The Highland Council

Agenda Item	**3**
Report No	**AC/22/25**

Committee: **Audit Committee**

Date: **12 November 2025**

Report Title: **Internal Audit Reviews and Progress Report – 30/07/2025 – 24/10/2025**

Report By: **Strategic Lead (Audit and Risk)**

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 August 2025.

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 **note** 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**.
iii. **Agree** the removal of the planned audit review of Fostering and Adoption (Section 6.1).
iv. **Note** that a new audit, "Review of exit packages" has commenced which will enable the Council to address the expectations of the Accounts Commission.

3. Implications

3.1 Resources – see update provided at section 9 with regard to the Internal Audit resources. From 6 October 2025, the full complement of staff is in place.

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 four reports issued during this period as detailed in the table below.

Service Cluster	Subject	Audit opinion
Place	Climate Strategy and Sustainability	Reasonable Assurance
Corporate	Wider review of internal controls following the Aberdeen City Council Tax Fraud	Substantial Assurance
People	Children's Services - Transition Arrangements	Reasonable Assurance
People	Family Teams	Substantial 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 Additional unplanned work had been added to the agreed audits (in response to Audit Scotland's report on the Aberdeen City Council Tax Fraud). We have also brought forward a review of Children's Services - Transition Arrangements to coordinate this with an NHS Highland internal audit review of the same area. These final reports are included within this item. As a result of this additional work, approval is requested from Committee to remove the planned audit review of Fostering and Adoption. It should be noted that this area has been subject to recent inspections by the Care Inspectorate in May 2025 with separate reviews of the Fostering, and Adoption Services.

Audits for the 2025/26 audit plan 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.

7. Other Work

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

- 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.

- Attendance at HR & Payroll 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.

- Attendance at officer meetings for Inverness Green Freeport

  Developing preparatory understanding of arrangements surrounding the role of the Highland Council as Accountable Body for the Inverness Green Freeport. The Green Freeports Framework sets a range of new expectations and assurance requirements including additional internal audit reporting requirements.

- Global Internal Audit Standards (GIAS)

  Work is continuing with regard to implementing and embedding the requirements of the GIAS.

- 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 seen an increase in activity in this area over the last reporting period.

  We have a current commitment of 9 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:

- Three ongoing Whistleblowing cases.
- One NFI case
- One individual case of salary overpayments which was referred by the Payroll Section.
- Three ongoing investigations, one reported by the Service.
- One suspected theft allegation. The allegations were proven and resulted in disciplinary action with the employee dismissed.

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.

8. Accounts Commission report – Glasgow City Council – Senior officer exit packages

8.1 On 4th September 2025, the Accounts Commission issued the above report. This raised serious concerns about the exit packages granted to five senior council officers which had a total cost of £1.035m. In particular, it was stated that the Council was unable to demonstrate effective scrutiny, governance and transparency in decision-making in respect of the exit packages. The report also included a section on "Lessons learnt for all Councils". This recognised that in response to the present challenging financial context other Councils may be undertaking restructuring and the need to ensure that these are covered by effective governance arrangements. Five areas for Councils to consider were set out.

8.2 Subsequently on 8th September 2025, the Deputy Chair of the Accounts Commission issued a letter to all Council Leaders and Chief Executives with a link to the report and stated that it was vital that all Councils take action to recognise the important learnings from the report. The following expectations were also detailed:

- The letter and issues highlighted in the report should be discussed by the Audit Committee.
- The Scheme of Delegation and decision-making processes should be reviewed.
- Action is taken to ensure all officers and members are familiar with the Key Principles of Public Life and these are fully supported by the organisation's culture.
- All early retirement packages, including exit packages for senior officers, are in accordance with the expectations of the Accounts Commission's report "Bye now, pay later?"

In order to address these expectations, a new, unplanned audit, "Review of Exit Packages" has commenced. This will be reported to the February meeting of the Audit Committee.

9. Internal Audit Resources

9.1 In the progress report to the August 2025 Audit Committee, reference was made to a restructure of the Internal Audit team and interviews for the vacant Auditor post. These took place as planned and the successful candidate started on the 6 October 2025.

9.2 The time taken to restructure and recruit to the vacancy does mean that the available audit days were less than anticipated when the audit plan was prepared. However, the plan includes an element of contingency time which can be used to offset vacancies in

the short term. Should this be insufficient and it is considered necessary to further amend the audit plan, this will be reported to the Committee and approval sought for any changes required.

Designation: Strategic Lead (Audit and Risk)

Date: 27th October 2025

Authors: Donna Sutherland, Strategic Lead (Audit and Risk)
Jason Thurlbeck, Corporate Audit Manager

Background Papers: N/A

Appendices: Appendix 1 - Internal Audits in progress

Appendix 1 – 2025/26 Internal Audits in progress

Service	Audit Subject	Priority	Planned Days	Current Status	Planned Committee Reporting Date
Audits c/ from 2024/25 Audit Plan					
Place	Property Maintenance & Repairs	High	30	Fieldwork in progress	February 2026
2025/26 Audit Plan					
Place	Asset Management	High	30	Planning initiated *	-
Corporate	Human Resources	High	30	Fieldwork in progress	February 2026
Place	Roads Operations and Maintenance	High	30	Planning initiated *	-
Corporate	IT Infrastructure	High	30	Planning initiated *	-
Corporate	ICT & Digital Services	High	30	Fieldwork in progress	February 2026
Place	Infrastructure projects	High	30	Planning initiated *	-
People	Emergency Social Work Service	Medium	30	Fieldwork in progress	February 2026
Corporate	Legal Services	Medium	30	Planning initiated *	-
Place	Ferries	Medium	30	Fieldwork in progress	February 2026
Corporate	General Ledger	High	30	Planning initiated *	-
Place	Property Capital Projects	High	30	Planning initiated *	-
Corporate	Strategic Improvement	Medium	30	Not yet started	-
Corporate	Payroll	Medium	30	Not yet started	-
People	Primary Schools	Medium	30	Not yet started	-
Corporate	Insurance	Medium	30	Not yet started	-
People	Early Years	Medium	30	Planning initiated *	-
People	Secondary Schools	Medium	30	Not yet started	-
People	Additional Support for Learning	Medium	30	Planning initiated *	-
People	Fostering and Adoption	Medium	30	Approval to delete requested	n/a

***** Once the Terms of Reference has been prepared, this will detail the planned Committee reporting date.

Internal Audit Final Report

Place Cluster

Climate Strategy & Sustainability

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	3
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 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 may put some of the system objectives at risk.

Distribution:
Assistant Chief Executive, Place
Climate Change Manager, Place
Net Zero Programme Manager, Climate Change & Energy Team
Programme Manager, Capital Board
Strategic Lead – Housing & Customer Services
Service Lead Housing Investment & Building Maintenance
Audit Scotland

Draft Date: 12/09/25
Final Date: 10/10/25

1. Introduction

1.1 The Council's Net Zero Strategy sets out the approach to addressing the climate emergency and contributing towards Scotland's national legally binding target to become Net Zero by 2045, aiming to achieve this sooner. The route map to Net Zero included in the Strategy also sets key interim targets to reduce emissions by at least 75% by 2030 and by at least 90% by 2040.

1.2 The Council's Delivery Plan includes a Net Zero, Energy Investment & Innovation portfolio with a view to deliver on the Council's Net Zero ambitions and maximise the opportunities available to the Council.

1.3 The audit looked to ensure that processes were in place to identify external funding streams relating to net zero deliverables, with awareness of these across key staff to ensure the Council was well placed to maximise access to external funding. The audit also assessed how well external funding streams were integrated with existing capital schemes and governance arrangements. The transition to Net Zero involves significant up-front costs. By maximising external funding sources and ensuring these were co-ordinated with existing schemes the Council can better resource the delivery of schemes to reduce emissions required to meet statutory obligations. The audit was aligned with corporate risks identified within this area, in particular corporate risk HCR9 – Net Zero Programme.

1.4 Highland Council has received £3.26m across the 2024/25 and 2025/26 financial years in climate related funding for 12 applications from Scottish Government and Salix funding streams. In addition, £9.1m of energy funding has been achieved through the ECO4 (Energy Company Obligation) funding for projects across Highland for 2025/26.

2. Main Findings

2.1 *Identification of funding streams*

This objective was fully achieved as there was a robust process in place to identify potential funding sources, and mechanisms through the Net Zero Strategy Group and individual thematic groups to share information on opportunities.

2.2 *Project Identification and Preparation*

This objective was partially achieved. The application process used by some funding bodies had short windows of opportunity to submit funding applications, with little or no advance notification of the often-complex funding requirements, which limited the ability of the Council to forward plan and be strategic in where to target resources to maximise access to funding. This has led to the Council and other stakeholders lobbying the Scottish and UK governments and Ofgem to simplify processes over the years.

There was however scope to be better prepared to react to funding windows by improving co-ordination across teams and by sharing knowledge of datasets that could support funding applications (See Action Plan Ref M1).

The short funding application windows and existing capital funding commitments made it more difficult to identify capital match funding where this was required by the funding body. Housing Revenue Account (HRA) match funding was further complicated by the individual Area budgets as these may not align with the project identified for the funding application (See Action Plan Ref M2).

2.3 *Learning from Funding Applications*

This objective was partially achieved. Feedback on funding applications was provided by funders, particularly where the application was unsuccessful. This enabled any strengths or weaknesses from the application to be identified. While there were some examples of learning from feedback from funders being shared, there was scope for this to be done on a more consistent basis (See Action Plan Ref M3).

There were no KPIs around the number of bids submitted or the success rate of applications to enable evaluation of Council performance in maximising external funding opportunities to support delivery of net Zero targets. This was due to the low volume of applications, however, a suite of KPIs is currently being

developed as part of the restructure of the Net Zero Strategy Group (See Action Plan Ref L1).

2.4 *Delivery of Projects*

This objective was fully achieved as delivery plans were in place for each of the sample of funding streams reviewed during the audit. The format and content of these varied due to differing requirements for each funding stream, but in each case the full information requested was provided by the Council to verify project delivery and compliance with funding conditions.

3. Conclusion

3.1 The audit found that while there were strong foundations in place for identifying and managing funding opportunities, there was scope for improvement in coordination, data sharing, and learning dissemination in relation to funding opportunities and applications. Addressing these areas will enhance the Council's ability to secure funding to accelerate delivery of its Net Zero commitments.

4. Action Plan

Ref	Priority	Finding	Recommendation	Management Response	Implementation	
					Responsible Officer	**Target Date**
M1	Medium	There was scope to be better prepared to react to funding windows by improving co-ordination across teams and by sharing knowledge of datasets that could support funding applications.	1) While there has been progress in improving funding application co-ordination through the Net Zero Strategy Group, further steps should be taken to embed collaboration through all net zero thematic groups. 2) There are a number of valuable datasets that can support funding applications. These should be better publicised to improve awareness and their use.	1) The Net Zero Strategy Group is being restructured to strengthen co-ordination across all service clusters. As part of this, a methodology will be developed for thematic group leads to maintain a live pipeline of potential projects for external funding. This pipeline will form a standing agenda item at each meeting of the Net Zero Strategy Group to ensure continuous oversight, cross-service alignment, and timely responses to new funding calls. The pipeline will also be reviewed formally on a quarterly basis to confirm accuracy and readiness for emerging opportunities. 2) A centralised data hub will be established by March 2026, overseen by the Climate Change & Energy Team. This hub will catalogue key datasets relevant to funding bids and provide guidance on their use. Data quality will be reviewed twice per year to maintain accuracy and relevance.	Net Zero Programme Manager with input from the Net Zero Strategy Group. Climate Change Co-ordinator (Data)	31/03/26 31/03/26

Ref	Priority	Finding	Recommendation	Management Response	Implementation	
					Responsible Officer	**Target Date**
M2	Medium	Short funding application windows and existing capital funding commitments made it more difficult to identify capital match funding where required. HRA match funding was further complicated by the individual Area budgets.	1) There should be regular discussion between the Net Zero Strategy Group and the Capital Board to ensure funding applications can be aligned to capital plans wherever possible. 2) The use of Area budgets within the HRA Capital Plan should be reviewed to assess whether this is the most effective way of structuring budgets to assist match funding for applications.	1) Regular and structured engagement will be established between the Net Zero Strategy Group and the Capital Board to ensure early alignment between emerging funding opportunities and the Council's approved capital programme. This will include the creation of a standing agenda item on funding alignment within both forums, enabling proactive identification of match-funding requirements and early visibility of potential pressures or opportunities. Meeting outcomes and agreed actions will be recorded to ensure clear ownership and follow-up through the respective governance routes.	Programme Manager, Capital Board	30/06/26
				2) This issue has moved on as we now focus on targeting need and targeting investment, with governance through the HRA Capital Board. The 2027-2032 HRA Capital Plan is going to January 2026 Housing & Property Committee and one of its principles will include flexibility of energy budgets to maximise funding and	Service Lead - Housing Investment & Building Maintenance	30/06/26

Ref	Priority	Finding	Recommendation	Management Response	Implementation	
					Responsible Officer	**Target Date**
				maximise works where the evidenced need is greatest.		
M3	Medium	While there were some examples of learning from feedback from funders being shared, there was scope for this to be done on a more consistent basis.	A process to share learning from funding applications should be developed to enable the consistent sharing of relevant information across thematic groups.	A formal "lessons learned" process will be introduced from April 2026 for all funding applications. This will include a short template capturing key feedback from funders and internal reflections on the process, whether successful or unsuccessful. Completed templates will be collated by the CCET Funding Manager and shared with the Net Zero Strategy Group each quarter, with key points circulated to all thematic groups to support continuous improvement in funding applications.	CCET Funding Manager	31/03/26
L1	Low	There were no KPIs around the number of bids submitted or the success rate of applications to enable evaluation of Council performance in maximising external funding opportunities to support delivery of net Zero targets.	The KPIs being developed as part of the Net Zero Strategy Group restructure should include metrics to track both the volume and success rate of funding applications.	A suite of KPIs will be developed and agreed by the Net Zero Strategy Group by April 2026. These will track: • The number and value of potential projects identified • The number of funding bids submitted • The value of bids • The success rate of applications; and • The contribution of secured funding to Net Zero targets. KPIs will be monitored quarterly and reported annually to the Net	Net Zero Programme Manager with input from the Net Zero Strategy Group.	31/03/26

Ref	Priority	Finding	Recommendation	Management Response	Implementation	
					Responsible Officer	**Target Date**
				Zero, Energy, Investment & Innovation Portfolio Board and Corporate Management Team. Progress will be reported to the Climate Change Committee to ensure visibility and accountability.		

Internal Audit Final Report

Corporate

Wider review of internal controls following the Aberdeen City Council Tax Fraud

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	2
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 **Substantial Assurance** can be given in that while there is 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 at risk.

Distribution:
Assistant Chief Executive - Corporate
Chief Officer, Revenues and Commercialisation
Chief Officer, Corporate Finance
Chief Officer, Business Solutions
Other Officers listed in the Action Plan

Draft Date: 10/09/2025
Final Date: 10/10/2025

1. Introduction

1.1 In January 2025 the Controller of Audit reported to the Accounts Commission in relation to a significant Council Tax refund fraud perpetrated against Aberdeen City Council. The fraud took place over 17 years and was investigated internally in 2023/24. An internal audit report on Highland Council's Council Tax refunds processes was undertaken earlier this year and reported to the Audit Committee with a rating of "full assurance".

1.2 The Controller of Audit's report also stated: "The Commission expects all councils in Scotland to ensure that fundamental internal controls are in place and working effectively and that: It is also important that across all councils, internal and external auditors raise and discuss any areas of potential concern." This audit report follows on from the Council Tax refund audit. It examined the key controls for other Council systems that facilitate payments, and this now completes the work to address the Accounts Commission's expectations.

1.3 This was a wide-ranging audit covering multiple systems, processes, and teams. This report is therefore a high-level summary of key findings and individual systems are only referred to where a recommendation is specifically addressing that part of the process.

1.4 Summary of systems covered as part of the audit:

- Financial system
- Treasury and online banking systems
- BACS payments sites
- Creditors software for checking transactions
- Housing system
- Payroll system (in part see 1.5)
- Civica and Revenues and Benefits systems
- Systems "feeding" the financial system: property, maintenance, fleet, libraries, educational allowances, health and social care providers.

1.5 This audit has not examined pension fund payments (to be covered in a separate audit) or the payments from endowments and trust funds, although an overview of the governance arrangements for these funds was provided. The payroll system was only examined in regard to how the BACS file was generated, payroll controls prior to this stage were not examined for this audit as a separate audit of payroll is due to take place in 2025/26.

2. Main Findings

2.1 ***Segregation of duties:*** *ensuring access to systems are restricted to appropriate levels (to negate the possibility of individuals processing transactions all the way through the payments process).*

This objective was achieved. There was good evidence of segregation of duties. For the areas reviewed there was no evidence that any single individual could process or was processing a transaction from start to finish. For each payment process reviewed there were multiple individuals involved in the transaction.

The majority of payments were made by BACS following 2 main types of process where a payment was set up on a system and involved at least 2 officers. For both types of BACS processing, batch files were then sent to separate teams (consisting of multiple employees) who uploaded the payment batch files to systems which were separate from the originals.

Payments not made by BACS were made by other electronic means; CHAPS and faster payments. These were governed by a separate process but there was evidence of segregation of duties for this and crucially at the stage where a payment was authorised via online banking to leave the bank account. In this case the system was set up

to necessitate 2 people approving a payment before it was made.

The financial system had permissions which allowed a small number of users to have access to all modules used, but each individual process had multiple individuals involved so the risk of creating and approving erroneous payments was low.

2.2 ***Reconciliations:*** *ensuring feeder systems are effectively reconciled to other systems (e.g. general ledger); using third-party information (suppliers' statements) and reconciling with payment systems.*

This objective was substantially achieved as reconciliations were regularly taking place between different systems and the financial ledger and also between the bank statements and ledger. Reconciliations took place at different stages of the processes examined.

On a monthly basis Finance Officers reconciled the bank statements to the financial ledger. Non domestic rates and housing rent refunds had additional system to ledger reconciliations. This would identify if an additional erroneous payment had been created. We were able to verify that there was evidence of these reconciliations being routinely carried out. However, there was a delay in processing journals for payroll transactions to the financial system which meant some transactions were not being reconciled timeously and there were a small number of outstanding cheques which prevented the reconciliation being completed in full. (See Action Plan M1).

Control checks took place to verify the transactions being submitted for payment. For 1 payment process taking payroll transactions to BACS payment, there was scope to improve the control environment by adding an additional check to verify that account and sort code data and individual payment amounts could not be wrongly amended. (See Action Plan M2).

2.3 ***System documentation:*** *system documentation should be maintained which details key controls to be carried out by staff to prevent fraud or error.*

This objective was partially achieved. Most, but crucially not all of the stages in the process had some form of written procedures. There was evidence of procedures needing to be updated for example referring to out of date systems and key contacts (naming individuals no longer in post). Overall, within the procedures some controls were documented for example batch file control checks, secondary approval of transactions but in only 1 case was the type of control made explicit (segregation of duties). Not having written procedures increases the risk of teams not being able to carry out operations as efficiently in the event of unplanned absence or key staff leaving.

The Council's Counter Fraud Policy states that "Management must ensure that sound financial systems and procedures, incorporating efficient and effective internal controls, are in place. This may include documented working manuals and operating procedures, which should be issued to relevant staff". Therefore, fully documenting processes and the key controls better demonstrates management's commitment to a robust control environment. (See Action Plan Ref L1).

2.4 ***Monitoring:*** *scrutiny monitoring should be at a level that would allow managers to identify anomalous payments at an early stage.*

This objective was achieved. Most monitoring took place prior to payments being uploaded to the BACS payment runs. Typically, feeder systems had at least 2 officers involved in a transaction which involved reviewing the rationale for payment. Creditors used specialist software to identify potential duplicate payments, and these were routinely queried with Services. Both BACs processes

involved running reports on failed debits, the details of which were provided to Services. Ultimately Budget Holders were responsible for transactions in the ledger codes assigned to them and instructions and training on budget management have been provided to them in 2025. There was scope to better document the monitoring undertaken in written procedures. (See Action Plan Ref L1).

3. Conclusion

3.1 There were key internal controls in place to reduce the risk of fraud when processing payments. High level review showed these to be working as expected. However, there was scope to improve the controls in specific areas and better document written procedures. Explicitly recording the controls in place, including any monitoring undertaken, would demonstrate the Council's commitment to a strong control environment.

4. Action Plan

Ref	Priority	Finding	Recommendation	Management Response	Implementation	
					Responsible Officer	Target Date
M1	Medium	There was a delay in processing journals for payroll transactions to the financial system which meant some transactions were not being reconciled timeously and there were a small number of outstanding cheques which prevented the reconciliation being completed in full.	Payroll should work with Finance to share information and ensure the backlog of journals is addressed. The outstanding cheques should be investigated and cancelled with any money owed to payees paid by another method. This should ensure that moving forwards reconciliations are complete and up to date.	A meeting will be held between Finance and Payroll to discuss 25/26 cancel and rework journals. This is to ensure Finance have sufficient information from Payroll to keep reconciliations up to date. Payroll plan to have all 24/25 journals processed by 31/12/25 with this work and the reconciliation updated accordingly. In future Finance and Payroll will share information to assist in keeping the reconciliation up to date. Payroll will liaise with Finance on details of cheques that need to be cancelled and contact payees where necessary to ensure correct payments have been made. The cheques will be cancelled and by year end the reconciliation completed.	For all parts of the action: Operations Manager, Payroll and Principal Accountant (with support from Payroll officers and Accounting Technician)	31/10/25 31/12/25 31/03/26
M2	Medium	For 1 payment process taking payroll transactions to BACS payment, there was scope to improve the control environment by adding an additional check to verify that account and sort code data and individual payment amounts could not be wrongly amended.	The process should be amended to ensure that data submitted for BACs payments reconciles fully to the pay reports generated by Resourcelink. The use of a checksum on the data file could simplify this process.	Payroll and BACs processing team will look into how to strengthen the controls to address the finding and recommendation, and make a formal decision on whether changes to the process can and should be made.	Pay and HR Transaction Manager with input from ICT Manager.	31/03/26

Ref	Priority	Finding	Recommendation	Management Response	Implementation	
					Responsible Officer	**Target Date**
L1	Low	Not all processes had written procedures, and some written procedures contained out of date information or did not explicitly refer to the controls in place including on the monitoring undertaken to ensure transactions were legitimate.	All payment processes should have up to date written procedures including setting out the controls in place specifically those outlined in this report: • Segregation of duties specifying the officers & teams involved in the process • Reconciliations including checks undertaken on control totals • The monitoring undertaken to ensure transactions are legitimate and what is done to identify unusual or potentially erroneous transactions.	Agreed. The following reviews will be undertaken: School Clothing Grants Non-Domestic Rates Purchase Cards/ Imprest Payments Procedures to be formally written for libraries system. Finance for reconciliation process.	Senior managers to cascade the report. Service Delivery Manager Revenues Manager Senior Operations Manager Senior Librarian and Head of Libraries, High Life Highland Accounting Technician	31/12/25

Internal Audit Final Report

People Cluster

Children's Services transition 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	4
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 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 may put some of the system objectives at risk.

Distribution:
Assistant Chief Executive, People
Chief Officer, Health and Social Care
Chief Officer, Integrated People Services
Strategic Lead, Care and Support
Practice Lead (Health and Disability)
Lead Officer Strategy, Performance and Quality Assurance

Draft Date: 25/08/2025
Final Date: 02/10/2025

1. Introduction

1.1 In 2012, the Highland Council and NHS Highland entered into a Partnership Agreement, establishing the arrangements for service integration in relation to both Children's and Adult Social Care Services, via a lead agency model. This resulted in the Highland Council (The Council) taking responsibility for Children's Health and Social Care Services and NHS Highland (NHSH) taking responsibility for Adult Social Care Services.

1.2 In 2018, The Joint Transitions Team was created with the aim of ensuring the smooth transition from Children's Health and Social Care Services to Adult Health and Social Care Services for young people, their carers and families. The original remit of the Joint Transitions Team was to work across the age range from 14 years to 25 years. The Highland Council and NHSH have formed a co-located team to deliver this.

The Council team worked with young people from age 14 years up to the age of 19 years if they are enrolled in school or on a legal order and up to age 21 years if they are in Continuing Care, with NHSH providing adult social care services after.

The geographical remit of the Joint Transitions Team was limited to the Inner Moray Firth Area.

1.3 The objective of the review was to ensure that there were effective transition arrangements to identify those moving from children's to adult's services. Internal Auditors of both the Council and NHSH have undertaken separate audits of the transitions process within their respective organisations. A sample of 10 cases where service users were to transition from children's to adult's services during the current financial year were used to assess the effectiveness of the transition arrangements. All 10 cases came under the responsibility of the Joint Transitions Team as they were located in the Inner Moray Firth Area. Records for each transition case were held on CareFirst, a dedicated SharePoint site and paper records.

2. Main Findings

2.1 *The Council has a clear and effective process for the planning of the transition of young people to adult services.*

This objective was partially achieved. There was a process for transition from children's to adult services and the basic steps for this were set out in 3 documents; a draft NHSH Standard Operating Procedure and a draft Transitions Pathway. There was also a funding flow chart confirming resource allocation between the Council and NHSH. However, parts of the process were not all formally documented, in particular the expectation of all parties with regard to meeting agendas and record keeping. This made it difficult to get a concise universally accepted understanding of a case's status and who was responsible for any outstanding matters.

Prior to the existence of the draft Standard Operating Procedure, draft Transitions Pathway and funding flow chart there was a Joint Transitions Protocol (2016) to establish best practice in transition planning. This was not being used and was considered out of date by the Joint Transitions Team. This usefully referred to key tasks and expectations where both organisations were lead agency and referred to a quality assurance mechanism for monitoring adherence to service pathways. There was therefore scope to better document the transitions process (See Action Plan M1).

2.2 *There are effective partnership arrangements in place to ensure that delays do not occur in the transition process.*

This objective was partially achieved. There was evidence that all 10 of the sample cases had been made known to NHSH adult services in a timely manner and evidence of joint working between the Council and NHSH at an operational level to achieve the transition outcomes. There was inconsistency in recording key information relating to transitions for example allocating social workers and in evidencing handover of key information (although Council social workers did confirm there were verbal exchanges of information). For the 10 cases, 5 had transitioned on time by the expected date. 5 of the cases had not transitioned because they had not reached the handover date but from the evidence

reviewed (with 1 exception referred to below) were on course to meet these dates.

For 3 of the 10 cases (2 which had transitioned and 1 which had yet to do so) there were also delays in NHSH taking over responsibility for the service provision resulting in Self Directed Support payments and agreement had been reached whereby the Council would continue to meet these costs. For 1 of these cases the delay could be explained by the difficulties of obtaining a guardianship order but the other 2 demonstrated delays in the planning process which may have been prevented by the Joint Transitions Team establishing early agreement on what funding would be required and who would be liable for payment.

For 1 of the 5 cases that had not yet transitioned this was because there had been significant delays to transition. Suitable residential accommodation provided by NHSH adult services had not been identified so the individual continued to occupy a Council residential site affecting the provision of respite accommodation for other children's service users. In this case the Council and NHSH have been in dispute over payment obligations. There was a Partnership Integration Scheme between the Council and NHSH that set out arrangements to be followed to resolve disputes. However, this was not being fully utilised to seek operational resolution (See Action Plan H1).

2.3 *All relevant services within the Council, including Education, engage effectively with NHS Highland to enable the identification of young people who are either in receipt of services or may require these in the future.*

This objective was substantially achieved. For the area reviewed, there were processes in place to enable communication within Council services, including Education, to enable early identification of young people who are either in receipt of services or may require these in the future, to enable a managed transition to NHSH provision. For 9 of the 10 cases the individual had been known to the Joint Transitions Team several months or even years ahead of any expected transition date and for the 1 other case the Education Service had referred the individual direct to NHSH indicating they had understood the process. There was joint working between the Council part of the Joint Transitions Team and both the child health and disabilty service and Education respectively.

Education Practice Leads (who liaise with schools to assess young people and then refer young people to the Joint Transitions Team) acknowledged there was scope to further improve Education staff's knowledge on making sure all young people who may require a service were made known to them. There remains a risk that existing service provision may be subject to change as service users reach adulthood, so raising awareness of the transition process and service is key. (See Action Plan L1).

2.4 *The transition process considers the children's services provided and how these transfer over to adult services.*

This objective was substantially achieved. There were adequate processes in place to ensure that transition arrangements consider the children's services provided and how these transfer over to adult services. At an operational level there was evidence of joint working between the Council social work part of the Joint Transitions Team and the NHSH social work team. There was evidence of an NHSH social worker being made aware of the service user in advance of the transition date and all parties had access to child plans, care plans and observations on the systems (CareFirst and SharePoint). However, there was an opportunity to further support the transition process through improved record keeping, for 1 of the sample cases the details of when an NHSH social worker had been allocated had not been recorded and processes were not in place to ensure that expected transiton dates were recorded in one place.

A failure to adequately record key information regarding transitions cases could hinder an effective and timely consideration of services required for transition. There was a risk of disagreement and dispute between partners in the Joint Transitions Team over their responsibilities if there were inadequate or inconsistent records for each case. (See Action Plan M2).

2.5 *There is regular reporting to the Council's Health, Social Care and Wellbeing Committee, and the Joint Monitoring Committee to enable effective scrutiny of the transitions process.*

This objective was not achieved. The Health, Social Care and Wellbeing Committee regularly received the minutes of the Joint Monitoring Committee (JMC) for noting. There was separate reporting on children's and adults' services by the Council and NHSH to the JMC. For the minutes of the meetings reviewed there were very little reported on the work of the Joint Transitions Team or the transitions process to either Committee, with the exception of updates on the Adult Social Care improving transition outcomes project which was part of the Council's Delivery plan. The separate reports on adults and children's services reported on progress achieving respective strategic plans, key performance indicators and financial performance of the respective partners. But there was little reference to the Joint Transition Team's objectives, work, performance or budgets. There were isolated transition references in the separate reports for example the Council referred to a significant cost pressure related to one case. There was scope to improve the transparency surrounding and communication of the Joint Transitions Team's remit and operations to allow members of the JMC to effectively scrutinise the process (See Action Plan M3).

There was a risk register prepared by the Joint Officer Group which was reported to the JMC for review. This listed the transitions process as a risk and recorded some mitigating actions. However, there was scope to enhance the risk register and risk reporting in line with best practice by establishing a clear risk appetite, better defining scoring criteria, allocating individuals as risk owners, detailing mitigation strategies with explanations of their impact, and setting out clear actions with defined timescales.

There was also an opportunity to increase transparency surrounding both partner organisation's risks that could impact transitions arrangements administered by the Joint Transitions Team. (see action plan M4).

3. Conclusion

3.1 There was good evidence that, at an operational level, the Joint Transitions Team was working collaboratively and prioritising the needs of young people during their transition to adult services. While adequate processes existed to support transitions from the Council to NHS Highland, these did not consistently result in timely service delivery. The absence of comprehensive written procedures, current agreements, and proactive planning can hinder the effectiveness of service provision.

This audit has highlighted clear opportunities to strengthen existing processes. Implementation of the recommendations outlined in Section 4 of this report will support management in making improvements.

It is important to note that this audit was conducted during a period of review of the integration scheme model, which may influence future developments in service delivery and governance.

4. Action Plan

Ref	Priority	Finding	Recommendation	Management Response	Implementation	
					Responsible Officer	Target Date
H1	High	The Council and NHSH have been in dispute over payment obligations. There was a Partnership Integration Scheme between the Council and NHSH that set out arrangements to be followed to resolve disputes. However, this was not being fully utilised to seek operational resolution.	An effective method for early resolution of disputes including an escalation process should be agreed and implemented so any potential delays in transferring accommodation are communicated to senior managers as early as possible.	In relation to operational disputes which result in increased risk to a service an escalation process should be co designed and implemented by THC and NHSH that links to the risk register allowing for early communication to senior management.	Chief Officer Health and Social Care	31/12/25
M1	Medium	Parts of the transitions process were not formally documented, in particular the expectation of all parties with regard to meeting agendas and record keeping.	The Joint Transitions Team would benefit from setting out all key tasks in the transitions process in a formal document including a minimum expectation for meeting records, specifically having action points for each meeting to show tasks, assigned responsibility and timescales so that there is clear accountability.	Joint meeting template to be agreed including actions and timescales, to be recorded on Client's file.	Strategic Lead Care & Support	31/12/25
		A Joint Protocol to establish best practice and set out respective lead agency responsibilities and a quality assurance mechanism existed but was not being used and considered out of date.	The Joint Protocol should be reviewed and brought up to date particularly to include a robust quality assurance mechanism for assessing the Transitions Service's performance.	Updated Joint Transition procedures to be agreed between the Council and NHSH be in line with National Transitions to Adulthood Strategy for Young Disabled People 2025-2030. To include pathway of support, funding and timescale. Introduction of a checklist identifying tasks for each organisation and timescales within the transition journey.	Strategic Lead Care & Support	31/03/26

Ref	Priority	Finding	Recommendation	Management Response	Implementation	
					Responsible Officer	**Target Date**
M2	Medium	There was an opportunity to further support the transition process through improved record keeping.	The Joint Transitions Team should improve record keeping to better support an effective transitions process. It would be good practice to ensure the systems are kept up to date for all referrals, requests for service and allocated workers. Having a written record of the planned transition date for all different services for each service user would ensure both parties in the Joint Transitions Team have an indisputable set of dates where services should transfer.	Procedures to be agreed between The Council and NHSH that will include a recorded planned transition date within transition pathway and will be recorded within the Transition checklist of the client.	Strategic Lead Care & Support	31/03/26
M3	Medium	There were very few references to the work of the Joint Transitions Team (or the transitions process reported to either the Health, Social Care & Wellbeing Committee or the Joint Monitoring Committee so performance was difficult to scrutinise.	The Partnership should agree a set of indicators to monitor the performance of the Joint Transitions Team and transitions process. These should be regularly reported to the Joint Monitoring Committee.	The recommendation will be implemented. Implementation of this recommendation along with M4 will allow for joint monitoring, review analysis and reporting of the Joint transition team only, this should also include all children's Disability services with a sub section of Joint Transition team, this should be a co-produced report by the Council and NHSH.	Lead Officer Strategy, Performance and Quality Assurance with input from Strategic Lead Care & Support	31/12/25
M4	Medium	There was a risk register prepared by the Joint Officer Group and reported to the Joint Monitoring Committee for review. This listed the transitions process as a risk and briefly listed some mitigating actions. There was scope to enhance the risk register and risk reporting in	The risk register should be updated to reflect good risk management practices by: • Establishing the risk appetite • Clarifying risk scoring criteria • Including more detailed mitigation actions	The recommendation will be implemented. This recommendation would allow for clear communication between agencies of the current service risks and the implications of NHSH risks to the Council both now and for forecasting measures and should include all	Lead Officer Strategy, Performance and Quality Assurance	31/12/25

Ref	Priority	Finding	Recommendation	Management Response	Implementation	
					Responsible Officer	**Target Date**
		line with best practice by establishing a clear risk appetite, better defining scoring criteria, allocating individuals as risk owners, detailing mitigation strategies with explanations of their impact, and setting out clear actions with defined timescales.	• Improving accountability with clear risk ownership • Explaining how mitigations reduce risk • Setting timescales for actions • Improving visibility of risks from all partner organisations that may affect transition arrangements. The risk register should be reviewed regularly to show how mitigations are influencing risk levels.	children's Disability Services along with Joint Transitions team.		
L1	Low	Whilst referrals were being made to the Joint Transitions Team by Education there was scope to increase staff awareness of the referral process to ensure young people who may require a service were being identified and assessed.	A communication and training refresh should go out to targeted key people in schools to facilitate referrals.	This recommendation will be implemented. This should be co-produced by both Education services and the children's disability team as will have a pan Highland effect.	Strategic Lead Care and Support	30/06/26

Internal Audit Final Report

People Cluster - Health and Social Care

Family Teams - child protection

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	3
Minor issues that are not critical but managers should address.	Low	2

Distribution:
Assistant Chief Executive - People
Chief Officer - Health and Social Care
Transition Head of Children and Justice
Strategic Lead Early Intervention and Protection
Strategic Lead Care and Support
Lead Officer Child Protection Committee
Business Manager Health and Social Care
Strategic Lead GIRFEC in Education
Child Protection Advisor, Education

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 **Substantial Assurance** can be given in that while there is 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 at risk.

Draft Date: 08/10/2025
Final Date: 27/10/2025

1. Introduction

1.1 Family Teams made up of Social Workers, Child Health professionals and support workers, work with multiple Council Services and other public agencies to support children and their families. The audit examined the child protection remit of Family Teams to ensure that Health and Social Care (H&SC) have identified the critical needs of child protection, prioritise work in the context of areas of highest risk and meet requirements set out by legislation and Scottish Government guidance.

1.2 Child protection refers to the processes and procedures involved in the assessment and planning of required action (together with the actions themselves) where there are concerns that a child may be at risk of harm. Getting It Right For Every Child (GIRFEC) is the Scottish Government's framework which sets out expectations for organisations responsible for supporting children.

1.3 There were 11 Family Teams covering defined geographical areas in Highland (e.g. Sutherland, Lochaber etc), each was overseen by a Practice Lead (Senior Social Worker). Concerns relating to children should be recorded on standard Child Concern Forms with CareFirst used to record Social Work involvement with children. The audit did not look at other work undertaken by Family Teams focusing solely on child protection.

2. Main Findings

2.1 *There are processes in place to ensure all children in the Highland Council area have access to a named person.*

This objective was substantially achieved. There were processes in place to ensure children had access to a named person, but these depend on individuals being in contact with the Council. The majority of children were covered by Health Visitors (for under 5s) and Headteachers for those enrolled in schools. Others known to the Council were to be assigned to other officers in Health or Education. Whilst most children accessed a named person via Head Teachers and Health Visitors not all of the exceptions to these were set out in an up-to-date document accessible to all Services. The Education Service had recently been restructured and was reviewing its arrangements for named persons in terms of who would be assigned for exceptions (See Action Plan M1).

2.2 *Statutory service requirements relating to child protection are identified and delivered effectively. All children involved in formal child protection processes are supported by a lead professional from Social Work.*

This objective was substantially achieved as there was a good control framework in place to handle child protection matters in accordance with legislative requirements and guidance. A Child Protection Committee (CPC) was in place and met regularly, detailed polices and guidance in line with national legislation and guidance had been published. Training on child protection was offered to all officers and attendance records were held by CPC officers with a summary of attendance (by course and Service) reported to CPC meetings.

The Council and CPC websites clearly showed the teams the public could contact if they had a concern about a child and what to do if a child was at immediate risk of harm. There was evidence that child protection concerns received were responded to appropriately and there were adequate processes for receiving concerns. A sample of concerns was reviewed, and responses seen to be reasonable and proportionate i.e. appropriate action was taken in a reasonable time frame. There were processes to receive concerns and some good evidence of concerns being allocated to the correct team timeously. There were also good processes in place to ensure that the Child Protection Register was kept up to date so all Services including relevant named persons were aware of this higher risk category of children.

However, there was scope to make improvements. There were some inconsistencies in how cases were recorded particularly in having a concise "next steps" note so Practice Leads could easily see what action was needed for open cases. It was also sometimes difficult to determine from records who the lead professional was for some cases, although there was good evidence Social Workers and Practice Leads were involved in all cases and knowledgeable about them. There was uncertainty across area Family Teams on whether all concerns should be recorded on CareFirst and an ongoing risk that concerns may be directed to personal mailboxes

which could lead to delays in responding if the individual was absent. The child protection processes on the CPC website were contained in a 156-page document which whilst extensive and detailed, reflecting legislation and Scottish Government guidance, did not concisely summarise the child protection process. Procedures were also made accessible via an electronic toolkit and mobile app for practitioners on Getting it right for every child & young person in Highland: interagency practice model & child protection procedures 2024. The Family Teams acknowledged a more practical operational process document would be beneficial (See M2). There was no clear process for managing cumulative concerns that, over time, or when combined, could indicate grounds for concern (See M3).

There was detailed data on child protection and evidence this was being reviewed by management and a sub-committee of the CPC, although the Service was working on several reviews to improve data quality for example on ensuring cases were correctly allocated to individual teams and workers on CareFirst and that referrals were not duplicated. There was reasonable reporting to the CPC and the Health and Social Care and Wellbeing Committee although the minutes of the CPC were not being consistently reported to the Health Social Care and Wellbeing Committee (See L1).

There was evidence of H&SC Service quality review. The Service was undertaking various reviews to improve processes, practice and data quality and acknowledged that the referrals process was a key part of that work. The Service also undertook its own audits of Interagency Referral Discussions and a more detailed annual review of a sample of child protection investigations using Care Inspectorate criteria. There were also internal management meetings to review quality with some action points raised. A consistent format for action plans and monitoring progress with implementation would be beneficial to aid and demonstrate improvement (See L2).

2.3 *Service initiatives to address staff shortages within Family Teams are effective, with adequate monitoring of the outcomes of these initiatives.*

This objective was achieved. The Service was aware of its staffing entitlement and vacancies and used this data to monitor its staffing levels. Staff shortages were a longstanding risk and managing this risk has to be seen in the context of a national shortage of Social Workers. A number of initiatives to address staffing shortages were being undertaken; although the Service acknowledged these had had some effect on vacancies it was too early to realise the full impact on service delivery. There was reporting to Health and Social Care and Wellbeing Committee on the staffing position and initiatives.

3. Conclusion

3.1 The Family Teams Service and the supporting Child Protection Committee had a good control framework for handling child protection concerns with policies, procedures, training and knowledge in place. There was evidence that cases were being handled appropriately. The Service demonstrated good management practice with a formalised process of internal review to drive improvement and had a good understanding of current areas for attention. There was further scope to enhance consistency of operational practice and to make the Named Person process more transparent and clearly communicated. Although this audit has focused on Family Teams, the effectiveness of this Service is closely tied to strong collaboration with other Services. In particular, the Education Service plays an invaluable role in supporting the raising of child protection concerns.

4. Action Plan

Ref	Priority	Finding	Recommendation	Management Response	Implementation	
					Responsible Officer	**Target Date**
M1	Medium	Most children had access to a named person and were covered by Health Visitors (for under 5s) and Headteachers for those enrolled in schools. For some scenarios there was less clarity on who the named person provided was and no single up to date written document setting out all the different scenarios of who the named person would be.	There should be an up-to-date document setting out who is the named person in each scenario. This should be publicly available and communicated to all Services particularly all teams in H&SC and Education and ensure that all Highland residents and agencies working with children know who will be responsible for coordinating concerns.	This will be coordinated with Education including seeking clarity on assigned named persons for all scenarios. Whilst the policy is publicly available it recognised it could be more accessible. When the replacement Highland Council website goes live, the Highland Practice Model will be more easily accessible.	Strategic Lead Care and Support	31/01/26
M2	Medium	The child protection process was not concisely documented to inform standard operating practices with regard to recording referrals and case information. The audit also recognised inconsistencies in whether all concerns should be recorded on CareFirst and an ongoing risk that concerns may be directed to personal mailboxes.	An operational document should be produced setting out standard practice with regard to recording referrals and case information. This document should clarify on what is to be recorded on CareFirst. The Service should ensure that processes avoid reliance on use of personal mailboxes.	There are procedures in place therefore in the first instance a reminder will be issued and then followed up with refresher training being communicated and made available to ensure compliance with the procedures surrounding referrals. This area will be highlighted as an area for improvement with the Child Protection Committee.	Lead Officer Child Protection Committee	30/06/26
M3	Medium	There was no clear process for managing cumulative concerns that, over time, or when combined, could indicate grounds for concern.	A process should be documented and implemented for recognising cumulative concerns that, over time, or when combined, could indicate grounds for concern.	GIRFEC/ Locality solution focussed meetings are to be reinstated that will help to mitigate this risk area. This will be raised with, and reassurance sought from the Child Protection Committee that processes for raising, recording and responding to cumulative	Lead Officer Child Protection Committee	28/02/26

Ref	Priority	Finding	Recommendation	Management Response	Implementation	
					Responsible Officer	**Target Date**
				concerns are appropriate, proportionate and consistent.		
L1	Low	The Child Protection Committee minutes were not consistently reported to the Health and Social Care and Wellbeing Committee.	Child Protection Committee minutes should be consistently and regularly reported to the Health Social Care and Wellbeing Committee.	In future the CPC minutes will be provided timeously to the Health Social Care and Wellbeing Committee.	Lead Officer Child Protection Committee	28/02/26
L2	Low	There were a number of quality assurance reviews, audits and management reviews to improve practice. But there was no consistent recording of action plans from this work setting out actions, responsible officers and next steps.	All Service reviews and audits should have an action plan template summarising findings next steps responsible officers and timescales. Progress with implementation should be monitored at respective management meetings or the Child Protection Committee and Health and Social Care and Wellbeing Committee as appropriate.	All learning from single agency audit activity will be shared across the wider children service partnership so that there is consistent reporting of the improvement journey to appropriate committees.	Strategic Lead Early Intervention and Protection	31/03/26