The Highland Council

Agenda Item	4
Report No	AC/02/25

Committee: **Audit Committee**

Date: **5 February 2025**

Report Title: **Internal Audit Reviews and Progress Report – 04/11/24 – 10/01/25**

Report By: **Strategic Lead (Corporate Audit)**

1. Purpose/Executive Summary

1.1 This report provides details of the work undertaken by the Internal Audit section since the last report to Committee in November 2024.

2. Recommendations

2.1 Members are asked to:

i. Consider and note the Final Reports referred to in Section 5.1 of the report.
ii. Scrutinise and approve the current work of the Internal Audit Section outlined at sections 6 and 7, and the status of work in progress detailed at **Appendix 1**.

3. Implications

3.1 **Resources** – A new Graduate Trainee Auditor started employment on the 12 December 2024. A further recruitment process will be required in the near future as a Senior Internal Auditor is transferring to a new role in Finance.

3.2 **Risk** - the risks and any associated system or control weaknesses identified as a result of audit work or corporate fraud investigations will be reviewed and recommendations made for improvement.

3.3 There are no Legal, Health and Safety or Gaelic implications arising from this report.

4. Impacts

4.1 In Highland, all policies, strategies or service changes are subject to an integrated screening for impact for Equalities, Poverty and Human Rights, Children's Rights and Wellbeing, Climate Change, Islands and Mainland Rural Communities, and Data Protection. Where identified as required, a full impact assessment will be undertaken.

4.2 Considering impacts is a core part of the decision-making process and needs to inform the decision-making process. When taking any decision, Members must give due regard to the findings of any assessment.

4.3 This is an update report and therefore an impact assessment is not required.

5. Internal Audit Reports

5.1 There have been three reports issued during this period as detailed in the table below.

Service Cluster	Subject	Audit opinion
People	Supervision of Community Payback Orders	Reasonable Assurance
Corporate	Review of Health and Safety Arrangements	Reasonable Assurance
Corporate	Efficiency of Debt Recovery Arrangements	Reasonable Assurance

Each report contains an audit opinion based upon the work performed in respect of the subject under review. The five audit opinions are set out as follows:

(i) Full Assurance: There is a sound system of control designed to achieve the system objectives and the controls are being consistently applied.
(ii) Substantial Assurance: While there is a generally a sound system, there are minor areas of weakness which put some of the system objectives at risk, and/ or there is evidence that the level of non-compliance with some of the controls may put some of the system objectives at risk.
(iii) Reasonable Assurance: Whilst the system is broadly reliable, areas of weakness have been identified which put some of the system objectives at risk, and/ or there is evidence that the level of non-compliance with some of the controls may put some of the system objectives at risk.
(iv) Limited Assurance: Weaknesses in the system of controls are such as to put the system objectives at risk, and/ or the level of non-compliance puts the system objectives at risk.
(v) No Assurance: Control is generally weak, leaving the system open to significant error or abuse, and/ or significant non-compliance with basic controls leaves the system open to error or abuse.

6. Internal Audit work in progress

6.1 The remaining audits for the 2024/25 Internal Audit Plan were approved at the November 2024 Committee meeting. These are in progress and their current status is provided at **Appendix 1**. The Internal Audit Team has continued to make best efforts to ensure timely completion of this audit work (noting resources at 3.1).

7. Other Work

7.1 The Section has been involved in a variety of other work during the period which is summarised below:

(i) Audits for other Boards, Committees and Organisations

Audit work has been undertaken during this period for the Valuation Joint Board, Pensions Board and for High Life Highland which will be reported to the respective Boards/ Committees in due course.

(ii) Attendance at People & Finance Systems Programme Board

Audit representation has been requested on the Board in an independent non-voting capacity. The role being carried out by the Corporate Audit Manager is to act as the "critical friend" to assist in providing assurance in matters relating to internal controls, governance and risk management.

(iii) Global Internal Audit Standards (GIAS)

Work is continuing with regard to implementing the requirements of the GIAS and the Committee will be kept updated as this progresses. As detailed in a separate agenda item, an updated Internal Audit Charter, including the Mandate has been prepared, and a new Internal Audit Strategy has been produced.

(iv) The National Fraud Initiative (NFI)

The Corporate Audit Manager is the Council's key contact for the NFI. Work during this period has included arranging for the required data sets to be submitted for the 2024/25 NFI exercise. Also attended the Audit Scotland key contact training in preparation for the start of the 2024/25 NFI. It is intended that the NFI self-appraisal checklist will be provided to the next Audit Committee for information.

(v) Corporate Fraud, Whistleblowing concerns and other investigations activity

The Single Point of Contact (SPOC) work is an ongoing commitment providing information to Police Scotland, the Department of Work and Pensions and the UK Immigration Enforcement Office. This work assists these organisations in investigating potential crimes and in making our communities safer. An allowance of time for these commitments is made within the Internal Audit Plan each year.

We have a current commitment of 31 cases. This comprises of several active cases subject to investigation and those where the investigation has been concluded but there is ongoing recovery or report to the Procurator Fiscal.

Ongoing investigations during this period include:

- Investigations resulting from whistleblowing reports:
    - Two completed and an investigation report issued to management (no system weaknesses identified).
    - Four cases closed (two where the Service has taken appropriate action and two where the allegations were established to be unfounded).
    - Two active ongoing investigations.
- Investigation of specific cases of overpayments from Payroll.
- Tenancy Fraud investigations.
- One fraud investigation notified by NHS Investigators which has implications for the Council.
- Two suspected theft allegations.

Where active fraud and whistleblowing investigations are in progress, no further information can be provided in order to prevent these being compromised. However, once the investigations have been completed including any associated disciplinary/ legal action where relevant, the system weaknesses reports will be provided to the Audit Committee to scrutinise.

Designation: Strategic Lead (Corporate Audit)

Date: 10 January 2025

Author: Jason Thurlbeck, Corporate Audit Manager

Background Papers: N/A

Appendices: Appendix 1 - Internal Audits in progress

Appendix 1 - Internal Audits in progress

Service	Audit Subject	Priority	Planned Days	Current Status	Planned Committee Reporting Date
People	Primary Schools - Review of financial arrangements	Medium	23	Fieldwork in progress	May 2025
Place	Climate Strategy & Sustainability	High	30	Planning in progress	May 2025
Place	Property Maintenance & Repairs	High	30	Planning in progress	May 2025
People	Family Teams	High	30	Planning in progress	May 2025
Corporate	Financial management and reporting	High	30	Fieldwork in progress	May 2025
Corporate	Elections management	High	30	Planning in progress	May 2025

Internal Audit Final Report

People

Justice Service - Supervision of Community Payback Orders

Description	Priority	No.
Major issues that managers need to address as a matter of urgency.	High	1
Important issues that managers should address and will benefit the Organisation if implemented.	Medium	4
Minor issues that are not critical but managers should address.	Low	0

Audit Opinion

The opinion is based upon, and limited to, the work performed in respect of the subject under review. Internal Audit cannot provide total assurance that control weaknesses or irregularities do not exist. It is the opinion that **Reasonable Assurance** can be given in that whilst the system is broadly reliable, areas of weakness have been identified which put some of the system objectives at risk, and/or there is evidence that the level of non-compliance with some of the controls that put some of the system objectives at risk.

Distribution:
Assistant Chief Executive of People
Chief Officer – Health and Social Care (Chief Social Work Officer), People
Head of Children and Justice, People
Principal Officer – Justice Services, People

Report Ref: HSC08/001
Draft Date: 04/12/24
Final Date: 16/01/25

1. Introduction

1.1 The objective of the review was to ensure that there was an effective framework for the supervision of Community Payback Orders (CPO). The review considered:

- Assessment of supervision requirements; and
- Recording of supervision carried out.

1.2 CPOs were introduced as the main community-based sentence by the Criminal Justice and Licensing (Scotland) Act 2010. Supervision is mandatory to all CPO requirements that do not involve unpaid work. The Scottish Government's Community Payback Order Practical Guidance (the Guidance) provides support to practitioners and managers involved in the delivery of justice social worker services and specifically CPOs. As of September 2024, there were 446 CPOs in the Council area, which included 407 that required supervision.

1.3 The audit involved a review of the assessment procedures and testing to ensure that qualified social workers assessed cases to determine the correct intensity of supervision. The controls for the resource management of supervision (including exceptions to the agreed supervision intensity) were assessed against the Guidance and tested to ensure that supervision was accurately recorded and completely reported. Testing covered CPOs (with a supervision requirement) that commenced in 2023/24.

2. Main Findings

2.1 *Assessment of supervision requirements*

The audit objective was partially achieved. A pre-sentence risk assessment should be undertaken to consider the pattern, nature, seriousness, likelihood and imminence of the individual re-offending. This is known as an initial risk assessment and should be summarised in the Criminal Justice Social Work Report (CJSWR). The CJSWR report is submitted to court and will help to inform decisions about whether a CPO should be imposed. The initial risk assessment should be completed on the Level of Service Case Management Inventory (LSCMI) system as an LSI-R:SV. Testing identified that 7 (35%) of the cases sampled were fully compliant as the initial risk assessment (LSI-R:SV) had been completed on the LSCMI system. The evidence available for 11 (55%) cases tested, demonstrated a lower level of compliance:

- 5 (25%) a paper based initial risk assessment (LSI-R:SV) had been completed and was obtained from the social worker;
- 2 (10%) the social worker stated that a paper based initial risk assessment (LSI-R:SV) had been completed but this was no longer available (archived); and
- 4 (20%) the social worker was unable to confirm that an initial risk assessment (LSI-R:SV) had been completed because they were not responsible for the individual when the initial risk assessment was undertaken.

The remaining 2 (10%) cases were not applicable for testing because the individuals had transferred out of the area and became the responsibility of another local authority. In these transferred cases the individual risk assessments will no-longer be accessible to view on the LSCMI system or paper-records will have been transferred to the other local authority. The completion of initial risk assessments on the LSCMI system provides good assurance that the pre-sentence assessment is robust and that the court has been provided with accurate risk information necessary to make a CPO decision. We are unable to provide this level of assurance for the 11 (55%) cases, detailed above.

Originally the LSCMI system was managed locally at each local authority but from 2020 it was hosted centrally by the Scottish Government. However, difficulties were encountered during the changeover, which resulted in the system being unavailable for some periods of time. During periods of unavailability social workers had to undertake risk assessments (initial and full) using paper-based substitutes. This issue was recorded on the Service risk register (as HSC13: LSCMI Risk Assessments). Whilst the IT availability issues have largely been resolved, the findings demonstrate that some social workers are not using the LSCMI system to complete both initial risk assessments (LSI-R:SV) and full risk assessments (LS/CMI 1 – 8). (See Action Plan Reference: M1)

A full risk assessment will be completed for all cases where a CPO imposed by the court contains a supervision requirement. This full risk assessment should be used to help inform the main elements

of the case management plan, including the level of supervision necessary to support rehabilitation. The full risk assessment will be recorded on the LSCMI system as LS/CMI 1 - 8. Testing identified that 13 (65%) of the cases sampled were fully compliant as the full risk assessment had been completed on the LSCMI system. The evidence available for 4 (20%) cases tested showed a lower level of compliance:

- 3 (15%) a paper-based full risk assessment (LS/CMI 1 - 8) had been completed and was obtained from the social worker; and
- 1 (5%) the social worker was unable to provide evidence to demonstrate that a full risk assessment (LS/CMI 1 - 8) had been completed.

The remaining 3 (15%) cases were not applicable for testing. 2 had been transferred out of the area, as detailed above and for one the individual did not attend any meetings, and a breach report was submitted to court before the full risk assessment (LS/CMI 1 - 8) could be completed. The completion of full risk assessments on the LSCMI system provides good assurance that the individual will have an effective case management plan and that they will be properly supervised. (See Action Plan Reference: M1)

When the court imposes a CPO (known as a disposal), the individual's details (including Person ID, Disposal ID, Full Name, Date of Disposal and Disposal Description) will be recorded on CareFirst (the Council's social care case management system). Social workers will use the CareFirst system to manage the CPO and should record all relevant information (including observations, contacts, attendance, summary risk assessment scores and report requests) to demonstrate that the individual is being supervised in accordance with the case management plan. As the LSCMI and CareFirst systems are hosted separately and are not interfaced there is no management information available to determine which CPOs have not been risk assessed using the LSCMI system. Management relies on the results of quality assurance exercises to determine the standard of record keeping that is carried out by social workers, which will include the completeness and quality of both risk assessments and supervision records. Any practice issues identified from these exercises will be fed back to social workers during supervision meetings with their manager. After a 2-year absence that was due to a long-standing vacancy and COVID the quality assurance exercises were restarted in August 2024. (See Action Plan Reference: M2)

The Guidance requires that the full risk assessment (LS/CMI 1 - 8) includes the level of supervision (very high, high, medium or low) that is necessary to support rehabilitation. Of the 17 cases where a full risk assessment (LS/CMI 1 - 8) should have been available, testing identified that 15 (88%) were compliant with the level of supervision intensity recorded. The evidence available for the remaining 2 (12%) cases showed a lower level of compliance:

- 1 (6%) there was a partially completed full risk assessment (LS/CMI – 1 - 8) on the LSCMI system but this did not include a risk category, however a paper-based full risk assessment (LS/CMI 1 - 8) was provided, which had a medium risk category; and
- 1 (6%) there was insufficient evidence available to confirm that a full risk assessment (LS/CMI 1 - 8) had been completed. (See Action Plan Reference: M1)

The Guidance states: "a fuller assessment……should be completed (by a trained practitioner) within 4 weeks of the requirement being imposed". Of the 16 full risk assessments (LS/CMI 1 - 8) available, all 16 (100%) were completed by a qualified social worker but only 5 (31%) had been completed within 4 weeks of the disposal date. The evidence available for the remaining 11 (69%) cases tested showed a lower level of compliance:

- 8 (50%) were recorded as completed more than 4 weeks after the disposal date); and
- 3 (19%) were recorded as completed before the disposal date

It is understood that full risk assessments (LS/CMI 1 - 8) may take more than 4 weeks to be completed when: (i) the individual did not attend for interview; (ii) the social worker changed; and/or (iii) the social worker was unable to schedule a meeting to promptly complete the LS/CMI 1- 8. However, there was no evidence on the LSCMI or CareFirst systems to confirm the exact reason for delay in any of the 8 cases tested.

In cases where the full risk assessment (LS/CMI 1 - 8) is prematurely started before the disposal date there is a facility within the LSCMI system that allows team managers to clear and reset the record. However, the social worker must inform the team manager when this reset is required. (See Action Plan Reference: M1)

The Guidance states that: "In the event that the responsible officer, in consultation with their line manager, considers that the full risk assessment (LS/CMI 1- 8) does not adequately reflect the level of risk posed, the professional override feature of LSCMI system may be used. A clear rationale and supporting evidence should be provided and recorded in the case records." It was identified that there were only 6 (2% of caseload) overridden cases. Testing identified that whilst a team manager approved each, we were unable to identify the reason for the over-ride in 5 (83%) cases. Without providing an explanation there is a risk that overrides are not justifiable and that individuals may be subject to an incorrect level of supervision. (See Action Plan Reference: M3)

2.2 *Recording of supervision carried out*

The audit objective was partially achieved. The Setting the Bar for Social Work in Scotland report, May 2022 (the Report) established an evidence-based indicative caseload limit for social work staff. Analysis of the caseload data for the Justice Team (as at 19/09/2024 together with the current establishment of 22.3 Full time equivalent (FTE) justice social workers (that have a statutory caseload) demonstrated that:

The majority of caseloads were at the high end of levels set out in the Setting the Bar Report:

- 4 (18%) justice social workers had caseloads that were in the maximum individual caseload range (29 - 34); and
- 11 (49%) justice social workers were on or above the average individual caseload stated in the Setting the Bar Report (26).

The Report stated that: "high caseloads have been reported as making it difficult for social work staff to achieve best practice and support people effectively." Difficulties in the recruitment of qualified social workers was recorded as an issue in the Council's corporate risk register (HCR3: Sustainable & Adaptive Workforce) and in additional to the existing controls includes a mitigating action of:

- The Developing the Workforce project within the Person-Centred Solutions Portfolio aims to help to address the acute issues stemming from difficulties recruiting social workers, which have serious, high-level impacts and are currently likely to occur due to national and local staffing shortages (HCR3.4)

Included within the establishment of 22.3 FTE justice social workers are 1.4 FTE vacancies, 0.5 FTE long term sickness and 3 FTE new or newly qualified social workers. Establishment shortages will have an adverse impact upon the caseloads of the other justice social workers. There is some evidence to demonstrate that this risk is being mitigated as 1 FTE new justice social worker post has recently been created. Management should continue to monitor caseloads and manage the risks associated with the recruitment and retention of justice social workers.

The Guidance states: "Individuals subject to a CPO with an individual supervision requirement should be seen at least weekly in the first four weeks by the responsible officer." Social workers should use the "Observations" field on CareFirst to evidence when individuals have been seen/supervised. Testing identified 3 (15%) sampled cases that were fully compliant with individuals being seen weekly by the social worker. The evidence available for the remaining 17 (85%) cases indicated a lower level of compliance:

- 2 (10%) the social worker had attempted to see the individual weekly during the first 4 weeks and/or there was a suitable explanation for not achieving this;
- 4 (20%) the individual had been seen by the social worker three times during the first 4 weeks; and
- 11 (55%) the individual had been seen two times or less by the responsible officer during the first 4 weeks.

The weekly supervision of individuals (within the first 4 weeks) will demonstrate that the individual's behaviour is being addressed and will help to facilitate the prompt completion of full (LS/CMI 1 - 8) risk assessment and the case management plan.

Both should be completed within 20 working days of the CPO being imposed. (See Action Plan Reference: H1)

The Guidance states: "Risk assessment should be used to help inform the main elements of the case management plan, including the level of supervision necessary to support rehabilitation." The intensity of supervision required will be informed through the completion of the full (LS/CMI 1 - 8) risk assessment, see above. For each of the four intensity levels (very high, high, medium and low) the Guidance recommends the supervision actions that should be undertaken. (See Appendix 1)

Social workers should use the "Observations" field on CareFirst to evidence their supervision of individuals. Testing of the 16 cases with an available risk assessed (LS/CMI 1 – 8) supervision intensity category (4 Very High, 5 High, 5 Medium and 2 Low) identified that there was insufficient evidence on CareFirst to demonstrate that all the recommended supervision actions had been achieved. Management consider that social workers may not always record the contact that they have and that other staff/partners have with individuals within the "Observations" field on the CareFirst system and that a hard paper copy of the signed care management plan (held in each area office) may be the only evidence to confirm that the plan has been reviewed. Additionally, there may be good explanations for not achieving the desired level of supervision, which also may not be fully recorded on CareFirst. (See Action Plan Reference: H1)

The Guidance states: "individual supervision should be undertaken by the responsible officer (nominated under section 227C of the 1995 Act), a role that is exercised by a justice social worker." Testing identified that a qualified social worker was regularly supervising most (90%) of individuals. However, there were 2 (10%) cases where for a period (2 months) there was only evidence of an unregistered officer (justice officer/community payback officer) observing the individual. The first case had a high intensity supervision category where the individual was only recorded as seen by an unregistered officer during both months 12 and 13 after the disposal date. (See Action Plan Reference: M4)

3. Conclusion

3.1 The audit has demonstrated that risk assessments were not always being fully recorded (on the LSCMI system). Part of this relates to control of the LSCMI IT system moving to the Scottish Government. Additionally, the actual supervision conducted was not always being fully recorded (on the CareFirst system), which may be attributable to high social worker caseloads. Although there was evidence to demonstrate that Justice Services were in regular contact with most individuals, the supervision was not always being recorded in accordance with the Scottish Government's Community Payback Order Practical Guidance. There is a fully effective framework. This audit highlights that the recording is not always fully complied with. This is an improvement task.

4. Action Plan

Ref	Priority	Finding	Recommendation	Management Response	Implementation	
					Responsible Officer	**Target Date**
H1	High	Social workers should use the "Observations" field on CareFirst to evidence their supervision of individuals. Testing of the 16 cases with an available risk assessed (LS/CMI 1 – 8) supervision intensity category (4 Very High, 5 High, 5 Medium and 2 Low) identified that there was insufficient evidence on CareFirst to demonstrate that all the recommended supervision actions were being achieved.	Management must ensure that: (i) social workers record all aspects of individual supervision on the CareFirst system and the evidence that supports their compliance with the Community Payback Order Practical Guidance is retained and available for management review; (ii) social workers record explanations in cases where the supervision requirements of the Community Payback Order Practical Guidance cannot be followed, and these explanations should be subject to supervisory review; and (iii) where necessary further training, support and guidance is provided for social workers.	We are encouraging Social Workers to use both the contact and observation sections. Reviews of Case Management Plans are carried out periodically. These reviews enable Social Workers, managers and clients to assess the progress of any agreed goals that aim to reduce reoffending and meet the client's needs. Managers meet Social Workers periodically (between 4-6 weekly) and discuss in amongst other subjects their caseloads and any issues with the supervision of the orders/licences. RSO reviews also take place via MAPPA meetings which take place more or less regularly depending on level of risk. The management team through our QA framework has already identified some of these issues and individual Social Workers are being supported to make sure all data is available. We have been able to identify certain areas of the CMP review process in which Team Managers	Principal Officer – Justice Services	30/06/25

Ref	Priority	Finding	Recommendation	Management Response	Implementation	
					Responsible Officer	**Target Date**
				require more information, and the current paperwork will be amended to reflect these needed changes A refresher training will be provided to all Social Workers		
M1	Medium	Testing identified: • 11 (55%) cases where the initial risk assessment (LSI-R:SV) had not been fully completed on the LSCMI system; and • 2 (12%) cases where the full risk assessment (LS/CMI 1 - 8) had not been fully completed on the LSCMI system.	Management should ensure that social workers complete all interim (LSI-R:SV) and all full (LS-CMI 1 - 8) risk assessments on the LSCMI system. Where necessary further training, support and guidance should be provided for social workers to achieve this.	CMP reviews will be added to CareFirst when a person is sentenced, the initial review needs to take place three months after the order has been issued therefore the complete LSCMI should be presented at the meeting. The Management Team has agreed to work on creating a document and process to enable Social Workers to complete all tasks required within the first three months of an order. This will be included in the refresher training.	Principal Officer – Justice Services	30/06/25
M2	Medium	Management relies on the results of quality assurance exercises to determine the standard of record keeping that is conducted by social workers, which will include the completeness and quality of both risk assessments and supervision records. After a 2-year absence that was due to a long-standing vacancy and COVID the quality assurance	Management should ensure that regular Quality Assurance checks are re-introduced to ensure that interim (LSI-R:SV) and full (LS-CMI 1 - 8) risk assessments (and supervision actions) are completed to the required standards. Any issues should be resolved during team manager/social worker supervision.	All area managers have been in post for two years or less and none of them had previous management experience. This is a very new management team but extremely motivated and fully invested in Quality Assurance. The members of the Management Team are very aware of the issues we had already found within our service	Principal Officer – Justice Services	31/10/25

Ref	Priority	Finding	Recommendation	Management Response	Implementation	
					Responsible Officer	**Target Date**
		exercises were restarted in August 2024.		and many remedial actions are already taking place. Our Care Inspectorate Link Inspector has agreed to support us in the creation of improvement plans. As a management team we are identifying and working through the hundreds of legacy records that had been open in the system due to the suspended access to the LSCMI IT system.	Principal Officer – Justice Services Principal Officer – Justice Services	30/04/25 31/08/25
M3	Medium	Of the very few (6 or 2% of caseload) overridden cases: • 1 not supported by a complete LS-CMI 1 - 8 risk assessment; • 2 no real explanation on LSCMI for the override; • 1 override has not changed the score; and • 1 override explanation of total risk score did not support recategorisation.	Management to ensure that appropriate explanations are provided on the LSCMI system when full risk assessment (LS/CMI 1 - 8) scores are overridden.	Overrides are only used exceptionally; every override needs to be approved by management and a discussion takes place between case manager and the Team Manager. Each override is considered individually. Of note is that this is the main area where the IT system was malfunctioning, so further investigation will be carried out to make sure this is not an error.	Principal Officer – Justice Services	30/04/25
M4	Medium	Individual supervision should be undertaken by the responsible officer (a justice social worker). Testing identified that: • 2 (10%) where for a period (2 months) there was only evidence of an unregistered	Management should ensure that records are maintained to demonstrate that individual supervision is being carried out in accordance with the Guidance.	All clients have a Social Worker allocated; the intervention work however does not have to be carried out by a Registered Social Worker. The client might be required to be seen weekly, but it is possible for a Justice	Principal Officer – Justice Services	30/04/25

Ref	Priority	Finding	Recommendation	Management Response	Implementation	
					Responsible Officer	**Target Date**
		officer – justice officer/community payback officer - observing the individual.		Officer or third sector organisation to be doing intervention work and for the Social Worker to see the client minimum once a month. This is common practice and compliant with National Guidance.		

Appendix 1

Extract From: Community Payback Order Practice Guidance (May 2022)

Section 7: Risk Assessment

Risk assessment should be used to help inform the main elements of the case management plan, including the level of supervision necessary to support rehabilitation. Supervision levels should be considered as:

- Very High intensity: Individuals should be seen by the responsible officer at least once a week and there should be up to 7 contacts per week with other staff or partners. Contact should include arranged and unannounced home visits with due care to the safety of staff to be informed by the assessment and review process. The levels of contact, along with the overall case management plan, should be reviewed at least every 3 months. The frequency of reviews should remain at least at 3 monthly intervals for as long as very high intensity levels of contact are in place.

- High intensity: Individuals should be seen by the responsible officer at least once per week and there should be up to 3 contacts per week with other staff or partners. Contact should include planned and unannounced visits with due care to the safety of staff to be determined by the assessment and review process. The frequency of reviews, where the level of contact is reviewed, should remain at 3 monthly intervals for as long as high intensity levels of contact are in place.

- Medium intensity: Individuals should be seen by the responsible officer once per week and this should be reviewed after the first 3 months. Contact may then be reduced to once per fortnight where an individual's circumstances and level of risk is assessed as stable. This would then be reviewed after a further 6-month period. Contact should include at least one planned or unannounced home visit between reviews. Therefore, where an individual requires a medium level of intensity, departmental reviews should be held 3 months after the imposition of the CPO, and if circumstances remain stable, at 9 months after the imposition of the CPO and 6 monthly thereafter.

- Low intensity: Where a court imposes a CPO in such circumstances, there should be one contact per week with the responsible officer for the first month, reducing to monthly contact thereafter. The overall case management plan, along with levels of contact, should be reviewed every 6 months. Should the review process determine that outcomes sought in relation to public safety, rehabilitation and reintegration have been sustained and evidenced, consideration should be given to application for early discharge following completion of unpaid work or the final payment of compensation, where applicable. Where particular circumstances indicate that the level of contact differs from that outlined above, this should be discussed with the responsible officer's line manager and appropriate action taken as required.

Internal Audit Final Report

Corporate

Review of Health and Safety Arrangements

Description	Priority	No.
Major issues that managers need to address as a matter of urgency.	High	1
Important issues that managers should address and will benefit the Organisation if implemented.	Medium	8
Minor issues that are not critical but managers should address.	Low	1

Audit Opinion

The opinion is based upon, and limited to, the work performed in respect of the subject under review. Internal Audit cannot provide total assurance that control weaknesses or irregularities do not exist. It is the opinion that **Reasonable Assurance** can be given as whilst the system is broadly reliable, areas of weakness have been identified which put some of the system objectives at risk, and/ or there is evidence that the level of non-compliance with some of the controls may put some of the system objectives at risk.

Distribution:
Chief Executive
Assistant Chief Executive – Corporate
Assistant Chief Executive – People
Assistant Chief Executive – Place
Head of People – Corporate
Occupational Health, Safety and Wellbeing Manager – Corporate
People Development Manager – Corporate
Service Lead Corporate Property – Place
All Chief Officers

Report Ref: HRF33/004
Draft Date: 03/01/25
Final Date: 21/01/25

1. Introduction

1.1 The audit involved a review of health and safety practice across the Council to ensure this was compliant with corporate policy and that legal obligations were being met. The approach taken was informed by the Chartered Institute of Public Finance and Accountancy (CIPFA) control framework applicable to health and safety and covered:

- Policies and guidance
- Roles and responsibilities
- Training
- Risk identification and management
- Accident and incidents
- Monitoring and reporting.

The audit fieldwork was carried out prior to the implementation of the new service structure which combined 8 services into 3 service clusters. The health and safety arrangements were examined for two sampled services, Education and Learning and Community and Place.

1.2 The audit excluded physical health and safety site inspections.

2. Main Findings

2.1 *Governance arrangements are in place to ensure health and safety compliance across the Council.*

This audit objective was partially achieved. There was a Corporate Occupational Health, Safety and Wellbeing Policy (the OHSW Policy) which was compliant with the requirements of the Health and Safety at Work Act 1974 (the Act). It had been approved at a meeting of the Highland Council on 30/07/20 and signed by the then Chief Executive. It had since been reviewed and updated to reflect the revised service structure and would be brought to the next meeting of the Central Safety Committee (CSC) for final approval, following which it would be signed by the Chief Executive. The sampled services health and safety policies were reflective of the OHSW Policy, contained all expected elements and had been reviewed and approved by the CSC.

There was an Occupational Health and Safety Strategy 2022-2025, an associated action plan, and also annual corporate and service health and safety action plans. The progress against these plans was monitored by the CSC.

There was guidance in place for all of the most common workplace risks identified by the Health and Safety Executive (HSE) apart from guidance relating to confined spaces and slips and trips. Only some of the guidance documents were dated and therefore it was not possible to determine when they had last been updated and some dated back as far as 1998. The OHSW Manager had tasked the OHSW Team with reviewing all guidance to ensure it was up to date and this was reflected in the Occupational Health, Safety and Wellbeing Plan 2023/24. However, the action had a due date of 31/03/24 but had not yet been completed (see action plan M1).

The Council's Scheme of Delegation assigned overall responsibility for ensuring that the Council complied with the requirements of the Act to the Chief Executive and the Corporate Resources Committee had responsibility for matters relating to the workforce, including the health, safety and wellbeing of employees. The CSC is a sub-committee of the Corporate Resources Committee and is formally delegated with carrying out all of the functions outlined in Regulation 9 of the Safety Representative and Safety Committees Regulations 1977. At service level, the OHSW Policy stated that practical responsibility was delegated to Executive Chief Officers and line managers in respect of the areas under their control. A senior manager from each service had been appointed as a Health and Safety Co-Ordinator and there were also trade union representatives for each service. However, 4 out of 12 trade union reps listed had retired and there was only 1 for Education and Learning (see action plan M2). There were also safety consultation groups for each service and the 3 Council areas (Ross, Skye and Lochaber, Inverness, Nairn, Badenoch and Strathspey and Caithness, Sutherland and Easter Ross).

The OHSW Team had a clearly stated remit and all OHSW senior staff were suitably qualified. The OHSW Team establishment

consisted of 11 FTE, with 2.6 FTE vacant Health and Safety Advisor posts currently. Multiple recruitment exercises had been carried out to fill these posts, the most recent of which was still ongoing, but suitable candidates had so far not been found. A Health and Safety Technician had undergone development training under an apprenticeship programme and was promoted to Health and Safety Advisor within the OHSW Team and options for wider advertising of the vacant posts would be explored in early 2025.

There should be a Responsible Premises Officer (RPO) assigned for each Council workplace with responsibility for the daily operation of the workplace premises, including all health and safety matters but this was not the case. However, it should be noted that all employees and line managers have a responsibility for ensuring appropriate health and safety arrangements are in place in the workplace. In June 2024, minutes from a meeting of the CSC noted that there were around 30 premises across the Council estate without an RPO but that where there was not an identified RPO key activities were still being actioned across the majority of these sites. There are approx. 1,106 operational General Fund assets (Schools, HLH Estate, Offices, Depots etc.) so 30 premises represented 2.7% of these assets. The Chief Officer – Property and Assets was leading on a piece of work to identify where there were gaps and report to the Corporate Management Team so that a solution could be found (see action plan M3).

2.2 *Health and safety risks are managed across the Council.*

This audit objective was partially achieved. Appropriate mandatory health and safety training was required to be completed by all employees, including an induction for new starts, but there was no specific training for managers. Management of Health and Safety was listed on the Employee Induction Checklist as a mandatory course which must be completed by all managers. However, the course ceased during covid and had not restarted. The OHSW Manager was in discussions with People Development on current training provisions, including specific training requirements for managers (see action plan M4). Health and safety information was also made available to staff on the Intranet, Viva Engage and through online drop-in sessions run by the OHSW Team.

There was some monitoring of mandatory training completion, but it was each line managers responsibility to ensure that staff had undertaken all relevant training and were aware of their responsibilities for health and safety matters. Uptake of these courses, including new start inductions, was relatively low across the Council (see action plan M5). The following figures were prepared by People Development for the period ending 30/06/24 and included all staff with a Council email address and therefore access to Traineasy:

- New start induction – 31%
- Introduction to Health and Safety – 32%
- Fire Awareness – 49%
- Run Hide Tell – 42%
- Display Screen Equipment – 53% (did not include teaching staff).

There was adequate guidance in place to ensure that risk assessments were undertaken to identify, assess and control health and safety risks and that they were formally and clearly documented. A sample of 9 risk assessments, 5 from Community and Place and 4 from Education and Learning, was examined and all had been completed using the standard template and contained all of the required information. Where the residual risk rating of an activity was calculated as 4 or over (significant and required further action), further control measures necessary to reduce risk to an acceptable level had been identified. The Guidance on Risk Assessments (the Guidance) stated that they should be reviewed regularly, at least annually, or as a result of a prescribed event e.g., an accident, incident or near miss or a change in legislation. 3 out of 9 sampled risk assessments had not been reviewed in line with the stated next review date which was over a year since it had been initially completed or last reviewed. The Guidance also stated that risk assessments should be carried out by employees who had completed risk assessment training, but this was not the case for 7 out of 9 sampled risk assessments (see action plan M6).

The OHSW Policy stated that Executive Chief Officers were responsible for ensuring that a risk profile was compiled for their service and the Guidance said that Heads of Service should ensure that the service/team risk register was up to date. For the sampled services, there was no health and safety risk profile or register in place for Education and Learning, and whilst Community and Place had undertaken some preparatory work, a formal risk profile or register had not been finalised. There was an action in the Occupational Health and Safety Strategy 2022-2025 Action Plan relating to the development of a Corporate Health and Safety Risk Register with a due date of 31/03/24, but this had not yet been done (see action plan M7).

There were service contracts in place to ensure that property-related services, plant and equipment were inspected, certified, and maintained by suitably qualified personnel. The Engineering Compliance and Maintenance Team within Property were responsible for the management and administration of these contracts and the process for this was set out in a Service Contract Administration Guide. The OHSW Manager confirmed that he was satisfied that that there were similar arrangements in place for non-property related services e.g., fleet, ferries etc.

2.3 *Health and safety monitoring and reporting is in place across the Council.*

This audit objective was partially achieved. The Assure system provided an effective and accessible means for accidents, incidents and near misses to be reported. Once reported, an automated email was sent to the relevant line manager who must review and investigate the incident and then submit the record to the OHSW Team for approval. Once submitted, the OHSW Team carried out checks to ensure that all relevant information had been submitted and that the investigation carried out had been sufficient and appropriate action taken. At this stage they would also check whether or not the incident should be reported to the HSE under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995 and ensure that the appropriate action had been taken. At the time of the audit there were 310 instances (dating back to 24/11/22) where an incident had been recorded on Assure and assigned to a manager for review but not submitted to the OHSW Team for approval. In these circumstances, there was an increased risk that sufficient and appropriate action may not be taken in response to the incident and there could also be a delay or failure in reporting the incident to the HSE if required under RIDDOR. However, since July 2024, the OHSW Team had started running monthly reports and contacting managers to follow up incidents recorded but not submitted in the previous month and this also included following up the historical incidents dating back to 2022. An automated escalation email was being sent from Assure to next level managers after 90 days to inform them that action was required, and they would be sent an email daily until it was submitted to the OHSW for approval. However, due to complaints received regarding the volume of emails, these notifications had been temporarily paused until a solution could be found (see action plan M8). There was Accident Reporting and Accident Investigation guidance on the Intranet, but this was dated 2014 and marked as under review (see action plan M1).

The OHSW Policy stated that at least six-monthly workplace safety inspections would be undertaken within all services as part of their health and safety plan and in addition, Health and Safety Advisers would undertake compliance monitoring and physical verification exercises on a regular basis. However, this type of proactive monitoring was not taking place at Council level or within the sampled services (see action plan H1).

Annual health and safety reports were prepared at both Council and service level, and these were in line with requirements set out in the OHSW Policy. However, there was a delay between the end of the reporting period (31/03/23) and the report being prepared and presented to the CSC for scrutiny (01/12/23) for the Council and Communities and Place reports (see action plan L1). Quarterly reports containing information on all health and safety matters were prepared by the OHSW Manager and presented to all meetings of the CSC and quarterly incident stats were provided to each meeting of the Service and Area Health and Safety Consultation Groups.

3. Conclusion

3.1 There was a well-established governance framework in place to support the implementation of health and safety policy and roles and responsibilities with the organisation were clearly stated. There were comprehensive policies and procedures in place covering almost all of the required areas, but these needed to be subject to a planned process of review and also regular compliance monitoring checks to ensure that all areas of the OHSW Policy were being adhered to. Adequate training had been made available to staff, but uptake was low, and this needed to be more effectively monitored by managers. The Assure system provided an effective system for the reporting of health and safety incidents, accidents and near misses but the required action was not always being taken by managers which resulted in additional work for the OHSW Team. Vacancies within the OHSW Team and a shortage of RPOs and trade union reps could impact on oversight of compliance with health and safety policy and guidance across the Council.

4. Action Plan

Ref	Priority	Finding	Recommendation	Management Response	Implementation	
					Responsible Officer	Target Date
H1	High	The OHSW Policy stated that: – at least six-monthly workplace safety inspections would be undertaken within services – Health and Safety Advisers would undertake compliance monitoring and physical verification exercises on a regular basis. This was not taking place.	A programme of regular compliance monitoring should be put in place as per the OHSW Policy and adherence should be monitored.	A programme of regular work has been restricted due to H&S Adviser vacancies (2.6FTE). Recruitment to these vacancies is actively being pursued. The OHSW Team will continue to carry out workplace inspections both proactively and reactively based on risk with existing resource and statutory requirements to ensure there are no statutory breaches.	OHSW Manager	27/06/25
M1	Medium	– The OHSW Team had been tasked with reviewing all guidance to ensure it was up to date. There was an action in the Occupational Health, Safety and Wellbeing Plan 2023/24 to this effect with a due date of 31/03/24 but it had not yet been completed. – There is Accident Reporting and Accident Investigation guidance on the Intranet, but they were dated 2014 and were marked as under review	A planned ongoing review process should be implemented to ensure that Health, Safety and Wellbeing policy and guidance is kept up to date. Documents should be in a standard format and include version control information.	There is a program of review of policies and guidance and development of new policies where gaps are identified. A standard format and version control will be adopted.	OHSW Manager/ Service Lead Corporate Property	30/12/25
M2	Medium	4 out of 12 trade union reps listed had retired and there was only 1 for Education and Learning.	Management should work with trade unions to determine the number of reps required to ensure adequate representation across all services and trade union bodies. Any gaps identified should be filled and an	Council managers will work with trade unions to establish the number of reps and produce a current and up to date list. Unions have been asked to provide a current list of safety reps.	Chief Officers/ Head of People/ OHSW Manager	27/06/25 28/02/25

Ref	Priority	Finding	Recommendation	Management Response	Implementation	
					Responsible Officer	**Target Date**
			updated list provided for staff on the Intranet.			
M3	Medium	There was not an assigned RPO for each Council workplace.	Gaps in the current RPO provision should be identified and filled to ensure that there is an assigned RPO for each Council workplace.	Property have identified gaps in the RPO provision. The identification and provision of RPO's for all operational properties will be agreed with respective Chief Officers. The RPO role will be reviewed and training provision for RPOs will be refreshed and rolled out.	Chief Officer – Property and Assets Chief Officer – Property and Assets OHSW Manager/ People Development Manager	Complete 30/06/25 30/12/25
M4	Medium	Delivery of the mandatory 'Management of Health & Safety' training course had ceased during covid and had not restarted.	Health and safety training requirements for managers should be reinstated and managers required to complete appropriate training.	This is in development between People Development and the OHSW Team and resources are being identified to deliver the training.	OHSW Manager/ People Development Manager	27/06/25
M5	Medium	Uptake of mandatory health and safety training, including new start inductions, was relatively low across the Council.	Managers should be instructed of their responsibility to ensure that staff had undertaken all relevant training and that all new starts had received an induction. A process should be established for monitoring uptake of training and escalating instances where mandatory training is not undertaken.	Managers will be reminded of H&S responsibilities and the need to undertake training. This will be regularly reviewed in line with service and organisational needs. This was raised at Operational Manager Team meeting on 20/01/25 and will continue to be regularly promoted via Staff Connections, Viva Engage. This is monitored and will be notified to Chief Officers quarterly.	Chief Officers/ Head of People/ People Development Manager	27/06/25
M6	Medium	For the 9 sampled risk assessments:	Staff who are responsible for undertaking risk assessments	Services will be reminded via an all-managers email, and a Viva	OHSW Manager	24/01/25

Ref	Priority	Finding	Recommendation	Management Response	Implementation	
					Responsible Officer	**Target Date**
		– 3 out of 9 sampled risk assessments had not been reviewed in line with the stated next review date – 7 out of 9 sampled risk assessments had been carried out/reviewed by an employee who had not undertaken risk assessment related training.	should be instructed of the requirements to undertake risk assessment training and also to review risk assessments regularly (at least annually).	Engage post of the need to review risk assessments regularly. We promote risk assessment training via Viva Engage and Staff Connections and also put on and promote drop-in risk assessment training sessions.		
M7	Medium	There was an action in the Occupational Health and Safety Strategy 2022-2025 Action Plan relating to the development of a Corporate Occupational Health and Safety Risk Register with a due date of 31/03/24, but this had not yet been done. There was not a health and safety risk profile or register in place for the sampled services, although Community and Place had undertaken some work in this area.	The requirements around risk registers and risk profiles should be assessed to establish if these are required. If so, the methodology for compiling these should be developed and communicated to all relevant staff.	The OHSW Team has reviewed the provision of risk registers in service areas. The Health and Safety Policy has been updated to put the responsibility to ensure risk registers are completed with Chief Officers. Guidance and support will be offered by the OHSW Team to help services produce risk registers.	Chief Officers/ OHSW Manager	30/12/25
M8	Medium	There were 310 incidents recorded on Assure, dating back to 24/11/22, which had not been submitted to the OHSW Team for approval by a manager. An automated escalation email was being sent to next level managers after 90 days. However, due to complaints received regarding the volume of emails (daily), these notifications had been	– The OHSW Team should continue monitoring these incidents on a monthly basis to ensure that all recorded incidents are investigated, and appropriate action taken. – These reviews should be evidenced, especially where an incident remains open on Assure. – A solution should be found to the issue of daily escalation emails being sent and these should start being sent to	This is now down to 220 as the OHSW Team have been working through closing out actions with the service areas. Monthly meetings are in place to review and close out accidents.	OHSW Manager	25/09/25

Ref	Priority	Finding	Recommendation	Management Response	Implementation	
					Responsible Officer	**Target Date**
		temporarily paused until a solution could be found.	next level managers after 30 days.			
L1	Low	There was a delay between the end of the reporting period (31/03/23) and annual health and safety reports being prepared and presented to the CSC for scrutiny (01/12/23) for the Corporate and Communities and Place reports.	Annual health and safety reports should be prepared and reported to the CSC at the earliest opportunity following the end of the reporting period.	The relevant service areas are reminded at service health and safety meetings. This will be raised at the next Central Safety Committee.	OHSW Manager	30/03/25

Internal Audit Report

Corporate

Efficiency of Debt Recovery Arrangements

Description	Priority	No.
Major issues that managers need to address as a matter of urgency.	High	0
Important issues that managers should address and will benefit the Organisation if implemented.	Medium	5
Minor issues that are not critical but managers should address.	Low	5

Audit Opinion

The opinion is based upon, and limited to, the work performed in respect of the subject under review. Internal Audit cannot provide total assurance that control weaknesses or irregularities do not exist. It is the opinion that **Reasonable Assurance** can be given in that whilst the system is broadly reliable, areas of weakness have been identified which put some of the system objectives at risk, and/or there is evidence that the level of non-compliance with some of the controls that put some of the system objectives at risk.

Distribution:
Assistant Chief Executive of Corporate
Chief Officer - Revenues and Commercialisation
Revenues Manager
Chief Officer – Corporate Finance
Assistant Chief Executive of Place
Strategic Lead Environmental Health and Bereavement Services

Report Ref: HCP22/001
Draft Date: 04/12/2024
Re-Draft Date: 19/12/2024
Final Date: 21/01/2025

1. Introduction

1.1 The objective of the review was to consider the efficiency and effectiveness of the debt recovery arrangements across the Council in relation to:

- Identification and recording of Council debts;
- Communication with debtors; and
- Recovery action by Services and the Corporate Debt Team.

Compliance with the Council's Financial Regulations across the arrangements was also considered.

1.2 The scope of debts subject to corporate debt recovery was assessed, which included systems for their prompt identification and accurate registration. We reviewed the content and regularity of formal communications to ensure that they maximise the likelihood of debts being collected. The role of Services was measured to ensure that they provide accurate and prompt information to secure the recovery of Council debts.

1.3 The audit assessed the debt recovery action taken by the Corporate Debt Team, sheriff officers and solicitors. It considered the approach and scope of the Council's Corporate Recovery Team in the recovery of all sundry debts. The audit did not consider the recovery of council tax, business rate and current HRA rent debts.

2. Main Findings

2.1 *Identification and recording of Council debts*

The audit objective was partially achieved. The Council has drafted a Debt Management Policy which will specify the roles and responsibilities of officers and the types of debts that should be referred to the Corporate Recovery Team for collection. It was identified that some types of debt including the recovery of Highland Opportunity (Investments) Limited (HOIL) loan debts do not involve the Corporate Recovery Team. (see Action Plan Refs: M1 and M2).

When compared to other local authorities, the Council's minimum sundry debtor invoice value (of £12.50) is amongst the lowest in Scotland with the average of the other local authorities being £20. This value was set a few years ago and reflected the cost of collection at the time but has not been updated since. (see Action Plan Ref: L1).

The payment of invoices is required within 30 days of the Sales Ledger system invoice issued date (as per Financial Regulations). Testing identified that this requirement had been met with 19 (95%) of debtors afforded the Council's standard credit terms (30 days) and then reminder/final notice before Sheriff Officer referral. 1 (5%) exception was found where an invoice for bereavement services remained unpaid after the due date, first/final reminder but with no further recovery action. (see Action Plan Ref: M3)

If for valid reasons all or part of an invoice has been issued in error, the budget holder should request a credit note for the appropriate amount and issue it to the customer, as stated in Financial Regulations. Testing identified 1 (5%) exception where the invoice cancellation had not been approved/reviewed by the budget holder in the respective Service/Cluster; and 9 (50%) cases where the respective Services completed forms which contained the general "invoice billing error" as the reason for cancellation. Without proper approval and a clear reason for the cancellation, replacement invoices may not be issued when required and income may not be collected. Furthermore, this could be used by budget holders within Services as a method of unofficially writing off valid debts (see Action Plan Ref: L2)

2.2 *Communication with debtors*

The audit objective was partially achieved. The issuing Service should seek to resolve the dispute with the customer within 10 working days (as per Financial Regulations). Testing identified 6 (60%) invoices placed in dispute that were not promptly resolved within 10 days, although it is recognised that disputes can take longer than 10 days to be resolved depending on the complexity

of the dispute: (i) 3 Bereavement debts outstanding for more than 4 years (See recommendation M3); (ii) 2 Health and Social Care debts unpaid for 18 and 6 months; and (iii) 1 Harbours debt unpaid after 4 months. The 2 latter disputed items, (ii) and (iii) were held for longer than the requested date. The 10-day dispute resolution time was not achievable in these cases because the Health and Social Care debts were not specified at the outset and the Harbours debt was raised in 2024/25 when the budget holder will not have received an Aged Debt Dashboard Report to progress the dispute. Prior to the introduction of CiA in April 2024, all budget holders received an aged debt report on a monthly basis detailing their outstanding debts for which they are responsible. (see Action Plan Ref: M4)

Customers will receive a combined reminder final notice after 31 days and a pre-court letter after 46 days (as per Financial Regulations). From 1 April 2024 the Council moved to a new finance system (CiA), in which all debtors now receive one 37-day letter, combining the previous finance system's (Integra) 2 reminder letters (reminder/final notice and pre-court letter). Testing identified that: (i) 3 (15%) reminders were issued between 44 and 63 days after the invoice due date. This was because the invoices (raised on Integra in March 2024 before the first reminder date) were transferred to CiA on 04/04/2024 and the first reminders were issued 30+ days after this invoice transfer date; and (ii) 3 (15%) – whilst the first reminder was issued in Integra (in March 2024) there was no evidence of a second reminder being issued in Integra or CiA. The Financial Regulations require update to reflect the new reminder letter process. (see Action Plan Ref: L3)

Budget Holders across each of the Service Clusters should review the Aged Debt report (monthly) and contact the customer before considering: (i) removal of service; (ii) monitor query codes; and (iii) liaise with the Recovery Team. Testing of debts of over £1,000 outstanding for more than 60 days identified: (i) 7 (35%) Budget Holders were not fully aware of the indebtedness as they had not received an Aged Debt Dashboard Report as a result of the implementation of CiA; (ii) 8 (40%) Budget Holders stated they were not aware that Services were required to take further action and communicate to the customers about the debt. However, Guidance was issued with every Aged Debt report issued by Integra; (iii) 4 (20%) Budget Holders had been in regular communication with the customer regarding the recovery of the debt; and (iv) 1 (5%) bereavement has historically been treated sensitively so no specific communication (see above). While it should be noted that no monthly Aged Debt reports have been issued to budget holders from CiA in 2024/25 to date, work has been ongoing by the CiA project team and the subject matter experts within the Revenues Team to develop a dashboard for implementation in Q4 2024/25. (see Action Plan Ref: L4)

Domestic customers can only pay by instalment for a longer than repayment period if a financial statement of indebtedness that has been provided by the Citizen's Advice Bureaux (CABx) and assessed and accepted by the Corporate Recovery Team. Testing identified 7 (35%) cases where debtors had been afforded extended debt plans where a CAB statement should be obtained: (i) 1 had a CAB financial statement which was accepted by the Corporate Recovery Team; (ii) 2 management discretion applied (as only 1-3 months over the recommended period); and (iii) 4 no CAB retained but 2 of these indicate that received/reviewed by the Recovery Team. (see Action Plan Ref: M5)

2.3 *Recovery action by both Services and the Corporate Debt Team*

The audit objective was substantially achieved. After 53 days debts less then £1,000 will automatically progress to formal recovery action including Court action or recovery by a firm of Sheriff Officers. After 60 days Debt greater than £999.99 will progress to formal recovery action including Court action or recovery by a firm of Sheriff Officers (as per Financial Regulations). For the sample of 20 total customer debts: (i) 9 (45%) with total indebtedness of under £1,000 where referral to the Sheriff Officer was the appropriate course of further action; the actual recovery action taken on these debts was compliant with 6 - Sheriff Officer and 3 - N/A as customer paid/agreed payment plan; and (ii) 11 (55%) with total indebtedness of over £1,000, where referral to legal representatives was the appropriate course of further action the actual recovery action taken on these debts was 2 – legal representative, 4 – N/A as customer paid/agreed payment plan, 1 in Dispute, 1 Cancelled, 2 Sheriff Officer and 1 no evidence of any recovery action - Bereavement Services. There was evidence to support that in

most cases tested that appropriate recovery action was progressed. Debt recovery actions are automatically taken based on individual invoice values. To enable enforcement to be initiated, total indebtedness is identified as part of the process. (see Action Plan Ref: L5)

3. Conclusion

3.1 The Council has broadly effective and efficient arrangements for the recovery of its debts. These arrangements could be further enhanced through finalising and issuing the debt management policy that clarifies the roles and responsibilities for the collection of all council debts. This should include consideration whether it would be more effective for all debt collection to sit within a single team. The implementation of CiA has had an impact upon the effective recovery of debts, which should be improved following the resumption of regular Aged Debt reports and the ongoing provision of training, guidance and support to budget holders.

4. Action Plan

Ref	Priority	Finding	Recommendation	Management Response	Implementation	
					Responsible Officer	Target Date
M1	Medium	The Council has a Debt Management Policy in preparation, which will specify the roles and responsibilities of officers and the types of debts that should be referred to the Corporate Debt Team for collection.	Management should implement the Council's draft corporate debt policy that outlines the Council's approach to recovery of all types of debts and specifies the roles and responsibilities of officers in the collection of those debts.	Report will be considered by Corporate Resources Committee.	Revenues Manager	30 June 2025
M2	Medium	It was identified that the Corporate Debt Team could be involved in the recovery of other debt collection arrangements across council activities.	Management should review the types of debts that could be referred to the Corporate Debt Team for collection. The Debt Management Policy should record the arrangements in place for the recovery of all debts across the Council. (See also M1)	A review will be undertaken during financial year 2025/26.	Chief Officer, Revenues & Commercialisation	31 March 2026
M3	Medium	Testing identified 1 (5%) invoice for bereavement services that remained unpaid for more than 30 days - after the due date, after the first/final reminder with no further recovery action.	Senior Management should review the recovery of bereavement debts and ensure that recovery action continues to be taken against the customer requesting the service.	A review will be undertaken by the Place Cluster.	Strategic Lead – Environmental Health and Bereavement Services	30 June 2025
M4	Medium	Testing identified 6 (60%) invoices placed in dispute that were not promptly resolved within 10 days: • 3 Bereavement debts outstanding for more than 4 years (See M3, above); • 2 Health and Social Care debts unpaid for 18 and 6 months; and • 1 Harbours debt unpaid after 4 months.	Senior Management in consultation with the Service should ensure that sundry debtor invoices in dispute are promptly resolved. Invoices should only be raised where a purchase order has been received from the customer and/or the Service has evidence to confirm that the quantities, scope and price for the goods/services has been agreed.	Disputes were highlighted as an action point on the monthly Integra Budget older reports for action by respective Services. The Aged Debt dashboard being developed in CiA will also highlight disputes for action by individual budget holders within Services. A dashboard will be developed within CiA for Senior Managers to detail disputes, aged debt etc. Supportive action can then be taken with budget	CiA project team and Revenues Manager	31 March 2026

Ref	Priority	Finding	Recommendation	Management Response	Implementation	
					Responsible Officer	**Target Date**
				holders by their Senior Management Teams.		
M5	Medium	Testing identified 7 (35%) cases where debtors had been afforded extended debt repayment plans: ○ 2 management discretion was applied; and ○ 4 no CAB statement retained but 2 of these indicate that received/reviewed by the Recovery Team.	Management should ensure that in cases where debtors are afforded payment plans for longer than specified in the Council's Financial Regulations, statements from the Citizen's Advice Bureau are obtained and retained to confirm their indebtedness.	All extended payment plans now authorised by the Operations Managers in Revenues Team	Revenues Manager	Completed
L1	Low	When compared to other local authorities, the Council's minimum sundry debtor invoice value (of £12.50) is amongst the lowest in Scotland with the average of the other local authorities being £20. This was based upon the calculated cost of debt recovery at the time, but this has not been reviewed for a few years.	Senior Management should review the minimum sundry debtor invoice value so that it reflects the current administrative cost of processing debts.	Agree and the ongoing review will be in accordance with the Council's Charging Policy agreed by the Corporate Resources Committee in December 2024.	Revenues Manager	31 March 2025
L2	Low	Testing identified: • 1 (5%) invoice cancellation had not been approved/reviewed by the budget holder; and • 9 (50%) forms contained a general "invoice billing error" as the reason for cancellation. Of the 14 cancellations where a new invoice was required: • 11 (79%) forms did not record the replacement invoice number.	Management should issue an instruction to budget holders with the link to the latest version of the invoice cancellation form (which includes more specific invoice cancellation reasons), record details of replacement invoices and be properly authorised.	Instruction will be issued to Budget Holders.	Chief Officer, Corporate Finance	28 February 2025

Ref	Priority	Finding	Recommendation	Management Response	Implementation	
					Responsible Officer	**Target Date**
L3	Low	Financial Regulations states that customers will receive a combined reminder final notice after 31 days and a pre-court letter after 46 days. From 1 April 2024, all debtors (in CiA) receive one 37-day letter, combining the previous reminder/final notice and pre-court letter.	Management should revise and re-issue the Council's Financial Regulations – Appendix 10 "Issue of Debtor Accounts" to reflect the change in CiA to issuing only one 37-day letter and other changes to the debtor's processes that have resulted from the introduction of the CiA system.	Council's Financial Regulations – Appendix 10 "Issue of Debtor Accounts" updated	Revenues Manager	Complete
L4	Low	Testing of 20 debts of over £1,000 outstanding for more than 60 days identified: (i) 7 (35%) Budget Holders had not received an Aged Debt Dashboard Report in 2024/25 ; (ii) 8 (40%) Budget Holders were not aware that Services were required to take further action and communicate to the customers about the debt; and (iii)) 1 (5%) bereavement debt no specific communication because these debts continue to be treated differently (see M3, above).	Management should issue the necessary instructions and guidance to budget holders of the requirement to take further action and communicate to the customers about debts that remain outstanding after 60 days.	All budget holders received guidance with their Integra debt reports. CIA dashboards will remind budget holders of the same guidance, and this will be highlighted in dashboard training.	Revenues Manager – Dashboard Project Manager (Strategic Improvement) - training	31 March 2025 31 March 2025
L5	Low	For the sample of 11 debts of over £1,000 tested (where referral to legal representatives was the appropriate course of further action): (i) 2 (18%) were referred to the Sheriff Officer (because per Policy/Financial Regulations recovery action is on the basis of individual invoice value – not total indebtedness, and ; (ii) 1 (9%) no evidence of	Management should review the current process to take such recovery action based on the customer's total indebtedness rather than individual invoice value. Any changes should be updated within the Council's Financial Regulations and associated instruction notes.	The process has been reviewed and current practice continues to identify total indebtedness.	Revenues Manager	Complete

Ref	Priority	Finding	Recommendation	Management Response	Implementation	
					Responsible Officer	Target Date
		any recovery action - Bereavement Services.				