HUNTINGDONSHIRE DISTRICT COUNCIL

Internal Audit Progress Report

Corporate Governance Committee – 16 September 2026

CONTENTS

Appendices

KEY MESSAGES

The internal audit plan for 2026/27 was approved by the Corporate Governance Committee (CGC) in March 2026. This report provides an update on progress against that plan and summarises the results of the work completed by to date.

2026/27 Internal Audit Plan – We have issued the folllowing internal audit reports as final since the last meeting:

- Licensing and Environmental Health (2026/27) – **Reasonable Assurance**
- Data Quality – Human Resources (2026/27) - **Partial Assurance**
- Health and Safety – Open Spaces and Countryside (2026/27) – **Partial Assurance**

We have also issued the following review in draft and are awaiting a final management response:

- Business Continuity Planning. **[To note]**

The Debt Management review has been completed and a draft report due to be issued w/c 7 September 2026.

Details of the progress made, and scheduling of the 2026/27 internal audit plan are included at Appendix A. **[To note]**

Final Reports

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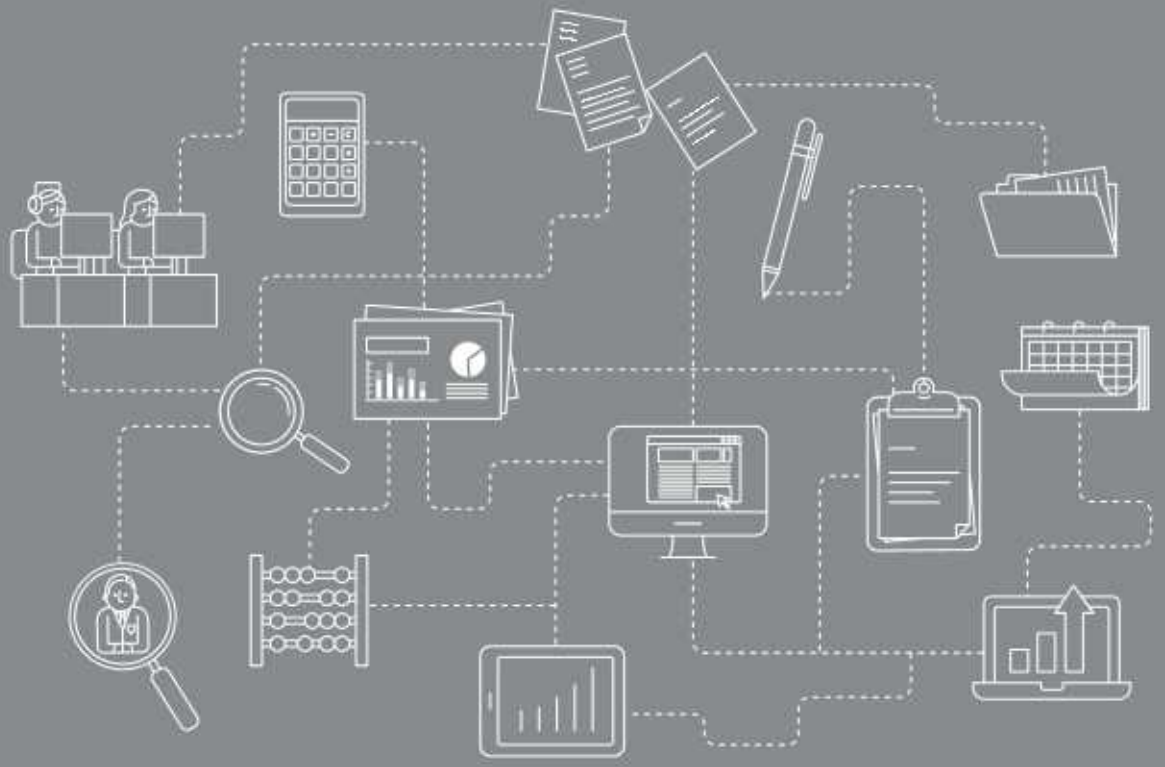


1. FINAL REPORTS

1.1 Summary of the key issues arising from the final reports being presented to this Committee

This section summarises the reports that have been finalised since the last meeting.

Assignment	Opinion issued	Actions agreed L	M	H
Licensing and Environmental Health (2025/26) The audit found that core governance processes within Taxi Licensing and Skin Piercing registraton are generally well established and operating effectively, with several areas of good practice identified. Information on taxi and private hire licensing, as well as skin piercing registrations, is clearly presented on the Council's website, including application requirements, relevant policies, conditions, and access to online application systems. Sample testing (10 practitioner and 5 premises skin piercing registrations; 5 each of taxi driver, vehicle and operator licences) confirmed that fees were correctly applied in line with those approved by Full Council. All sampled taxi licences were appropriately supported by evidence of required checks, including DBS, right to work, safeguarding training, DVLA and insurance verification, and vehicle safety requirements. All skin piercing registrations sampled were completed promptly following inspector approval. For taxi licensing, performance is monitored via a monthly KPI reported to the Performance Board chaired by the Corporate Director (Communities); review of January to March 2026 reports confirmed that 100% of licences were issued within five working days of validation, verified to system records. The review did, however, identify opportunities to further strengthen governance arrangements, and **one low** and **one medium priority** management actions have been agreed. While policies and procedures relating to taxi licensing and skin piercing registration are generally comprehensive and provide clear guidance, key elements of document governance such as defined ownership, version control, and formal approval are not applied consistently. This creates a risk that outdated or unauthorised guidance may be used. Sample testing of 10 practitioner and 5 premises skin piercing registrations also identified some inconsistencies in the application of established procedures. These included variations in the issuing of standard pre-registration advisory communications, use of the standard inspection report template, and evidence of checks to confirm that associated premises were appropriately registered when processing individual applications. **No high priority actions**	Reasonable Assurance	1	1	0
Data Quality – Human Resources (2026/27) Overall, we found that the Council's arrangements for the maintenance and reporting of employee data are partially effective. Whilst a framework of controls is in place to support the maintenance and reporting of employee data, these controls are not applied consistently across all areas reviewed. We identified weaknesses in employee records management, the accuracy and maintenance of employee start date records, and the maintenance of job descriptions.	Partial Assurance	2	1	1

Assignment	Opinion issued	Actions agreed L	M	H
We noted weaknesses in how certain aspects of employee data are documented and governed in practice. In particular, roles and responsibilities for maintaining data accuracy are not clearly defined within guidance, and documentation does not consistently include version control or review information. In addition, weaknesses were identified in the governance and maintenance of employee records. In particular, arrangements for maintaining, reviewing and updating job descriptions are not operating effectively, resulting in missing, outdated and undated documentation, while inconsistencies were also identified in the recording of employee start dates. Arrangements were in place to maintain employee records within the iTrent system, supported by electronic personnel files and regular workforce reporting to the EC. Core employee data fields tested were generally supported by underlying documentation, and communications were in place to prompt staff to review and update their information. In addition, workforce reporting is produced on a regular basis and subject to established governance arrangements, and key HR processes are supported by system functionality and underlying records. While these issues do not indicate that employee data is fundamentally unreliable, they may affect the consistency of workforce information required to support LGR activity. This is particularly important in the context of LGR, where accurate and up-to-date workforce data will be essential to support organisational planning and transition. **High priorty management action:** Management will undertake a comprehensive review of all job descriptions to ensure that they are up-to-date and aligned to the role structure and records held within iTrent in preparation for Local Government Reorganisation. For those employees for which there is no valid job description, these will be developed in a timely manner and communicated to staff. **Responsible Owner:** Leanne Harfield, Head of HR **Deadline:** 31 December 2026				
Health and Safety – Open Spaces and Countryside (2026/27) Overall, we identified a number of weaknesses in the design, operation and oversight of health and safety controls across the areas reviewed. There was insufficient evidence to demonstrate that key health and safety information, including incidents and near misses, was subject to effective scrutiny and challenge through the appropriate governance channels. Local procedures lacked consistent version control, formal review and approval, and clear alignment to the overarching corporate Health and Safety Policy. In addition, risk assessment arrangements were not operating effectively, with overdue and incomplete assessments identified and an assessment tracker that did not clearly record all required assessments or their review dates. We also identified gaps in both mandatory corporate and site-based health and safety training records, limiting assurance that all staff had completed the training necessary to undertake their roles safely. However, we did identify some positive aspects of the control framework. The Council has established an overarching Health and Safety Policy, documented governance arrangements, defined responsibilities and escalation routes, and local Safe	**Partial Assurance**	2	6	1

Assignment	Opinion issued	Actions agreed L	M	H
Working Practice guidance for open spaces and countryside activities. Risk assessments were in place for the areas reviewed and generally documented relevant hazards and existing control measures. We have therefore concluded a partial assurance opinion. While the framework is established, the recurring weaknesses identified reduce assurance over the consistent operation of health and safety controls in practice, particularly in relation to governance reporting, risk assessment reviews and training compliance. Management actions have been agreed to address these areas, comprising one high, six medium and two low priority actions. **High priorty management action:** We will ensure all mandatory health and safety training is identified and all staff still required to complete the training are reminded. Compliance will be regularly monitored, and persistent non-compliance will be reported to line managers and the appropriate governance forum. Appropriate action will be taken against persistent non-compliance with relevant employees. **Responsible Owners:** Robbie Bratchell Nick Massey Jo Peadon Karen Martin-Peters **Deadline:** 31 January 2027				

Appendices

02

APPENDIX A: PROGRESS AGAINST THE INTERNAL AUDIT PLAN 2026/27

	Assignment	Status / Opinion issued / Start date	Actions agreed			Target CGC	Actual CGC meeting
			H	M	L		
1	Recruitment and Retention	Final Report – Reasonable Assurance	0	2	2	July 2026	July 2026
2	**Licensing and Environmental Health**	**Final Report – Reasonable Assurance**	**0**	**1**	**1**	**July 2026**	**September 2026**
3	**Data Quality – Human Resources**	**Final Report – Partial Assurance**	**1**	**1**	**2**	**July 2026**	**September 2026**
4	**Health and Safety**	**Final Report – Partial Assurance**	**1**	**6**	**2**	**September 2026**	**September 2026**
5	Business Continuity	Draft Report issued 11/08/2026				November 2026 (was Sept 2026)	
6	Debt Management	Debrief held, in QA				November 2026 (was Sept 2026)	
7	Community Health and Wealth Fund	Fieldwork in progress				November 2026	
8	Capital Expenditure Follow Up	Fieldwork in progress				November 2026	
9	Creditor Payments Follow Up	Fieldwork in progress				November 2026	
10	Disabled Facility Grant Verification	September 2026				November 2026	
12	Insurance	October 2026				January 2027	
13	Mandatory Training	October 2026				January 2027	
14	Transformation Follow Up	November 2026				March 2027	
15	Safeguarding	December 2026				March 2027	
16	General Ledger Follow Up	January 2027				March 2027	
17	ICT Budget Management Follow Up	January 2027				March 2027	
18	Risk Management	January 2027				March 2027	
19	Preparedness for LGR	February 2027				June 2027	
19	IT Disaster Recovery	February 2027				June 2027	
20	Full Follow Up	February 2027				June 2027	

APPENDIX B: OTHER MATTERS

Changes to the Internal Audit Plan since the last meeting in July 2026

For the 2026/27 plan, we have agreed some minor changes to the scheduling of internal audits, following discussions with management. The LGR audit has been moved to February 2027 at the request at the CEO, the General Ledger Follow Up has been scheduled for January 2027 (to take account of deadlines for actions), and the CHAWS audit has been brought forward (fieldwork in progress).

Detailed below are the changes to the 2026/27 plan previously reported to the Committee

Note	Auditable area	Reason for change
1	**Various audits - 2026/27**	For the 2026/27 plan, we have agreed some minor changes to the scheduling of internal audits, following discussions with management. This includes the **BCP** internal audit being brought forward to July 2026, the **Mandatory Training** audit moving back to October 2026, the **Transformation Follow Up** moving to September 2026 and the **General Ledger Follow Up** moving forward to August 2026.
2	**Various audits - 2026/27**	For the 2026/27 plan, we are in the process of scoping audits and agreeing timeframes with management. At the March 2026 meeting we submitted a draft and oversubscribed internal audit plan. We can confirm that the following audits have been removed from 2026/27 programme of work following discussions with management as these were not deemed slightly lower priority areas for 2026/27. These areas will be reconsidered as part of the 2027/28 internal audit planning process and kept under review during the next few months **(Car Parking Enforcement, Sickness Absence Management, Planning).**

Head of Internal Audit opinion 2026/27

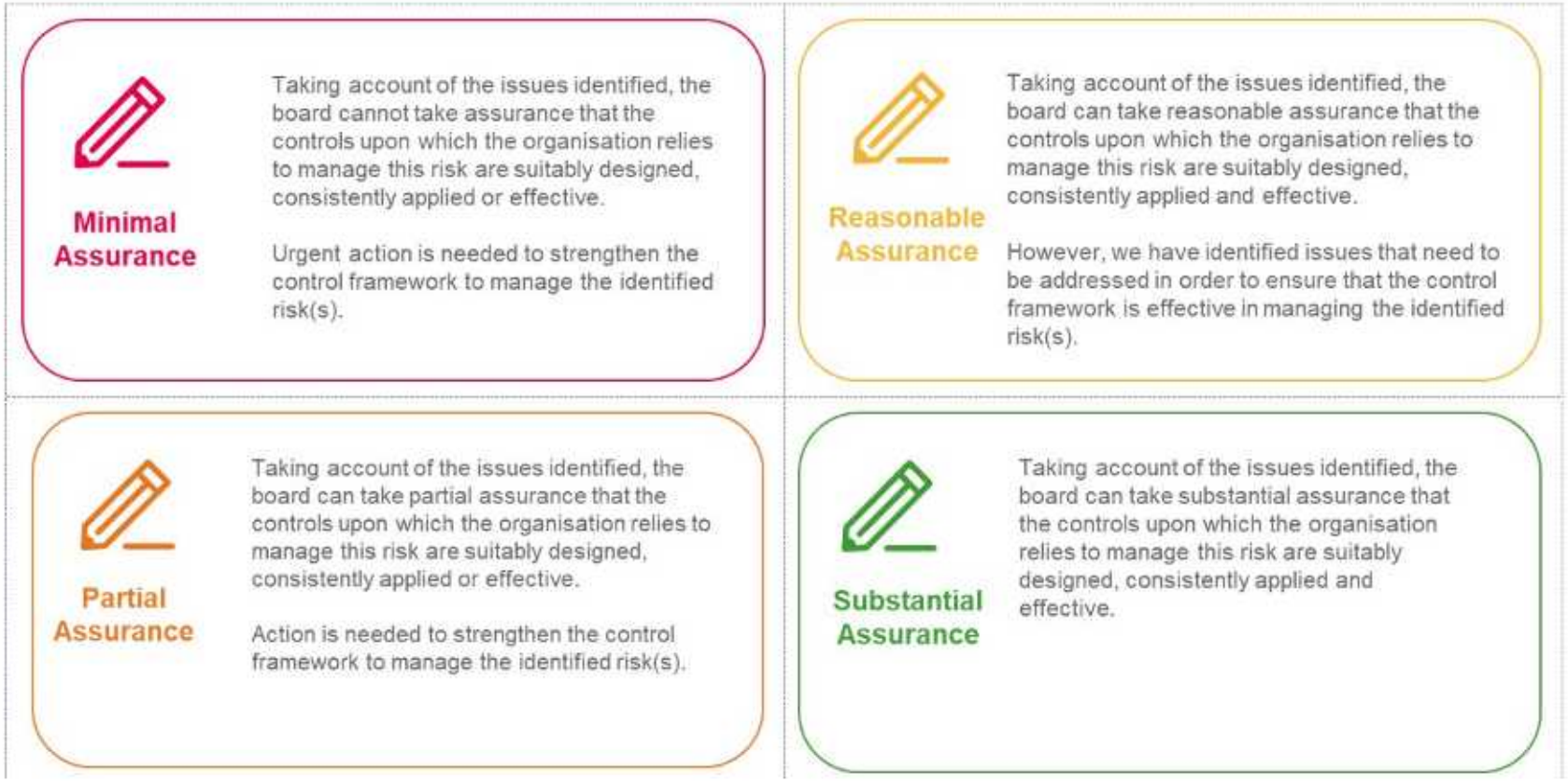
We have issued two negative opinion to date from our final reports (Data Quality – Human Resources and Health and Safety – Open Spaces and Countryside). We will continue to update the CEO, S151 Officer, other CLT members, and the CGC as and when reports are issued and if there is any potential impact to the year-end opinion. We will also provide updates at future CGC meetings.

Quality assurance and continual improvement

To ensure that RSM remains compliant with the IIA standards and the financial services recommendations for Internal Audit we have a dedicated internal Quality Assurance Team who undertake a programme of reviews to ensure the quality of our audit assignments. This is applicable to all Heads of Internal Audit, where a sample of their clients will be reviewed. Any findings from these reviews being used to inform the training needs of our audit teams.

The Quality Assurance Team is made up of; the Head of the Quality Assurance Department (FCA qualified) and an Associate Director (FCCA qualified), with support from other team members across the department. This is in addition to any feedback we receive from our post assignment surveys, client feedback, appraisal processes and training needs assessments.

APPENDIX C: ASSURANCE OPINIONS



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