internal controls operating effectively and being consistently applied to support the achievement of objectives in the area audited.
REASONABLE ASSURANCE	There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified which may put at risk the achievement of objectives in the area audited.
LIMITED ASSURANCE	Significant gaps, weaknesses or non-compliance were identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the area audited.
NO ASSURANCE	Immediate action is required to address fundamental gaps, weaknesses or non-compliance identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the area audited.

The table below summarises the risk ratings used during our audits:

RISK RATING	DESCRIPTION
CRITICAL	Major or unacceptable risk which requires immediate action.
SIGNIFICANT	Important risk that requires attention as soon as possible.
MODERATE	Risk partially mitigated but should still be addressed.
STRENGTH	No risk. Sound operational controls and processes confirmed.

For grant claim audits:

Unqualified opinion - the terms and conditions of the grant were generally complied with;

Qualified opinion - the terms and conditions of the grant were not fully complied with; the identified breaches of terms and conditions will be reported to the grantor and internally to relevant Head of Service/Chief Officer.

AUDIT COMMITTEE OCTOBER 2025

INTERNAL AUDIT SECTION PROGRESS REPORT
2025/26 – 6 MONTHS

APPENDIX 3

Performance Indicators

N/A – not available

	2025/25	Q1	Q2	Q3	Q4	Target
1	Percentage of planned audits completed	10%	32%	49%	82%	80% pa
2	Average no. of days from audit closing meeting to issue of a draft report	2.7 days	1.7 days	2.3 days	1.8 days	15 days
3	Average no. of days from receipt of response to draft report to issue of the final report	N/A*	3.3 days	3.0 days	3.8 days	10 days
4	Percentage of recommendations made that were accepted by the clients	N/A*	100%	100%	100%	95%
5	Percentage of clients at least 'satisfied' by audit process	N/A*	100%	100%	100%	95%

	2025/26	Q1	Q2	Q3	Q4	Target
1	Percentage of planned audits completed	9%	30%			30% in Q2 80% pa
2	Average no. of days from audit closing meeting to issue of a draft report	1.5 days	3.2 days			15 days
3	Average no. of days from receipt of response to draft report to issue of the final report	N/A	3.9 days			10 days
4	Percentage of recommendations made that were accepted by the clients	N/A	100%			95%
5	Percentage of clients at least 'satisfied' by audit process	N/A	100%			95%

Appendix 4

SUMMARY OF WEAKNESSES – HEALTH & SAFETY BUILDING COMPLIANCE

The audit examined how the Council completed compliance checks on the buildings it operates (the process) and previous to this team being established in 2021 no one was undertaking the regular checks of the respective sites. This review found significant weaknesses, resulting in a 'Limited' assurance rating. It is important to note that this does not imply that the buildings themselves are unsafe or present any major health and safety concerns. Key issues include overdue lift inspections, incomplete documenting of gas safety checks, missing or unclear policies, and inconsistent reporting. Not all buildings had been regularly checked, and there was no clear system for determining inspection frequency. Communication and record-keeping needed improvement, and there was no formal process for managers to respond to the issues raised.

It was noted that for a large portion of the findings below, it was explained to the auditor that appropriate checks had actually been completed, and documents had been viewed on compliance visits, but this had simply not been recorded or included on the visit reports.

RISK RATING	DESCRIPTION	TOTAL IDENTIFIED
CRITICAL	Major or unacceptable risk which requires immediate action.	2
SIGNIFICANT	Important risk that requires attention as soon as possible.	15
MODERATE	Risk partially mitigated but should still be addressed.	7
STRENGTH	No risk. Sound operational controls and processes confirmed.	6

Ref.	CRITICAL
3.04	Some lift inspections were found to be overdue.
3.09	Gas Safety checks were not always evidenced. Where gas leaks were identified, although remedial action was taken, this was not reported to senior management.

Ref.	SIGNIFICANT
1.03	The Council did not have a full suite of Health and Safety Policies to outline how the Authority would comply with statutory requirements around building health and safety.
1.04	The purpose of the Health and Safety Compliance Team, its remit and responsibilities were not formally documented.

Ref.	SIGNIFICANT
1.05	Compliance visits have not been undertaken at all buildings used by the Council. There was no risk-based methodology used to determine the frequency of visits.
3.02	Compliance visits were being performed by two officers.
3.03	There was an absence of detail around the expected level of compliance. Not all key risk areas were being examined on visits.
3.05	Not all Legionella risk assessments were found to be current.
3.06	It was not always recorded that the condition of asbestos-containing materials (ACMs) was reviewed during compliance visits.
3.07	Fire Risk Assessments at sites were sometimes historic and had not been reviewed by a 'competent individual'.
3.08	No checks were being undertaken on glazing across the authority's buildings.
3.10	Health and Safety Compliance Officers did not always evidence the testing undertaken to support the findings contained within the visit reports. Site information folders were not held detailing comprehensive information, reports and advice issued to each establishment.
3.11	Compliance reports were inadequate did not clearly detail the assessment of controls and necessary actions required. There was little evidence that recommendations issued from previous visits were being fully revisited.
3.12	Reports were not always issued to the appropriate management level.
3.13	No process was in place for site managers to accept / dispute the recommendations made and to agree a course of action. Recommendations made were not categorised or prioritised based on risk, nor was the risk of non-compliance highlighted to the reader.
3.14	No quantitative or qualitative performance measures existed to monitor the service.
3.15	There was insufficient communication and collaboration between the Health and Safety Compliance Team and Corporate Health and Safety.

Ref.	MODERATE
1.06	The central record of MCC properties, which contained the status of specific risk assessments, was found to be out of date and had missing information.
1.07	A training needs analysis has not been completed for the Compliance Officer role and therefore the level and type of training required was unknown.
2.04	The site contact list was inaccurate and contained names of employees who had left MCC more than 12 months ago.
3.16	Site management responsibility training had not been provided to all nominated Site Managers.
3.17	No unannounced visits were undertaken.

Ref.	MODERATE
3.18	Checks were flagged on the visit reports as ‘no longer required’, however, they appeared to still being completed by the site and continued to be reviewed by the Health and Safety Compliance Officers.
3.19	Reports should indicate where checks were not applicable as opposed to simply omitting them, for example radon, asbestos and sprinkler systems.