Internal Audit Progress Report
Audit Committee (30 September 2025)

Pendle Borough Council

Contents

Global Internal Audit Standards (UK public sector)

Our work was completed in accordance with Global Internal Audit Standards (UK public sector).

1 Introduction

This report provides an update to the Accounts & Audit Committee in respect of progress being made with delivery of the 2025/26 internal audit plan and brings to your attention matters relevant to your responsibilities as members of the Accounts & Audit Committee.

This progress report provides a summary of Internal Audit activity and complies with the requirements of the Global Internal Audit Standards (UK public sector).

Comprehensive reports detailing findings, recommendations and agreed actions are provided to the organisation, and are available to Committee Members on request. In addition, a consolidated follow up position is reported on a periodic basis to the Audit Committee.

This progress report covers the period 22 July to 19 September 2025.

2 Key messages for Accounts & Audit Committee

Since the last meeting of the Accounts & Audit Committee, there has been the focus on the following areas:

Audit Reviews

The following reviews have been finalised:

- **Disabled Facilities Grant** – Moderate assurance
- **Customer Services review** – Substantial assurance
- **Follow up** – see Appendix D

The following reviews are in progress:

- **Payroll** – draft report being finalised
- **IT Critical application – IDOX system** – draft report
- **VAT audit** – fieldwork
- **Health & Safety** – fieldwork
- **Governance** – fieldwork
- **Contract Management** - planning

Follow up of previous internal audit recommendations

A summary of the current status of follow-up activity is included in Appendix D, however, we would draw the committee's attention to the following:

- Of the 68 recommendations set out in Appendix D, 10 of these are not due for follow up.
- This leaves 58 recommendations of which 36 (62%) have been fully actioned and 22 (38%) recommendations which are in progress.
- There are no critical and 3 high priority recommendations outstanding/not yet due. All three high priority recommendations relate to the Information Governance audit and are in progress with a revised date of 31 December 2025.

See **Appendix D** for further details.

Audit Plan Changes

Audit Committee approval will be requested for any amendments to the original plan and highlighted separately below to facilitate the monitoring process.

There are no proposed changes to the audit plan.

Added Value

Briefings

Our latest briefings/blogs/podcasts are:

- 25/26 MIAA Insight - AI Governance Checklist
- 25/26 MIAA Insight - Local Authority Audit Committee Members Roles and Responsibilities

Events

- The Value of Storytelling in health and social care (9th October 2025): Storytelling has the power to engage, influence, teach and inspire listeners. That's why we argue for organisations to build a storytelling culture and place storytelling at the heart of their learning programs. There's an art to telling a good story, and we all know a good story when we hear one. But there's also a science behind the art of storytelling.
- The Kindness Deficit: What Happens When Care Stops Caring (4th November 2025):There is no doubt that we are all living through a time of collective collapse; our systems, our ecology and what was most familiar, are both fractured and fragile. We all feel this. Fear, survival and self-importance may be in the driving seat, with kindness and care, relegated to the back of the bus. Whilst we may all acknowledge how important kindness is, why have we pushed it away and how is it costing us? Our NHS is founded on the principles of care, compassion and kindness. In this session, we ask how this kindness deficit became our reality and how as a system, have we stopped caring enough.

Appendix A: 2025/26 Contract Performance

The Global Internal Audit Standards (UK public sector) state that 'In the UK public sector, a chief audit executive must prepare such an overall conclusion at least annually in support of wider governance reporting, mindful of any specific sector obligations or processes. This overall conclusion must encompass governance, risk management and control.'

Below sets outs the overview of delivery for your Head of Internal Audit Opinion for 25/26:

HOIA Opinion Area	TOR Agreed	Status	Assurance Level	Audit Committee Reporting
Core/Mandated Assurances				
Risk Management		Q3		
Finance Systems Deep Dive		Q4		
Council tax & NNDR(Revenue & Benefits)		Q4		
Risk Based Assurances				
Payroll	✓	Report being finalised	Substantial	
Governance Review	✓	Q2 - Fieldwork		
VAT Audit	✓	Q2 - Fieldwork		
Contract Management		Q2 - Planning		
Health and Safety	✓	Q2 - Fieldwork		
Nelson Town Deal		Q3		
Procurement		Q3		

HOIA Opinion Area	TOR Agreed	Status	Assurance Level	Audit Committee Reporting
Licensing		Q4		
IT Critical application review: IT Asset Management		Q3		
Project Management Arrangements (was Carbon Plan)		Q4		
2024/25 reviews not included in 2024/25 HOIAO				
IT review – IDOX system	✓	Draft report stage		
Customer services review	✓	Final report issued	Substantial	30 September 2025
Follow Up				
Qtr 1	N/A	Completed	Not applicable	29 July 2025
Qtr 2	N/A	Completed	Not applicable	30 September 2025
Qtr 3	N/A	In progress		
Qtr 4	N/A			

Appendix B: Performance Indicators

The primary measure of your internal auditor's performance is the outputs deriving from work undertaken. The following provides performance indicator information to support the Committee in assessing the performance of Internal Audit.

Element	Reporting Regularity	Status	Summary
Delivery of the Head of Internal Audit Opinion (Progress against Plan)	Each Audit Committee	Green	There is ongoing engagement and communications regarding delivery of key reviews to support the Head of Internal Audit Opinion.
Issue a Client Satisfaction Questionnaire following completion of every audit.	Each Audit Assignment	Green	Questionnaire issued with each audit report.
Percentage of recommendations raised which are agreed	Each Audit Committee	Green	Actions agreed by the Council on all recommendations raised.
Qualified Staff	Annual	Green	MIAA have a highly qualified and diverse workforce which includes 75% qualified staff. The Senior Team delivering the Internal Audit Service to the Council are CCAB/IIA qualified.
Quality	Annual	Green	MIAA operate systems to ISO Quality Standards. MIAA conforms with the Global Internal Audit Standards (UK public sector).

Appendix C: Key Areas from our Work and Actions to be Delivered

Report Title	**Disabled Facilities Grant**			
Executive Sponsor	Director of Place			
Assurance opinion	Moderate			
Objective	The overall objective was to evaluate the controls in place to manage the key risks which would affect the effective operation of the organisation's system for authorisation, payment and monitoring of Disabled Facilities Grants (DFG) by Pendle Borough Council. Scope Limitation - An opinion on the accuracy of assessments of eligibility, relevance of works, standards of completion and planning / building regulations approval were outside the scope of this review.			
Recommendations	0 x Critical	0 x High	7 x Medium	1 x Low
Summary	Overall, the review identified that controls were designed and operating effectively with regard to records maintained in relation to grants awarded. However, there were areas of operational practice that were inconsistent with the Disabled Facilities Grants Policy and operational agreed practice. The Disabled Facilities Grants Policy was available for stakeholders to access and reviewed in August 2024, the policy was comprehensive overall, although some enhancements were identified, including facilitation charges being incorrectly recorded. There was no reference in the Policy or elsewhere to the process for raising complaints, appeals process management arrangements and escalation to the ombudsman. There was no process currently within the policy of receiving feedback or client feedback questionnaires. The grant request process from notification from Occupational Therapists through to contract payments was operating satisfactory in compliance with the policy. Appropriate documentation was being completed and evidence obtained to support the grant application, with all grants being approved including discretionary grant support and means testing contributions from applicants. Records are both			

	electronic and paper although retention processes could be strengthened. The testing indicated that legal charges had not been correctly set within IDOX for all appropriate DFG cases with risk of not recouping charges. The council had a list of contractors to undertake the DFG work; insurance certification checks had not been undertaken for all contractors. There were financial monitoring spreadsheets in place, although discrepancies with facilitation charges and reconciliation of contributions were identified. All payments required a final inspection before payments were made, which were paid timely after approval. It was identified that there is on-going monitoring by the Finance Department of the spending, committed spend and available budget, along with council finance budget monitoring reports received and finance reporting to Executives. There is no formal governance and reporting structure for DFG, with minimal reporting apart from waiting lists and finance reporting. There is limited escalation and risk management of the service not meeting its requirements with the available funding and meeting its legal requirements. In summary the key findings were: • DFGs where there should be a legal charge on the property had not been recorded for three of DFGs and assurance on historic cases being correctly recorded for DFG on the IDOX system. **(Medium priority)** • The Disabled Facilities Grant Policy requires some amendments and classification. The Policy does not include any reference to complaints and appeals and feedback from stakeholders. **(Medium priority)** • Insurance certificates had not been obtained for all contractors; lack of assurance contractors have insurance. **(Medium priority)** • The facilitation fees charged for the council services have in some cases been incorrectly calculated and some inconsistency in process adapted in the calculation of charges. **(Medium priority)** • Contributions made by some of the clients towards their DFG had not been recorded and didn't reconcile with the DFG payment spreadsheet. **(Medium priority)** • There was no formal reporting and monitoring framework in place for DFG apart from financial monitoring arrangements, with limited information and KPI's produced. **(Medium priority)**

	• Risks associated with the delivery of DFG and the available resources need to be included within the Risk Register and monitored by the council. **(Medium priority)** • Some documents could not be located as paper files are not segregated and filled sysematically. Ensuring there is a process to justify two quotations when policyl states three quotes are required. **(Low priority)**
Key Areas Agreed for Action	• System settings have been amended. It should be noted that there is a manual check also in place for all land charges searches against the Idox database to ensure that Land charges are not missed. **(Medium priority, action completed)** • Complaints are dealt with as per the Council's complaint Policy. However, the DFG Policy will be updated to reference the complaints policy and to include the other recommendations. **(Medium priority, action by 31 January 2026)** • Contractor list has been updated, and insurance certification is now held for all contractors on the list. Renewals will be diarised to ensure that up to date insurance documentation is always held. **(Medium priority, action by 1 October 2025)** • All inconsistencies found during testing related to grants that had reduced or increased above or below a banding following a variation in grant amount. The idox system does not easily allow alterations to the fees set following approval. As a result of this it would be more appropriate to revise the Policy so as to base the percent charged on the initial grant approval otherwise we risk creating errors. In addition, the fees charged on discretionary grants needs to be clarified within the Policy. **Medium priority, action by 31 January 2026)** • There are 3 reasons for a contribution to be raised 1 There is a contribution required through the test of resources. This contribution is not related to the grant amount. The invoice is raised separately and is monitored on the financial system. The grant only gets approved following payment of the contribution. These contributions have not always been recorded on the spreadsheet. This contribution is however always recorded on the IDOX database. 2 There is a contribution from a Housing Association. Some Housing Associations will contribute towards grants. However we can not compel the Housing Associations to contribute, nor is the contribution amount within our control. Again, this contribution is not related to the grant amount. We must approve the grant regardless of whether it is paid or not. These contributions are not recorded on the spreadsheet.

	3 There is a contribution from the client/client's family where there is a shortfall in funding. This is the only contribution which is related to the grant amount. The invoice is raised separately and is monitored on the financial system. The grant only gets approved following payment of the contribution. This contribution is recorded on the spreadsheet and on the IDOX system. The Team leader will ensure that all contributions are recorded on the spreadsheet at the point of approval. **(Medium priority, action by 30 September 2025)** • DFG's are reported as a PI rather than a KPI. The PI's on DFG's are under revision. The policy will be reflected in line with the new PI's. **(Medium priority, action by 31 January 2026)** • The risks are operational risks and are limited to each case. Having discussed this with the Risk Management Team it is not felt that DFG's should be placed on the SRR. All of the above points will be considered and dealt with by Policy / management. • All documents were found during the testing. All documents are checked as being present during the approval process by the Residential Team leader. A case would not be approved unless all documentation was present. Of the cases tested, those that were difficult to find were complex cases that had been reapproved, and the initial application documents were found to have been stapled to the back of the application form by one officer. Officers will be asked to bundle application documents up going forward. Reasons for not obtaining 3 quotes will be recorded at approval stage. **(Low priority, action by 30 September 2025)**
Key Risks Highlighted with No Agreed Action	N/A

Report Title	**Customer Services review**			
Executive Sponsor	Director of Resources			
Assurance opinion	Substantial			
Objective	The overall objective of the audit was to evaluate the systems, processes and controls in place to manage and oversee the customer services function and performance against the contract. Limitations - Our audit did not review the processes involved or provide assurance on the handling of individual customer concerns. Our review does not provide assurance that Liberata is delivering all aspects of the Customer services SLA with the Council. We did not check the accuracy of any contract payments made to Liberata.			
Recommendations	0 x Critical	0 x High	3 x Medium	0 x Low
Summary	Customer service provision is provided to the council by Liberata, a service level agreement being in place to clearly outline the service offered and the responsibilities of both parties. In September 2024 a three-year KPI framework was agreed, which included two KPIs in respect of customer services. We were informed that all customer service agents are well trained on induction with ongoing training in place throughout the year, there are lookup features in the Genesys system which provide the latest guidance for queries received. The level of Liberata staff in place to provide the customer services contract could not be assessed due to cross client working of the staff involved. The 2 KPIs that are included in the framework are classed as incentive KPIs, these make up part of the weighted incentive payment that is to be made at the end of each year, Liberata were below target for both of these in March 2025, these are highlighted and discussed in all relevant meetings and actions to improve compliance are noted therefore no recommendation has been made. There is a third PI in respect of quality which is self-assessed by Liberata on a sample of less than 1% of calls received, this was below target in March 2025 but above target cumulatively for the year. Visits to the call and walk-in centres in August 2025 provided evidence that the Agents were very helpful and knowledgeable and handled the queries witnessed efficiently. There was no call waiting on the day of the visit and each call was completed by offering help for any other query. The use of online			

	services was offered where practicable and in the walk-in centre Jadu was noted as completed after each interaction. The council receive a suite of reports from Liberata which highlight volumes of queries received, and their themes and quality of resolutions. These are discussed in joint SLA meetings, and in meetings at all levels of the council through to the executive meetings providing high level oversight of the systems in place. The council receive a monthly Resolution Capture Tool, RCT, report from Liberata which records calls by type of query and by department. This report can be filtered by the Council to highlight any key themes and reasons for calls received, however there is no detailed analysis and insight provided by Liberata. Whilst the council do receive information regarding customer call themes there was no correspondence or update received on any current urgent issues as they occur. **(Medium priority)** It is acknowledged that data in respect of the walk-in centre may not be completely accurate and there are no systems in place to record any customers leaving the walk-in centre without being seen by an agent. **(Medium priority)** To measure the PI in respect of quality the sample taken is less than 1% of calls received which is less than what would be considered good practice. The quality of calls is assessed internally by Liberata with no independent assurances. **(Medium priority)**
Key Areas Agreed for Action	• The Council will instruct Liberta to provide more detailed analysis, insights and narrative on the call centre performance. Liberata to inform the Council of key trends in avoidable contact which become apparent on an ongoing basis. **(Medium priority, immediate action)** • Consideration will be given to the recommendations made on the walk-in centre and implemented as agreed appropriate. Please note that consideration is already being given to the introduction of an appointments-based system. **(Medium priority, 31 March 2026)** • The recommendations made around the call quality performance indicator are agreed and will be discussed with Liberata. **(Medium priority, 31 March 2026)**
Key Risks Highlighted with No Agreed Action	N/A

Appendix D: Follow up of previous internal audit recommendations

AUDIT TITLE (YEAR)	NO OF RECS	ASSURANCE LEVEL	PROGRESS ON IMPLEMENTATION				OUTSTANDING RECOMMENDATIONS				COMMENTS
			✓/S	P	X	Not due/ FUIP	C	H	M	L	
Council Tax and NNDR (2022/23)	3	Substantial	2	1	-	-	-	-	1	-	One recommendation is in progress regarding production of debt write off policy, work on this is ongoing.
Mandatory Training (2023/24)	5	Substantial	1	4	-	-	-	-	4	-	Recommendations not due for follow up – revised dates have been provided again for these recommendations 31 October 2025. (Original dates were June/July 2024, then revised to 30 Nov 24 & 31 January 2025, further revised to 30 June/31 July 2025). The recommendations are in progress, work has begun to collect information in terms of what training has been provided. Two training systems currently in use, review being undertaken to assess if Sharepoint can be used to record all training. The outstanding recommendations relate to putting in place a mandatory training policy, developing a training needs assessment, putting in place a process so that mandatory training can be recorded and monitored centrally, and producing compliance reports on mandatory training.
Budget setting & monitoring (2023/24)	8	Substantial	8	-	-	-	-	-	-	-	All recommendations actioned.
Third Party Suppliers – Liberata (2023/24)	4	Substantial	4	-	-	-	-	-	-	-	All recommendations actioned.
Information Governance (2023/24)	5	Limited	-	5	-	-	-	3	2	-	Recommendations in progress. Revised dates of 31 December 2025 (original implementation date 31 August 2024, then revised to 31 December 2024, 31 May 2025 and 31 August 2025). The high priority recommendations relate to review of Council's IG resources, identifying IG training needs, ensuring there is a Record of Processing Activity including policy, ensuring all information assets are recorded in an Information Asset Register with IAO and IAA identified and ensuring that any contracts with suppliers which have an IG

AUDIT TITLE (YEAR)	NO OF RECS	ASSURANCE LEVEL	PROGRESS ON IMPLEMENTATION				OUTSTANDING RECOMMENDATIONS				COMMENTS
			✓/S	P	X	Not due/ FUIP	C	H	M	L	
											implication or provide support to IT systems that process council data are identified and that the contracts include the relevant IG clauses and a DPIA is undertaken. Work is ongoing to implement these recommendations. MIAA are providing support to the Council in the implementation of these recommendations.
Staff performance/ Appraisals (20234/24)	6	Limited	4	2	-	-	-	-	2	-	The outstanding recommendations relate to a PDR policy, although there is guidance documentation in place and also consideration of competency/values based recruitment processes and standardised role competencies / behaviour framework. There is a revised implementation date of 31/1/26.
IT Cyber Resilience (2023/24)	2	Substantial	2	-	-	-	-	-	-	-	All recommendations actioned.
Council tax & NNDR (2024/25)	4	Substantial	3	1	-	-	-	-	1	-	The outstanding recommendation relates an enhancement being made to the Citizens Access system. This has been marked as in progress as a new system will be implemented but the full functionality has not yet been tested. The revised implementation date for this recommendation is 31 December 2025.
Colne Municipal Theatre (2024/25)	4	N/A	3	1	-	-	-	-	-	-	The new project/ programme management documentation is being rolled out to the Extended Management Team on 30/9/25 with a view to being used from1/10/25.
Complaints & Learning (2024/25)	10	Moderate	2	8	-	-	-	-	6	2	Original implementation date 31 March 2025, revised dates 30 June 2025. Recommendations in progress and further follow up in progress.
Finance Deep Dives – AP/AR (2024/25)	8	Moderate	4	-	-	4	-	-	3	1	Remaining recommendations not due.

AUDIT TITLE (YEAR)	NO OF RECS	ASSURANCE LEVEL	PROGRESS ON IMPLEMENTATION				OUTSTANDING RECOMMENDATIONS				COMMENTS
			✓/S	P	X	Not due/ FUIP	C	H	M	L	
Risk Management (2024/25)	3	Substantial	2	-	-	1	-	-	1	-	Remaining recommendation has a revised implementation date of 31 October 2025 (original date was 31 July 2025). The outstanding recommendation relates to agreeing and including a risk appetite within the strategic risk register.
Council tax & NNDR (2024/25)	2	Substantial	1	-	-	1	-	-	1	-	Remaining recommendation not due until 30 November 2025.
Emergency Planning (2024/25)	4	Substantial	-	-	-	4	-	-	3	1	Follow up not due.
Totals	**68**	**-**	**36**	**22**	**-**	**10**	**-**	**3**	**24**	**4**	**Plus one recommendation not risk rated**

Key to recommendations:

✓/S	Implemented or Superseded
P	Partially implemented/recommendation in progress
X	Recommendation not implemented
ND/FUIP	Not due for follow up/Follow up in progress

C	Critical priority recommendation
H	High priority recommendation
M	Medium priority recommendation
L	Low priority recommendation

Appendix E: Assurance Definitions and Risk Classifications

Level of Assurance	Description
High	There is a strong system of internal control which has been effectively designed to meet the system objectives, and that controls are consistently applied in all areas reviewed.
Substantial	There is a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently.
Moderate	There is an adequate system of internal control, however, in some areas weaknesses in design and/or inconsistent application of controls puts the achievement of some aspects of the system objectives at risk.
Limited	There is a compromised system of internal control as weaknesses in the design and/or inconsistent application of controls puts the achievement of the system objectives at risk.
No	There is an inadequate system of internal control as weaknesses in control, and/or consistent non-compliance with controls could/has resulted in failure to achieve the system objectives.

Risk Rating	Assessment Rationale
Critical	Control weakness that could have a significant impact upon, not only the system, function or process objectives but also the achievement of the organisation's objectives in relation to: • the efficient and effective use of resources • the safeguarding of assets • the preparation of reliable financial and operational information • compliance with laws and regulations.
High	Control weakness that has or is likely to have a significant impact upon the achievement of key system, function or process objectives. This weakness, whilst high impact for the system, function or process does not have a significant impact on the achievement of the overall organisation objectives.
Medium	Control weakness that: • has a low impact on the achievement of the key system, function or process objectives; • has exposed the system, function or process to a key risk, however the likelihood of this risk occurring is low.
Low	Control weakness that does not impact upon the achievement of key system, function or process objectives; however implementation of the recommendation would improve overall control.

Limitations

The matters raised in this report are only those which came to our attention during our internal audit work and are not necessarily a comprehensive statement of all the weaknesses that exist, or of all the improvements that may be required. Whilst every care has been taken to ensure that the information in this report is as accurate as possible, based on the information provided and documentation reviewed, no complete guarantee or warranty can be given with regards to the advice and information contained herein. Our work does not provide absolute assurance that material errors, loss or fraud do not exist.

Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management and work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, nor relied upon to identify all circumstances of fraud or irregularity. Effective and timely implementation of our recommendations by management is important for the maintenance of a reliable internal control system.

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