Public Document Pack

To: Councillor Malik, Convener; Councillor Houghton, Vice Convener; and Councillors Allard, Bonsell, Bouse, Fairfull, Graham, McLellan, McRae, Massey, Radley, Mrs Stewart and van Sweeden.

Town House,
ABERDEEN 6 September 2023

AUDIT, RISK AND SCRUTINY COMMITTEE

The Members of the **AUDIT, RISK AND SCRUTINY COMMITTEE** are requested to meet in **Council Chamber - Town House on THURSDAY, 14 SEPTEMBER 2023 at 2.00 pm. This is a hybrid meeting and Members may also attend remotely.**

The meeting will be webcast and a live stream can be viewed on the Council's website. https://aberdeen.public-i.tv/core/portal/home

JENNI LAWSON
INTERIM CHIEF OFFICER – GOVERNANCE (LEGAL)

B U S I N E S S

NOTIFICATION OF URGENT BUSINESS

1.1 There are no items of urgent business at this time

DETERMINATION OF EXEMPT BUSINESS

2.1 Members are requested to determine that any exempt business be considered with the Press and Public excluded

DECLARATIONS OF INTEREST

3.1 Members are requested to intimate any declarations of interest

DEPUTATIONS

4.1 There are no requests at this time

MINUTES OF PREVIOUS MEETING

5.1 Minute of Previous Meeting of 27 June 2023 (Pages 5 - 10)

5.2 Minute of Special Meeting of 15 August 2023 (Pages 11 - 14)

COMMITTEE PLANNER

6.1 Committee Business Planner (Pages 15 - 16)

NOTICES OF MOTION

7.1 There are none at this time

REFERRALS FROM COUNCIL, COMMITTEES AND SUB COMMITTEES

8.1 There are no referrals at this time

COMMITTEE BUSINESS

Risk Management

9.1 Information Governance Management Annual Statement 2022-2023 - CUS/23/293 (Pages 17 - 32)

Legal Obligations

9.2 Use of Investigatory Powers Report - Quarter 3 - GOV/23/292 (Pages 33 - 40)

Internal Audit

9.3 Internal Audit Progress Report - IA/23/008 (Pages 41 - 60)

9.4 Adults with Incapacity - AC2314 (Pages 61 - 82)

EXEMPT/CONFIDENTIAL BUSINESS

10.1 There are no items of exempt business at this time.

Should you require any further information about this agenda, please contact Karen Finch, tel 01224 053945 or email kfinch@aberdeencity.gov.uk

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AUDIT, RISK AND SCRUTINY COMMITTEE

ABERDEEN, 27 June 2023. Minute of Meeting of the AUDIT, RISK AND SCRUTINY COMMITTEE. Present:- Councillor Houghton, Vice-Convener; and Councillors Ali, Allard, Bonsell, Bouse, Fairfull, Kusznir (as substitute for Councillor Houghton), McLellan, McRae, Malik, Massey, Radley, Mrs Stewart and van Sweeden.

The agenda and reports associated with this minute can be found here.

Please note that if any changes are made to this minute at the point of approval, these will be outlined in the subsequent minute and this document will not be retrospectively altered.

APPOINTMENT OF CONVENER

1. In the absence of the Convener, and as the Vice Convener was joining the meeting online, in terms of SO 19.1.3 the Committee agreed to appoint Councillor Malik to chair the meeting.

DECLARATIONS OF INTEREST OR TRANSPARENCY STATEMENTS

2. There were no declarations of interest or transparency statements made.

MINUTE OF PREVIOUS MEETING OF 11 MAY 2023

3. The Committee had before it the minute of their previous meeting of 11 May 2023.

The Committee resolved:-
to approve the minute as a correct record.

COMMITTEE BUSINESS PLANNER

4. The Committee had before it the Committee Business Planner as prepared by te Interim Chief Officer – Governance (Assurance).

The Committee resolved:-
to note the content of the business planner.

ALEO ASSURANCE HUB - COM/23/180

5. The Committee had before it a report by the Director of Commissioning which provided assurance on the governance arrangements, risk management and financial management of Arm's Length External Organisations (ALEO's) as detailed within the ALEO Assurance Hub's Terms of Reference.

AUDIT, RISK AND SCRUTINY COMMITTEE
27 June 2023

The report recommended:-
That the Committee -
(a) notes the level of assurance provided by each ALEO on governance arrangements, risk management and financial management;
(b) notes that the report incorporated Hub officers' initial levels of assurance of the governance arrangements, risk management and financial management of bp Aberdeen Hydrogen Energy Limited; and
(c) notes that the Assurance Hub officers and ALEO Service Leads would discuss any outstanding issues specified in the appendices and identified at the Audit, Risk and Scrutiny Committee with ALEO representatives, with a view to further improving the assessment ratings at the next Hub meeting.

In response to a request from a member, the Interim Chief Officer – Governance (Assurance) agreed that for future reports the appendices would contain a title.

In response to a question relating to Bon Accord care and the financial information presented in the additional circulation, to note that there was a typographical error and that the financial year should have been for 2022-2023.

In response to a question relating to Bon Accord Care and the increase in demand for services, the Director for Commissioning advised that with the demographics of the city, the demand for care services and in particular specialised services had been increasing and that these were being managed via the strategic plan that had been approved by Bon Accord Care recently, a copy of which could be circulated to the Committee for their information.

In response to a question relating to the low risk rating at Appendix H – Sport Aberdeen and whether the Council were required to notify Auditors of the Judicial Review relating to the closure of Bucksburn Swimming Pool, the Interim Chief Officers – Governance advised that there was no requirement to notify auditors of the Judicial Review process and that until such time as that process had concluded the risk rating remained at low.

The Committee resolved:-
to approve the recommendations contained in the report.

USE OF INVESTIGATORY POWERS Q2 - COM/23/181

6. The Committee had before it a report by the Director of Commissioning which was provided to ensure that Elected Members reviewed the Council's use of investigatory powers on a quarterly basis and had oversight that those powers were being used consistently in accordance with the Use of Investigatory Powers Policy.

The report recommended:-
that the Committee note the covert surveillance activity.

In response to questions relating to the level of participation from the most recent poll and awareness raising, Ms Johnstone advised that a number of officers had access to the portal, however around 30% of them were more frequent users and responded on a regular basis. She further advised that the portal was a restricted portal which contained training materials and polls for users to complete.

In response to a question relating to the assurance that the Scheme was working effectively, Ms Johnstone advised that Authorised Officers reviewed and where appropriate approved applications as they were submitted.

The Committee resolved:-
to approve the recommendation contained in the report.

LOCAL GOVERNMENT TRANSPARENCY CODE - CUS/23/179

7. With reference to article 17 of the minute of meeting of Council of 22 February 2023, the Committee had before it a report by the Director of Customer Services which presented a report in response to the notice of motion from Councillor Kusznir, which requested the preparation of a feasibility study to explore the establishment of a parallel Local Government Transparency Code, similar to the one in place for local authorities in England.

The report recommended:-
that the Committee –
(a) note the current position regarding data publication and compliance; and
(b) note that a report from the Chief Officer – Customer Experience and People and Organisational Development will be provided pending the outcome of Scottish Government consultation and further review.

In response to a question regarding how many of the total number of requests had come from Councillors, the Customer Services Manager advised that she would liaise with colleagues to see if that data was still collected and whether it was consistant.

In response to a question regarding the number of requests for spatial data to be published, the Chief Officer – Data Insights advised that the figure was very low and that he would circulate the information via email.

In response to questions regarding why the Council could not proceed prior to the outcome of the Scottish Government consultation and the timeframe for reporting, the Chief Officer – People and Organisational Development and Customer Experience advised that the Council were required to comply with the Code, Scottish Government guidance and legislation. She further advised that there were resource implications as further changes may be required following the results of the consultation. In relation to

the timeframe for reporting, it was noted that it was not currently known when the findings from the consultation would be available.

Councillor Allard, seconded by Councillor McLellan moved:-
That the Committee approve the recommendations contained within the report.

Councillor Kusznir, seconded by Councillor Massey, moved as an amendment:-
That the Committee:-
2.1 understands the current position regarding data publication and compliance in Scotland; and
2.2 instructs the chief officer – Customer Experience and People and Organisational Development to come back to committee following the publication of the results of the recent consultation to further consider the progression of a parallel Aberdeen Taxpayers Transparency Code for approval.

On a division, there voted:- for the motion (7) – Councillors Allard, Bouse, Fairfull, McLellan, McRae, Radley and van Sweeden; for the amendment (6) – the Convener and Councillors Ali, Bonsell, Kusznir, Massey and Mrs Stewart.

The Committee resolved:-
to adopt the motion.

In terms of Standing Order 34.1, Councillor Kusznir intimated that he would like this matter to be referred to full Council in order for a final decision to be taken. Councillor Kusznir was supported by the Convener, and Councillors Ali, Bonsell, Massey and Mrs Stewart.

SCOTTISH PUBLIC SERVICES OMBUDSMAN DECISIONS AND INSPECTOR OF CREMATIONS COMPLAINT DECISIONS - CUS/23/177

8. With reference to article 8 of the minute of it's meeting of 23 March 2023, the Committee had before it a report by the Director of Customer Services which provided information on all Scottish Public Services Ombudsman (SPSO) and Inspector of Cremations decisions made in relation to Aberdeen City Council since the last reporting cycle, to provide assurance to Committee that complaints and Scottish Welfare Fund applications were being handled appropriately.

The report recommended:-
that the Committee note the details of the report.

The Committee resolved:-
to approve the recommendation contained in the report.

AUDIT, RISK AND SCRUTINY COMMITTEE
27 June 2023

INTERNAL AUDIT PROGRESS REPORT - IA/23/006

9. With reference to article 7 of the minute of it's previous meeting, the Committee had before it a report by the Chief Internal Auditor which provided an update on the progress against the approved Internal Audit plans, audit recommendations follow up and other relevant matters for the Committee to be aware of.

The report recommended:-
That the Committee:
(a) note the progress of the Internal Audit Plan; and
(b) note the progress that management had made with implementing recommendations agreed in Internal Audit reports.

In response to questions from Members, the Chief Internal Auditor advised that Internal Audit follow up with management on all outstanding audit recommendations and that five of the ten outstanding recommendations have been progressed since the report had been issued.

The Chief Officer – Finance apologised for not submitting responses to the Chief Internal Auditor ahead of the papers being issued and that he would provide the updates after the meeting.

The Committee resolved:-
to approve the recommendations contained in the report.

INTERNAL AUDIT ANNUAL REPORT 2022-2023 - IA/23/007

10. The Committee had before it a report by the Chief Internal Auditor which presented the Internal Audit Annual Report for 2022-23.

The report recommended:-
That the Committee -
(i) to note the Annual Report for 2022/23;
(ii) to note that the Chief Internal Auditor had confirmed the organisational independence of Internal Audit;
(iii) to note that there had been no limitation to the scope of Internal Audit work during 2022/23;
(iv) to note the outcome of Internal Audit's self-assessment against the requirements of the Public Sector Internal Audit Standards; and
(v) to note the content of Internal Audit's Quality Assurance and Improvement Plan.

In response to a question regarding how the areas of risk were identified, the Chief Internal Auditor advised that previous audit findings, the audit planning process and discussions were used to identify the risks to the Council.

In response to a question regarding the whether time was allocated for Consultancy or additional works, the Chief Internal Auditor advised that 10% of audit time was built into the schedule to cover unscheduled reviews.

In response to a question regarding the key performance indicators, the Chief Internal Auditor advised that a new audit methodology was introduced in April 2022 and that there had been a significant number of previous years audits carried over into the 2022-23 assurance year which had impacted the ability to complete the scheduled audits for the year.

In response to a question regarding the quality assurance and improvement plan, the Chief Internal Auditor advised that all of the recommendations had been closed off and that an external quality assessment was currently underway.

In response to a question regarding the percentage of audits completed, the Chief Internal Auditor advised that the remaining reviews were with management and that he expected these to be finalised giving 100% complete for next year.

The Committee resolved:-
to approve the recommendations contained in the report.

- **COUNCILLOR M. TAUQEER MALIK, Convener**

AUDIT, RISK AND SCRUTINY COMMITTEE

ABERDEEN, 15 August 2023. Minute of Meeting of the AUDIT, RISK AND SCRUTINY COMMITTEE. Present:- Councillor Malik, Convener; Councillor Houghton, Vice-Convener; and Councillors Al-Samarai (as substitute for Councillor Radley), Ali, Allard, Bonsell, Bouse, Fairfull, McLellan, McRae, Massey, Mrs Stewart and Yuill (as substitute for Councillor van Sweeden).

The agenda and reports associated with this minute can be found here.

Please note that if any changes are made to this minute at the point of approval, these will be outlined in the subsequent minute and this document will not be retrospectively altered.

DECLARATIONS OF INTEREST OR TRANSPARENCY STATEMENTS

1. There were no declarations of interest or transparency statements made.

COMMITTEE BUSINESS PLANNER

2. The Committee had before it the Committee Business Planner as prepared by the Interim Chief Officer – Governance (Assurance).

The Committee resolved:-

(i) to delete item 8 (SPSO Decisions, Inspector of Crematoria Complaint Decisions) due to no decisions being published since the last report to the Committee; and

(ii) to otherwise note the content of the business planner.

EXTERNAL AUDITOR'S REPORT ON THE AUDIT OF THE 2022/23 ANNUAL ACCOUNTS

3. The Committee had before it a report by Audit Scotland, External Auditors which presented their draft annual external audit report and summarised their audit opinions and conclusions on significant issues arising from the audit of the Council's and the registered charities where the Council were the sole trustees 2022/23 annual accounts.

In response to a question relating to the pension assets and how those would be shown in the balance sheet and in future years, Mr Oliphant, External Auditor, advised that this was the first time that pension assets were included in accounts rather than liabilities and that these were based on the figures reported by the Council actuary. He stated that the figures presented in the accounts for future years would depend on the valuation of the assets at the time taking into account that where the value of the minimum funding requirement contribution exceeded the future service cost, the asset should not be recognised.

In response to a question relating to the re-evaluation of the Spots Village and how that impacted the balance sheet, the Chief Officer - Finance advised that there was a rise in the value of the Council owned shares in the Sports Village which had increased the useable reserves. He stated that the funds were not additional cash sums but were grant funds to be used for specific purposes, that were not yet spent in the annual accounts for 2022-23.

In response to a question relating to the materiality levels and how those figures were arrived at, Ms MacDonald, External Auditor, advised that (1) for the overall materiality, some aspects of audit work were based on professional judgement and that the 1.5% had been set based on intelligence gathered from the previous external auditor and known factors such as the control and environment in place; (2) for the performance materiality, the figure set is used as a guide to inform the auditor of any additional work that may be required if that target was to be reached or there was a cause for concern; and (3) for the reporting threshold, as auditors there is a requirement to report anything to those charged with governance on all unadjusted misstatements that were more than the threshold amount of £250,000.

In response to a question relating to the 5 recommendations contained in the action plan and the reporting mechanisms for those, Ms MacDonald, External Auditor advised that the recommendations would be included in the planning for the audit of the 2023/24 accounts and that a report would be submitted to this Committee providing a progress update on those recommendations in Spring 2024. The Chief Officer – Finance advised that the Council's Risk Board would be monitoring the recommendations to ensure that they were being completed.

The Committee resolved:-
(i) to note the content of the report;
(ii) to note that in relation to the action plan, that a progress report would be submitted to this Committee in early 2024; and
(iii) to thank the External Auditors and Council employees for their work on the annual accounts.

AUDITED ANNUAL ACCOUNTS 2022/23 - RES/23/261

4. With reference to article 4 of the minute of its meeting of 11 May 2023, the Committee had before it a report by the Director of Resources which sought approval for (1) the signing of the Council's 2022/23 audited Annual Accounts; and (2) a nominated trustee (Councillor) to sign the registered charities accounts for 2022/23.

The report recommended:-
That the Committee -
(a) approve the Council's audited Annual Accounts for the financial year 2022/23; and
(b) approve the audited Annual Accounts 2022/23 for those registered charities where the Council is the sole trustee and nominate a trustee to sign the accounts.

In relation to queries relating to the descriptions relating to Council Tax Income (states Income Tax due) and the HRA in relation to Ratio of Financing Costs to Net Revenue (missing some text after Gross) on page 66 of the annual accounts, the Chief Officer – Finance advised that he would ensure the corrections were made to the accounts.

In response to a question relating to the management commentary to the accounts and how those matched to the accounts, the Chief Officer – Finance advised that there were a number of factors that make up the accounts, some of which were complex and that for future reports he would see where improvements could be made to make the information clearer.

In response to a question relating to the current level of Covid 19 grant funding and whether there were conditions attached to how it could be spent, the Chief Officer – Finance advised that the remaining Covid 19 grant funding had been earmarked and was currently in the reserves. He stated that the remaining funds would be used to support the Council's financial resilience back up for the current year.

In response to a question around the use of customers in the accounts, the Chief Officer – Finance advised that the language used in the accounts was constantly reviewed and that for future accounts this would be amended.

In response to a question relating to the Council Leaders named in the accounts, the Chief Officer – Finance advised that where there were inaccuracies in the accounts he would amend them.

In response to a question relating to the short term borrowing of £145.6m on the balance sheet from the North East Scotland Pension Fund (NESPF), the Chief Officer – Finance advised that the NESPF had requested that the Council hold funds for them with the Council paying interest for the period it holds the funds.

The Committee resolved:-

(i) to approve the Convener of the Finance and Resources Committee to sign the audited accounts for the registered charities; and

(ii) to otherwise approve the recommendations contained in the report.

- COUNCILLOR M.TAUQEER MALIK, Convener

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	A	B	C	D	E	F	G	H	I
1	**AUDIT, RISK & SCRUTINY COMMITTEE BUSINESS PLANNER** **The Business Planner details the reports which have been instructed by the Committee as well as reports which the Functions expect to be submitting for the calendar year.**								
2	**Report Title**	**Minute Reference/Committee Decision or Purpose of Report**	**Update**	**Report Author**	**Chief Officer**	**Directorate**	**Terms of Reference**	**Delayed or Recommended for removal or transfer, enter either D, R, or T**	**Explanation if delayed, removed or transferred**
3	**14 September**								
4	Use of Investigatory Powers Quarter 3 Report	to present the quarterly use of investigatory powers report	Agenda Item 9.2	Jessica Anderson	Governance	Commissioning	5.2		
5	Internal Audit Update Report	To provide an update on progress of the Internal Audit Plan, Audit Recommendations Follow Up and other relevant information for the Committee.	Agenda Item 9.3	Jamie Dale	Governance	Commissioning	2.2		
6	Adults with Incapacity	The objective of this audit is to ensure that there are evidence-based controls in place regarding funds managed on behalf of clients.	Agenda Item 9.4	Jamie Dale	Governance	Commissioning	2.2		
7	Information Governance Management Annual Report	to present the annual report for the Council's Information Governance	Agenda Item 9.1	Martin Murchie	Data Insights	Customer	1.4		
8	**23 November**								
9	Use of Investigatory Powers Quarter 4 Report	to present the quarterly use of investigatory powers report		Jessica Anderson	Governance	Commissioning	5.2		
10	SPSO Decisions, Inspector of Crematoria Complaint Decisions	In order to provide assurance to Committee that complaints and Scottish Welfare Fund applications are being handled appropriately, this report provides information on all Scottish Public Services Ombudsman (SPSO) and Inspector of Crematoria decisions made in relation to Aberdeen City Council since the last reporting cycle.		Lucy McKenzie	Customer Experience	Customer	6.4		
11	Internal Audit Update Report	To provide an update on progress of the Internal Audit Plan, Audit Recommendations Follow Up and other relevant information for the Committee.		Jamie Dale	Governance	Commissioning	2.2		
12	Internal Audit Reports	Reports which have been finalised will be presented to the Committee.		Jamie Dale	Governance	Commissioning	2.2		
13	External Audit Annual Report	To present the External Audit Annual Report		Anne MacDonald	Governance	Commissioning	3.1		
14	Annual Committee Effectiveness Report	To report on the annual effectiveness of the committee		Karen Finch	Governance	Commissioning	GD 8.5		
15	ALEO Assurance Hub Update	To provide an update of risk and financial management and governance arrangements in accordance with Hub TOR and annual workplan.		Vikki Cuthbert	Governance	Commissioning	1.3		
16	**Service Updates**								

	A	B	C	D	E	F	G	H	I
1	**AUDIT, RISK & SCRUTINY COMMITTEE BUSINESS PLANNER** **The Business Planner details the reports which have been instructed by the Committee as well as reports which the Functions expect to be submitting for the calendar year.**								
2	**Report Title**	**Minute Reference/Committee Decision or Purpose of Report**	**Update**	**Report Author**	**Chief Officer**	**Directorate**	**Terms of Reference**	**Delayed or Recommended for removal or transfer, enter either D, R, or T**	**Explanation if delayed, removed or transferred**
17	Reconciliation of Granite - Union Terrace Gardens	**ARSC 30 June 2022 - Item 3** (v) to add two Service Updates to the business planner, those being: Reconciliation of Granite, Union Terrace Gardens and Review of Items Recorded as 'Missing' From Art Gallery & Museums Collections	Review of Items Recorded as Missing from Art Gallery and Museums Collections was provided in September 2022	John Wilson	Capital	Resources			

ABERDEEN CITY COUNCIL

COMMITTEE	Audit, Risk and Scrutiny
DATE	14 September 2023
EXEMPT	No
CONFIDENTIAL	No
REPORT TITLE	Information Governance Management Annual Statement 2022-2023
REPORT NUMBER	CUS/23/293
DIRECTOR	Gale Beattie
CHIEF OFFICER	Martin Murchie
REPORT AUTHOR	Martin Murchie
TERMS OF REFERENCE	1.4

1. PURPOSE OF REPORT

1.1 To provide Committee with an annual report on the Council's Information Governance Performance, including information about the changes implemented through the Council's information assurance improvement plan.

2. RECOMMENDATION(S)

2.1 It is recommended that Committee:

Note the information provided about the Council's information governance performance at sections 3.1 – 3.5 and in the Information Governance Report at Appendix 1.

3. CURRENT SITUATION

3.1 The Council's Audit, Risk and Scrutiny Committee agreed the Council's revised and updated Information Governance Management & Reporting Framework in September 2016; as part of this the Committee agreed to receive an annual report in relation to the Council's information governance performance.

3.2 Ensuring the proper use and governance of the Council's information and data is an ongoing activity. New and changing legislation, systems, staff, and ways of doing business, as well as new and emerging cyber threats all shape and change the environment within which the Council operates in relation to effective use and governance of its information and data.

3.3 Keeping up means a careful balancing between the requirement to monitor and be adaptable to our changing environment, and the requirement to agree and implement assurance improvements over the medium term.

3.4 To this end, actions to improve assurance in the medium term are identified, actioned and monitored through the Information Governance and Cyber Security risks on the Corporate Risk Register; regular updates on which are reported separately to the Council's Audit, Risk & Scrutiny Committee.

3.5 Please refer to Appendix 1 for the consolidated Annual Report on the Council's Information Governance Performance from April 2022-March 2023.

4. FINANCIAL IMPLICATIONS

There are no direct financial implications arising from this report. There are potential indirect financial implications related to penalties for non-compliance, as outlined at section 5.3, below.

5. LEGAL IMPLICATIONS

5.1 The Council's use and governance of its information is subject to a variety of legislation including: The UK General Data Protection Regulation, the Data Protection Act 2018, the Public Records (Scotland) Act 2011, the Freedom of Information (Scotland) Act 2002, the Environmental Information (Scotland) Regulations 2004, and the Re-use of Public Sector Information Regulations 2015.

5.2 The Annual Information Governance Performance Report at Appendix 1 forms part of the Council's wider Information Governance Management and Reporting Framework and is a key component of ensuring that the Council is undertaking adequate monitoring of its compliance with the above legislation.

5.3 The General Data Protection Regulation and the Data Protection Act 2018 came into force on 25 May 2018 and brought significantly increased penalties for non-compliance with data protection law than was previously the case. The maximum penalty for non-compliance is now 4% of turnover, or €20 million, whichever is higher.

5.4 The approach taken to date has been focussed on ensuring that the Council has a robust framework in place to enable compliance with Data Protection legislation, to reduce the risk that the Council would be subject to enforcement action and financial penalty.

5.5 The UK left has now left the EU, and so applicable Data Protection legislation in the UK is now the UK GDPR, and the Data Protection Act 2018. The UK has now received an 'Adequacy Decision' from the EU in respect of its data protection arrangements, which simplifies the arrangements in relation to data flows between the UK and the EU, now that the transition period has ended.

6. ENVIRONMENTAL IMPLICATIONS

There are no environmental implications arising from this report.

7. RISK

Category	Risks	Primary Controls/Control Actions to achieve Target Risk Level	*Target Risk Level (L, M or H) *taking into account controls/control actions	*Does Target Risk Level Match Appetite Set?
Strategic Risk	Strategic Risk	There are no risks arising directly from the presentation of this report. This report is part of the Council's wider Information Assurance framework which mitigates against information related risk as presented in the Corporate Risk Register	See controls column	Yes
Compliance	Compliance	As above	As above	Not applicable
Operational	Operational	As above	As above	Not applicable
Financial	Financial	As above	As above	Not applicable
Reputational	Reputational	As above	As above	Not applicable
Environment / Climate	Environment/Climate	As above	As above	Not applicable

8. OUTCOMES

COUNCIL DELIVERY PLAN 2022-2023	
	Impact of Report
Aberdeen City Council Policy Statement **Working in Partnership for Aberdeen**	The Council's Information Governance arrangements are a vital part of enabling the Council to realise its aims across its policy statement.
Aberdeen City Local Outcome Improvement Plan	
Prosperous Economy Stretch Outcomes	Information and data are key assets of the Council and recognised in the Aberdeen City Local Outcome Improvement Plan 2016-26 and the Aberdeen City Council Strategic Business Plan as critical enablers of the Council achieving its priorities for people, place and economy. The activities outlined in Appendix 1 of this report framework are focussed on ensuring that the Council's information is good quality, accurate, and up to date to inform decision-making, that it is used and governed in a way which is effective and lawful, that the Council has the right arrangements in place to enable data to be shared appropriately and safely with partners, where this is necessary, and to ensure that our information can effectively evidence our decisions and actions so the Council can demonstrate accountability.
Prosperous People Stretch Outcomes	As above
Prosperous Place Stretch Outcomes	As above
Regional and City Strategies	The Council's Information Governance arrangements are vital to the implementation of regional and city strategies.

9. IMPACT ASSESSMENTS

Assessment	Outcome
Integrated Impact Assessment	Not required
Data Protection Impact Assessment	Not required
Other	Not required

10. BACKGROUND PAPERS

None

11. APPENDICES

Appendix 1: Annual Information Governance Annual Statement 2022-2023

12. REPORT AUTHOR CONTACT DETAILS

Name	Martin Murchie
Title	Chief Officer – Data & Insights
Email Address	mmurchie@aberdeencity.gov.uk

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Information Governance Management

Annual Report 2023

Senior Information Risk Owner

April 2022 - March 2023

1 Introduction

1.1 The Council's Audit, Risk and Scrutiny Committee agreed the Council's revised and updated Information Governance Management & Reporting Framework in September 2016; as part of this the Committee agreed to receive an annual report in relation to the Council's information governance assurance.

1.2 This report collates, analyses and monitors the Council's performance in relation to freedom of information, data protection and information security, to give assurance that trends, issues, incidents, and breaches are dealt with appropriately as they arise.

1.3 Ensuring the proper use and governance of the Council's information and data is an ongoing activity. New and changing legislation, systems, staff, and ways of doing business, as well as new and emerging cyber threats, all shape and change the environment within which the Council operates in relation to effective use and governance of its information and data.

1.4 Keeping up means a careful balancing between the requirement to monitor and be adaptable to our changing environment, and the requirement to agree and implement assurance improvements over the medium term.

1.5 To this end, actions to improve assurance in the medium term are identified, actioned and monitored through the Information Governance and Cyber Security risks on the Corporate Risk Register; regular updates on which are reported separately to the Council's Audit, Risk & Scrutiny Committee.

1.6 The Council's Information Governance arrangements were subject to Internal Audit, reported in February 2020. The objective of the audit was to provide assurance that the Council has adequate controls in place to mitigate the risks identified in the Corporate Risk Register and that these controls are operating as expected. The audit found that comprehensive and clear policies, procedures and mandatory training are in place and that corporate risk and related controls are being monitored by the Information Governance Group, chaired by the Council's Senior Information Risk Owner, with exception reporting to Corporate Management Team. Information Governance controls were found to be comprehensive and control assessments well-supported.

1.7 The National Records of Scotland, Public Records (Scotland) Act (PRSA) 2011 Assessment Team, assessed the Council's annual update of its arrangements under the Act in May 2020. The Assessment Team found that the Council continues to take its statutory obligations seriously and maintains the required records management arrangements in full compliance with the Act.

2. Information Governance Performance Information April 2022 - March 2023

2.1 Data Protection Rights Requests

Fig 1: Annual number of requests received

Type of Request	2021/22	2022/23
Subject Access	258	298
Third Party	327	395
Other Rights Request	17	23

Fig 2: Requests received in the 12 month to end March 2023

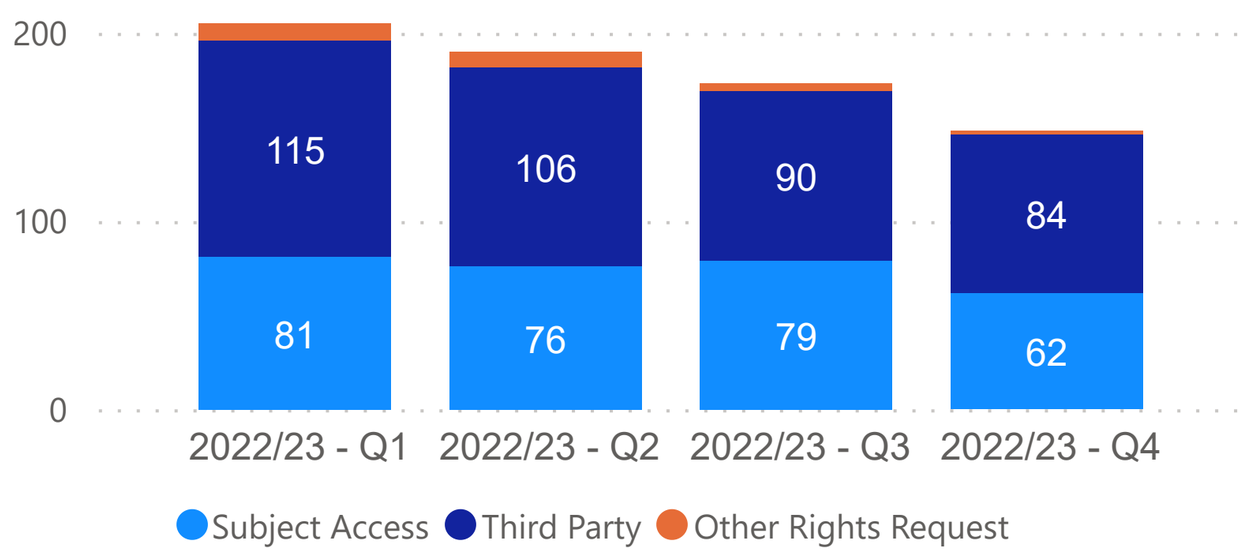


Fig 3: Corporate compliance with timescales for requests

Type of Request	2021/22	2022/23
Subject Access	77%	68%
Third Party	84%	83%
Other Rights Request	88%	91%

Data Protection Rights Requests

Data protection law gives people certain rights about their data, including the right to access their data.

Third Party Requests

Other organisations (for example, Police Scotland, or the Care Inspectorate) can also request a customer's personal data under certain circumstances.

Other Rights Requests

In certain circumstances individuals have other rights around their data: including the right to object, to erasure, to restrict processing and to data portability.

Timescales for responding

The statutory timescales for responding to data protection requests is between 30 and 90 days, depending on the complexity of the information being requested. The Council's service standards for responding to Subject Access Requests (SARs) within statutory timescales is 80% of all non complex SARs within 1 month of receipt and 70% of all complex SARs within 3 months of receipt. For other Rights Requests the service standard is 100% within 1 month of receipt.

There are no statutory timescales for responding to third party requests for personal data.

Commentary

In the last year, improvement has been noted in the handling of SARs within some service areas as a result of targeted training and changes to internal processes, but performance remains below target. Requests relating to care experienced files continues to be an area where it is challenging to meet response deadlines. This is due to the specialism required to deal with such requests. A review of the associated procedures and roles/responsibilities across the teams involved is being undertaken and a plan identified to seek improvement and ensure a better experience for our customers. There has been an increase in third party requests and analysis into the reason for this has been undertaken but there are no evident trends.

2.2 Data Protection Breaches

Fig 4: Annual number of reported data breaches

Year	Data Protection Breaches	Near Misses	Reports to the ICO
2021/22	199	20	4
2022/23	215	33	4

Data Protection Breaches

All information security incidents should be reported. The action taken will depend on the nature of the incident or breach. Incidents will either be classified as:

- A data protection breach
- Not a data protection breach
- Not a data protection breach but a near miss

Where a breach is likely to pose a risk to the rights and freedoms of affected individuals then the Council must also notify the Information Commissioner's Office (ICO).

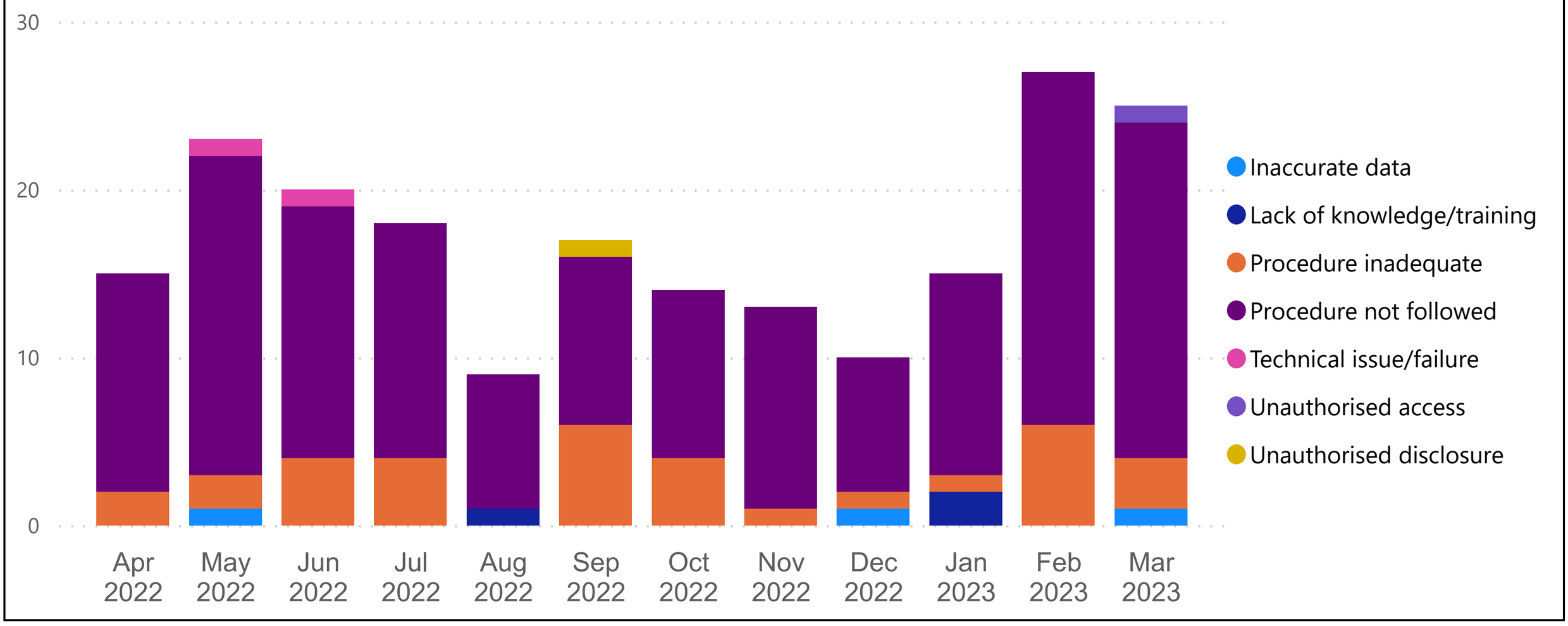
Commentary on number and type of breaches

There has been an increase in reported data protection breaches this year. The figures indicate that there is a strong organisational awareness of what constitutes a breach and how to report one. The number of reported breaches remains consistent with comparable organisations based on what we know about data protection breach trends across the UK and in particular, across local government. The strong trend is that reported numbers of data protection breaches has risen year on year since GDPR came into force in May 2018, and therefore the trend of increased reported data protection breaches at the Council is consistent with that.

Not following existing procedures continues to be the main root cause of incidents. As part of incident handling, we always look at any underlying factors which may have contributed to staff not following procedures and recommend actions to reduce the likelihood of recurrence. The Council has a baseline of controls in place which include mandatory training for all staff, regular communications in the form of the Data Protection blog and targeted support where necessary.

Please note change to organisation structure from November 2022 at Figure 6.

Figure 5: Breaches by root cause in 12 months to end of March 2023

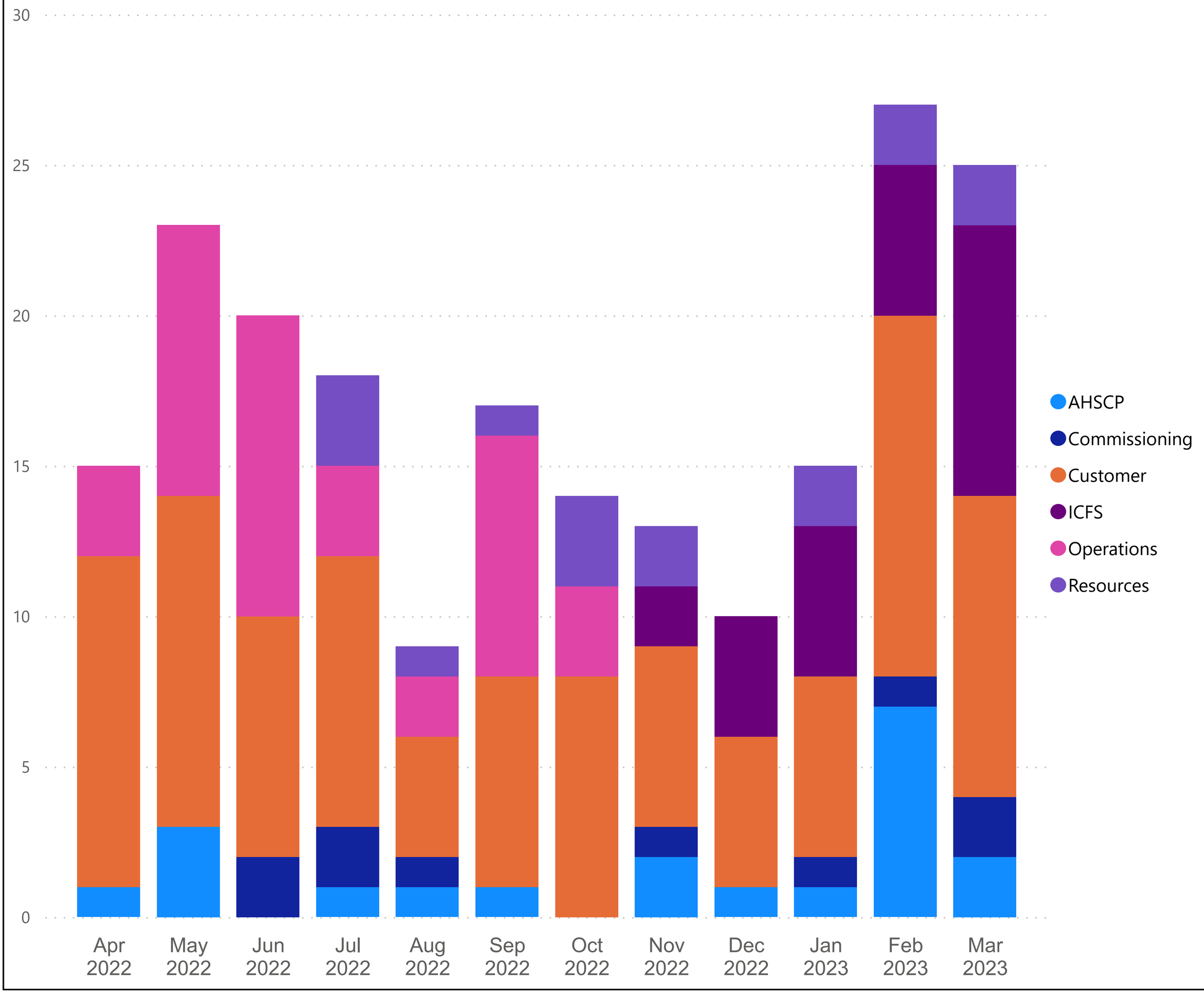


ICO Reported Breaches

The number of data breaches reported to the ICO has remained consistent, in each case the Council has been able to evidence organisational controls sufficient to ensure that the ICO have closed all with no further action being taken.

2.2 Data Protection Breaches (cont'd)

Figure 6: Breaches by Function in 12 months to end March 2023



Lessons Learned

The Council's incident handling framework means that lessons learned are identified for each incident with Service Managers, who take forward any actions identified to strengthen controls and help prevent a re-occurrence. Data protection breach data is regularly considered by Chief Officers through the Council's network of Data Forums. Lessons learned data has been made available via a real-time dashboard within the Managers Portal so it can be used across the organisation for wider learning and improvement.

Please note change to organisational structure from November 2022

2.3 FOISA and EIR Information Requests

Fig 7: Annual number of requests received in the period

Number of requests received	2021/22	2022/23
Number of FOISA Requests	915	1399
Number of EIR Requests	350	251

FOISA and the EIRs in brief

The Freedom of Information (Scotland) Act 2002 (FOISA) and the Environmental Information (Scotland) Regulations 2004 (EIR) give anyone the right to request information held by the Council, subject to certain exceptions.

Timescales for responding

The Council must respond to any request we receive within 20 working days. The Council's service standard for responding to FOISA and EIR requests within statutory timescales is 85%.

Commentary on requests received

The number of requests has increased during 2022/23. Analysis has highlighted trends in requests such as budget information, electric vehicles, energy transition, renewable energy and bus gates.

Fig 8: Request numbers in 12 months to end March 2023

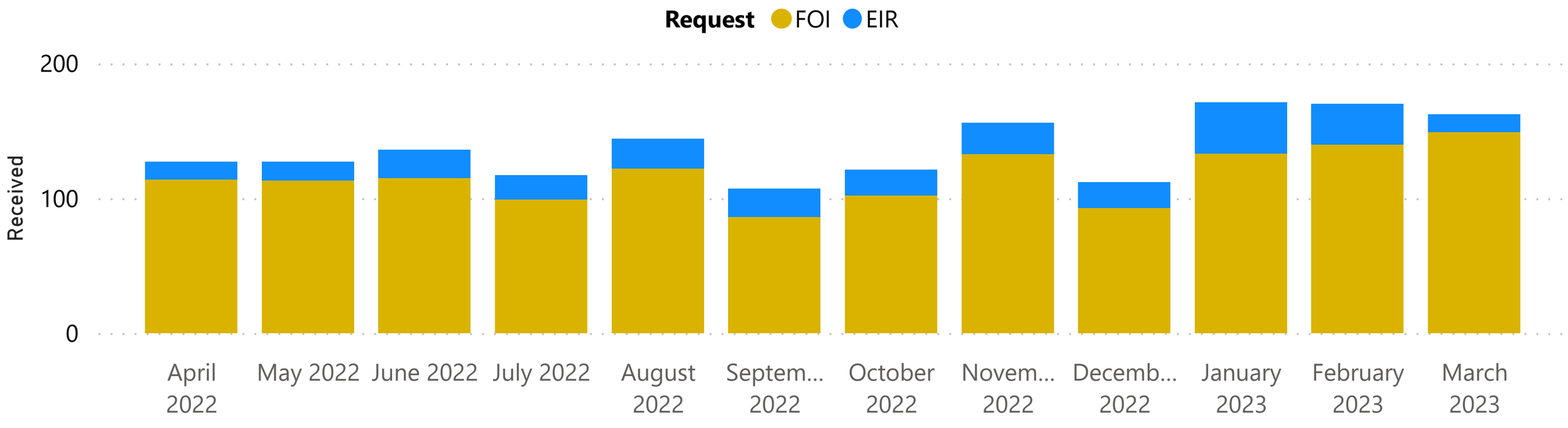


Fig 9: Compliance with timescales in the period

Report_Type	2021/22	2022/23
FOISA Requests	89%	84%
EIR Requests	91%	83%

Commentary on compliance

Compliance is slightly below target. There is scope for improvement and an action plan is in place, including targeted training, more robust management reporting and increased focus on the quality control of responses by the Access to Information Officers to ensure that responses are as helpful and clear as possible.

2.4 FOISA and EIR Request Internal Reviews

Fig 10: Internal Reviews received by type in the period

Type of review received	2021/22	2022/23
No response received	8	18
Unhappy with response	20	31

Internal Reviews in Brief

If the Council does not provide a response to a FOISA or EIR request within 20 working days, or if the requester is unhappy with the response we have given, they can ask the Council to review it.

Where a requester is unhappy with our response, an internal review panel will decide whether or not to uphold the original response or overturn it.

Fig 11: Internal Review Panel outcomes in the period

Type of review outcome	2021/22	2022/23
Response overturned or amended	16	30
Response Upheld	12	19

Commentary on Internal Reviews

All reviews were answered on time over the period and the number of reviews based on lateness has decreased. Where decisions were overturned due to further information being held by the Service, further guidance has been given around undertaking sufficient searches.

2.5 FOISA and EIR Request Appeals

Fig 12: FOISA and EIR Appeals received and closed in the period

Type	2021/22	2022/23
Received	7	2
Closed	3	3

Right to Appeal

Where a requester remains unhappy with a response to a FOISA or EIR request after an internal review, they have the right to appeal to the Scottish Information Commissioner for a decision.

Commentary on Appeals

The high level of outstanding Appeals is related to the amount of time it is taking for OSIC to assign Investigating Officers to cases at present. They are experiencing a large volume of appeals. All ongoing Appeals are with OSIC for action and there is no current action for the Council to take.

2.6 Cyber Incidents

Fig 13: Annual number of internal cyber incidents

Incident Type	2021/22	2022/23
Internal Cyber Incident Attempts Prevented	0	0
Internal Cyber Incidents	0	3

Internal Cyber Incidents

These are risks or threats to the Council's information software, infrastructure or computer network that originate from within the premises or organisation.

Commentary on Internal Cyber Incidents

Three internal cyber incidents were flagged by security defences and quickly resolved. There was no negative impact on the network.

External Cyber Incidents

These are risks or threats to the Council's information software, infrastructure or computer network that originate from outside the premises or from the public (e.g. hackers).

Fig 14: Annual number of external cyber incidents

Incident Type	2021/22	2022/23
External Cyber Incident Attempts Prevented	6,308,039	7,568,417
External Cyber Incidents	1	0

2.7 Lost ID Badges

Fig 15: Annual number of lost ID Badges in the period

Incident Type	2021/22	2022/23
No. lost ID badges	108	137

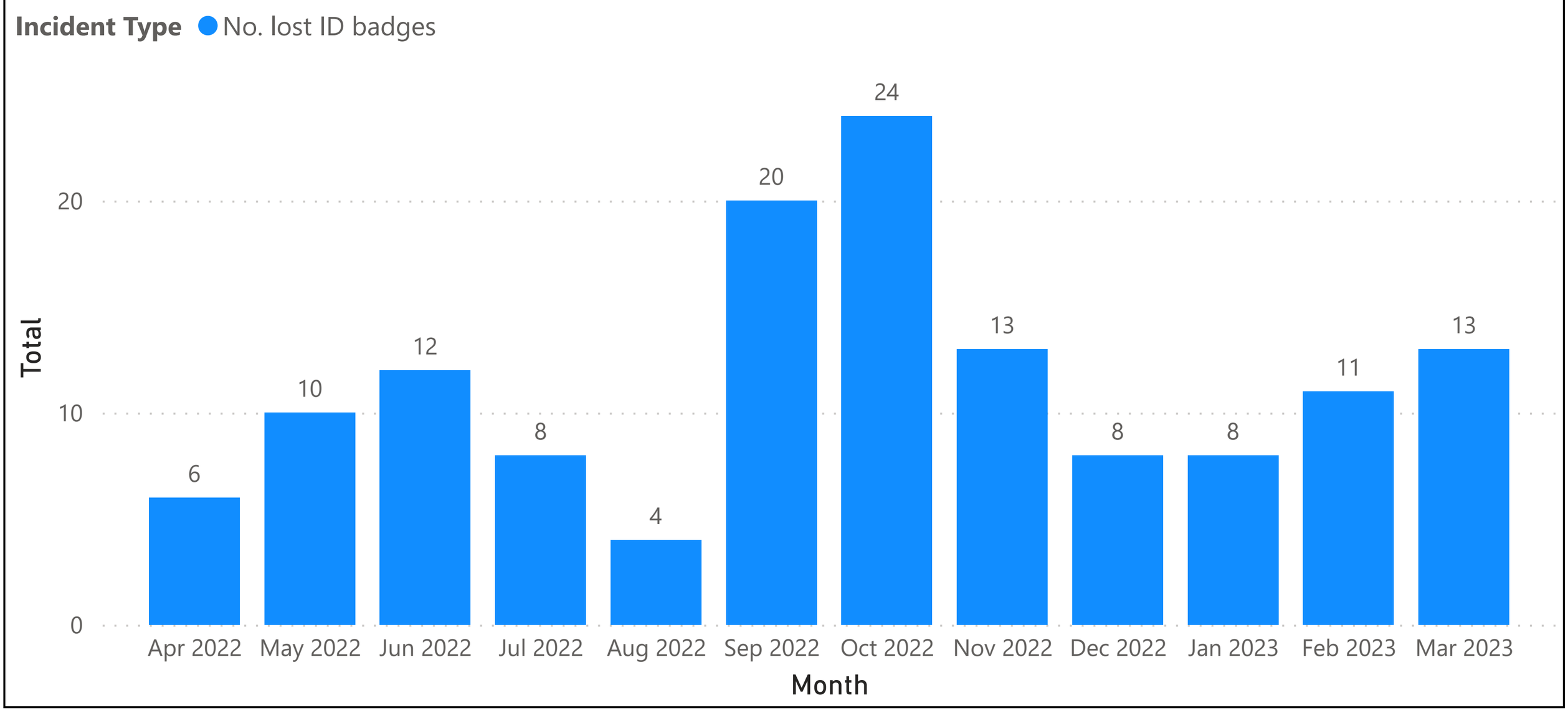
Lost ID Badges

These are tangible and material risks or threats to the Council's information assets that originate from within the premises or organisation.

Commentary on Lost ID Badges

There has been an increase in the number of lost ID badges in the last 12 months. This increase coincides with more staff returning to office based working and figures comparable with pre COVID.

Fig 16: Lost ID Badges in the period



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ABERDEEN CITY COUNCIL

COMMITTEE	Audit Risk and Scrutiny Committee
DATE	14 September 2023
EXEMPT	No
CONFIDENTIAL	No
REPORT TITLE	Use of Investigatory Powers- Q3-2023
REPORT NUMBER	COM/23/292
DIRECTOR	Gale Beattie
CHIEF OFFICER	Jenni Lawson- Interim Chief Officer - Governance
REPORT AUTHOR	Jess Anderson, Team Leader- Regulatory and Compliance, Legal Services
TERMS OF REFERENCE	5.2

1. PURPOSE OF REPORT

1.1 To ensure that Elected Members review the Council's use of investigatory powers on a quarterly basis and have oversight that those powers are being used consistently in accordance with the Use of Investigatory Powers Policy.

2. RECOMMENDATION(S)

That the Committee:-

2.1 Note covert surveillance activity.

2.2 Note the update on Communications Data.

3. CURRENT SITUATION

3.1 The Council has powers under the Regulation of Investigatory Powers (Scotland) Act 2000 (RIPSA), and Investigatory Powers Act 2016 (IPA) to use different investigatory techniques. RIPSA provides a legal framework for covert surveillance by public authorities, an independent inspection regime to monitor these activities and sets out a process for the authorisation of covert surveillance by designated officers, for the duration of that authorisation and for the review, renewal or termination of authorisations. It gives the Council powers to conduct two types of covert surveillance:

1. Directed Surveillance (is covert surveillance in places other than residential premises or private vehicles); and
2. the use of a Covert Human Intelligence Source (the use of an undercover officer).

This Committee has had oversight of covert surveillance activity under RIPSA since 2017.

3.2 The IPA permits the Council to acquire Communications Data for a lawful purpose. Communications data is the way in which, and by what method, a person or thing communicates with another person or thing. The IPA sets out the manner and process by which Communications data can be obtained and this is supported by the Home Office's Communications Data Code of Practice[1]. The Council has not used Communications data since approximately 2005, however the ability to acquire it still remained. In response to concerns from the Operations and Protective Services cluster that there is an increase in online offences, more so during the pandemic, Legal Services and Trading Standards worked together to put in place operational procedures to ensure compliance with the requirements of the IPA. The operational procedure in respect of Communications data was approved on 27 April 2023.

3.3 The Investigatory Powers Commissioner (IPCO) has oversight of both RIPSA and IPA and as such, the Council's use and management of powers under these will form part of the normal inspection process. The last inspection took place in April 2020 and was reported to this Committee on 8 October 2020[1]. The IPCO have recently notified the Chief Executive that the Council is due for an inspection and an initial response has been sent to the IPCO. Committee will be updated as the inspection progresses.

3.4 The Council approved the Use of Investigatory Powers Policy in December 2021[2]. This policy governs compliance with both RIPSA and the IPA. It remains a mandatory requirement that all members of staff wishing to use investigatory powers must undertake training prior to being able to make an application to use such investigatory powers.

3.5 Committee is being asked to note the update on the use of these powers, and the Council's compliance with the Policy, particularly in respect of covert surveillance activity during the period 15 June up until 4 September 2023.

Quarter 3- 2023

Covert Surveillance – RIPSA

3.6 During the period 15 June until 4 September 2023 (the final deadline for reports to this committee for the meeting), there has been one application for Directed Surveillance. The application related to the sale of age restricted tobacco and vapour products and was cancelled in accordance with the Council's internal procedure. In the report on Q2, the Report Author was unable to advise

[1] Agenda for Audit, Risk and Scrutiny Committee on Thursday, 8th October, 2020, 2.00 pm (aberdeencity.gov.uk)
[2] Agenda for Audit, Risk and Scrutiny Committee on Thursday, 2nd December, 2021, 2.00 pm (aberdeencity.gov.uk)

Committee as to the nature the authorisations at the time as these were still "live". For the sake of completeness and to ensure that reporting on such activity is consistent, Committee is asked to note that both applications have been cancelled and related to alleged Consumer Protection offences.

3.7 There have been no further applications for covert surveillance made, or approved, within this quarter.

Communications Data- IPA

3.8 As noted above, the Chief Officer- Governance has approved the operational procedure in respect of Communications data. Arrangements have been made with NAFN[3] to provide services to the Council required by the IPA. Three training sessions were provided by Legal Services to Officers in Protective Services in July. The training took place on Teams and included interactive elements. The training focused on the Council's procedure and complemented extensive training modules provided by NAFN. Out of 33 officers in Protective Services invited to attend, 27 attended. Those officers are now able to utilise Communications Data where it is necessary and proportionate to do so.

3.9 There have been four applications requested for Communications Data during this quarter.

Authorising Officers (AO)

3.10 There was no AO meeting this quarter due to leave arrangements.

Training

3.12 During this quarter, training has been delivered to an incumbent Authorising Officer. This AO is now operational.

3.13 As noted above, training on Communications Data has also been delivered this quarter.

Awareness Raising

3.14 Officers have been advised of the incumbent AO, and details have been provided on the online restricted forum.

4. FINANCIAL IMPLICATIONS

4.1 There are no financial implications arising from this report.

5. LEGAL IMPLICATIONS

5.1 The Scottish Government Code of Practice on Covert Surveillance sets an

expectation that elected members review and monitor the use of RIPSA on a quarterly basis. This is also a matter which is taken into account by the IPCO when they carry out their inspections.

5.2 The Home Office Code of Practice on Communications Data states that any public authority wishing to acquire Communications Data must have regard to the Code and that there should be a robust process in place for accessing such data which should be overseen by the Senior Responsible Officer.

5.3 Quarterly reporting of the Council's use of investigatory powers to Elected Members provides assurance that the Council's use of such powers is being used consistently and that the standards set by its policy remain fit for purpose.

5.4 It is recommended as good practice, under paragraph 4.43 of the Scottish Government's Code of Practice for Covert Surveillance and Property interference, that elected members consider a statement on the Council's Regulation of Investigatory Powers (Scotland) Act 2000 (RIPSA) policy and statistical information on relevant activity on an annual basis.

5.5 The management, knowledge and awareness of those involved with RIPSA activity was something which was commended by the IPCO in his inspection in 2020. Officers hope that reporting on the use of investigatory powers more broadly, enhances transparency and provides another level of scrutiny and assurance on the use of these powers.

6. ENVIRONMENTAL IMPLICATIONS

6.1 There are no environmental/ climate risks arising from the recommendations in this report.

7. RISK

The assessment of risk contained within the table below is considered to be consistent with the Council's Risk Appetite Statement"

Category	Risks	Primary Controls/Control Actions to achieve Target Risk Level	*Target Risk Level (L, M or H) *taking into account controls/control actions	*Does Target Risk Level Match Appetite Set?
Strategic Risk	There are no strategic risks		L	**Yes**
Compliance	That the Council's	This Committee receives quarterly and annual reports on its	L	**Yes**

	use of RIPSA is not legally compliant. The Council's acquisition of communications data does not comply with the Home Office Code of Practice.	use of investigatory powers under RIPSA and the IPA and related policy mitigates this risk highlighted in this Section.		
Operational	Employees are not suitably trained for surveillance work. Failure to report to and update Committee on surveillance activity means that it would undermine public confidence in the Council and how it operates.	Appropriate and mandatory training arms staff with the correct skills to carry out surveillance and thus, there is little to no risk to staff. All requests for training are met. Reporting to Committee occurs quarterly on surveillance activity.	L	**Yes**
Financial	There are no financial risks arising from this report		L	**Yes**
Reputational	Failure to update Committee on RIPSA activity would mean that the Council would be at risk of reputational damage when this is raised by the IPCO in their inspection.	External inspections on RIPSA activity operate every 3-4 years. This provides external assurance to the Committee of the Council's compliance with RIPSA. Further, whilst there is no requirement to report to Committee about the Council's use of Communication Data, the broader reporting of both demonstrates	L	**Yes**

		the Council's wish to be transparent about its use of such powers. The Inspection Report is shared with Committee and an Action Plan created (where necessary) and is endorsed and approved by Committee.		
Environment / Climate	There are no environmental or climate impacts arising from this report.		L	**Yes**

8. OUTCOMES

COUNCIL DELIVERY PLAN 2022-2023	
	Impact of Report
Aberdeen City Council Policy Statement **Working in Partnership for Aberdeen**	The report does not have an impact on the Policy Statement
Prosperous Economy Stretch Outcomes	Whilst the recommendations of this report are for noting, the use of investigatory powers by the Council as an investigatory tool may have an impact on the economy as a result of enforcement action taken by services such as Trading Standard, e.g. such as in enforcing the law around counterfeit goods.
Prosperous People Stretch Outcomes	Enforcement activity undertaken by the Council by using, where appropriate, its powers under the IPA and RIPSA, may have an impact on this by tackling the selling of counterfeit goods.
Prosperous Place Stretch Outcomes	

Regional and City Strategies	This report does not have an impact on the Regional and City Strategies.

9. IMPACT ASSESSMENTS

Assessment	Outcome
Integrated Impact Assessment	The purpose of this report is to update Committee on the Council's use of investigatory powers. Further, there is no requirement to consider the Fairer Scotland Duty as this report does not seek approval for any Strategic decisions and is merely providing Committee with an update on this type of activity.
Data Protection Impact Assessment	The purpose of this report is to update Committee on the Council's use of investigatory powers. As such, a Data Protection Impact Assessment is not required.
Other	There are no other impact assessments relevant to this report.

10. BACKGROUND PAPERS

10.1 There are no background papers.

11. REPORT AUTHOR CONTACT DETAILS

Name	Jess Anderson
Title	Team Leader, Regulatory and Compliance, Legal Services, Governance, Commissioning.
Email Address	JeAnderson@aberdeencity.gov.uk
Tel	01224 053608

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ABERDEEN CITY COUNCIL

COMMITTEE	Audit, Risk and Scrutiny Committee
DATE	14 September 2023
EXEMPT	No
CONFIDENTIAL	No
REPORT TITLE	Internal Audit Update Report
REPORT NUMBER	IA/23/008
DIRECTOR	N/A
CHIEF OFFICER	Jamie Dale, Chief Internal Auditor
REPORT OFFICER	Jamie Dale, Chief Internal Auditor
TERMS OF REFERENCE	2.3

1. PURPOSE OF REPORT

1.1 The purpose of this report is to provide the Committee with an update on Internal Audit's work since the last update. Details are provided of the progress against the approved Internal Audit plans, audit recommendations follow up, and other relevant matters for the Committee to be aware of.

2. RECOMMENDATIONS

It is recommended that the Committee:

2.1 Note the progress of the Internal Audit Plan;

2.2 Note the progress that management has made with implementing recommendations agreed in Internal Audit reports;

3. CURRENT SITUATION

3.1 Internal Audit's primary role is to provide independent and objective assurance on the Council's risk management, control and governance processes. This requires a continuous rolling review and appraisal of the internal controls of the Council involving the examination and evaluation of the adequacy of systems of risk management, control and governance, making recommendations for improvement where appropriate. Reports are produced relating to

each audit assignment and summaries of these are provided to the Audit Committee.

4. FINANCIAL IMPLICATIONS

4.1 There are no direct financial implications arising from the recommendations of this report.

5. LEGAL IMPLICATIONS

5.1 There are no direct legal implications arising from the recommendations of this report.

6. ENVIRONMENTAL IMPLICATIONS

6.1 There are no direct environmental implications arising from the recommendations of this report..

7. RISK

7.1 The assessment of risk contained within the table below is to be consistent with the Council's Risk Appetite Statement.

Category	Risks	Primary Controls/Control Actions to achieve Target Risk Level	*Target Risk Level (L, M or H) *taking into account controls/control actions	*Does Target Risk Level Match Appetite Set?
Strategic Risk	Ability of the Council to meet its strategic objectives	The Internal Audit process considers strategic risks involved in the areas subject to review. Any risk implications identified through the Internal Audit process are detailed in the resultant Internal Audit reports. Recommendations, consistent with the Council's Risk Appetite Statement, are made to address the identified risks and Internal Audit follows up progress with implementing those	M	**Yes**

		that are agreed with management. Those not implemented by their agreed due date are detailed in the attached appendices.		
Compliance	Council does not comply with relevant internal policies and procedures and external guidance.	The Internal Audit process considers compliance risks involved in the areas subject to review. Any risk implications identified through the Internal Audit process are detailed in the resultant Internal Audit reports. Recommendations, consistent with the Council's Risk Appetite Statement, are made to address the identified risks and Internal Audit follows up progress with implementing those that are agreed with management. Those not implemented by their agreed due date are detailed in the attached appendices.	L	**Yes**
Operational	Failure of the Council to deliver agreed services.	The Internal Audit process considers operational risks involved in the areas subject to review. Any risk implications identified through the Internal Audit process are detailed in the resultant Internal Audit reports. Recommendations, consistent with the Council's Risk Appetite Statement, are made to address the identified risks and Internal Audit follows	L	**Yes**

		up progress with implementing those that are agreed with management. Those not implemented by their agreed due date are detailed in the attached appendices.		
Financial	Financial failure of the Council, with risks also to credit rating.	The Internal Audit process considers financial risks involved in the areas subject to review. Any risk implications identified through the Internal Audit process are detailed in the resultant Internal Audit reports. Recommendations, consistent with the Council's Risk Appetite Statement, are made to address the identified risks and Internal Audit follows up progress with implementing those that are agreed with management. Those not implemented by their agreed due date are detailed in the attached appendices.	L	**Yes**
Reputational	Impact of performance or financial risk on reputation of ACC.	The Internal Audit process considers reputational risks involved in the areas subject to review. Any risk implications identified through the Internal Audit process are detailed in the resultant Internal Audit reports. Recommendations, consistent with the Council's Risk Appetite Statement, are made to address the	L	**Yes**

		identified risks and Internal Audit follows up progress with implementing those that are agreed with management. Those not implemented by their agreed due date are detailed in the attached appendices.		
Environment / Climate	Service delivery impacting negatively on City net zero targets.	The Internal Audit process considers environmental/climate risks involved in the areas subject to review. Any risk implications identified through the Internal Audit process are detailed in the resultant Internal Audit reports. Recommendations, consistent with the Council's Risk Appetite Statement, are made to address the identified risks and Internal Audit follows up progress with implementing those that are agreed with management. Those not implemented by their agreed due date are detailed in the attached appendices.	L	**Yes**

8. OUTCOMES

8.1 The proposals in this report have no impact on the Council Delivery Plan.

8.2 However, Internal Audit plays a key role in providing assurance over, and helping to improve, the Council's framework of governance, risk management and control. These arrangements, put in place by the Council, help ensure that the Council achieves its strategic objectives in a well-managed and controlled environment.

9. IMPACT ASSESSMENTS

Assessment	Outcome
Impact Assessment	An assessment is not required because the reason for this report is to report Internal Audit's progress to Committee. As a result, there will be no differential impact, as a result of the proposals in this report, on people with protected characteristics.
Data Protection Impact Assessment	Not required

10. BACKGROUND PAPERS

10.1 There are no relevant background papers related directly to this report.

11. APPENDICES

11.1 Appendix A – Internal Audit Update Report

12. REPORT AUTHOR CONTACT DETAILS

Name	Jamie Dale
Title	Chief Internal Auditor
Email Address	Jamie.Dale@aberdeenshire.gov.uk
Tel	(01467) 530 988

ABERDEEN CITY COUNCIL

Internal Audit

Audit, Risk and Scrutiny Committee
Internal Audit Update Report
September 2023

Contents

1 Executive Summary

1.1 Introduction and background

Internal Audit's primary role is to provide independent and objective assurance on the Council's risk management, control, and governance processes. This requires a continuous rolling review and appraisal of the internal controls of the Council involving the examination and evaluation of the adequacy of systems of risk management, control, and governance, making recommendations for improvement where appropriate. Reports are produced relating to each audit assignment and these are provided to the Audit, Risk and Scrutiny (ARS) Committee. Along with other evidence, these reports are used in forming an annual opinion on the adequacy of risk management, control, and governance processes.

This report advises the ARS Committee of Internal Audit's work since the last update. Details are provided of the progress against the approved 2022/23 and 2023/24 Internal Audit plans, audit recommendations follow up, and other relevant matters for the Committee to be aware of.

1.2 Highlights

Full details are provided in the body of this report however Internal Audit would like to bring to the Committee's attention that since the last update:

- One review has been completed, with the last review from the previous year in the process of being finalised.
- Work is underway with regards to delivery of the 2023/24 Internal Audit Plan.
- 19 audit recommendations have been closed.

1.3 Action requested of the ARS Committee

The Committee is requested to note the contents of this report and the work of Internal Audit since the last update.

2 Internal Audit Progress

2.1 2022/23 Audits

Service	Audit Area	Position
HSCP	Adults with Incapacity (Management of funds)	**Final report issued**
Resources	Corporate Asset Management	**Review in progress**

2.2 2023/24 Audits

Service	Audit Area	Position
Children and Family Services	Pupil Equity Fund	**Review in progress**
Children and Family Services	Secondary School Visits	**Review Scheduled**
Commissioning	Procurement Compliance	**Review in progress**
Commissioning	City Region Deal	**Review in progress**
Commissioning	Environmental Action	**Review Scheduled**
Council Led HSCP Services	Social Care Financial Assessments	**Review Scheduled**
Council Led HSCP Services	Care Management System	**Review in progress**
Customer	Volunteer Arrangements	**Review Scheduled**
Customer	Recruitment	**Review Scheduled**
Customer	PREVENT	**Review Scheduled**
Customer	Data Protection	**Review in progress**
Customer	Attendance Management	**Review Scheduled**
Customer	Cyber Controls	**Review Scheduled**
IJB	Compliant Handling	**Review in progress**
IJB	IJB Hosted Services	**Review Scheduled**
NESPF	Pensions Investment Strategy	**Review Scheduled**
Resources	Vehicle and Driver Compliance	**Review in progress**
Resources	Stores Stock Controls	**Review in progress**
Resources	Revenue Budget Setting and Financial Strategy	**Review in progress**
Resources	Creditors System	**Review Scheduled**
Resources	COVID-19 Spend	**Review Scheduled**
Resources	Private Sector Housing	**Review Scheduled**

2.3 Audit reports presented to this Committee

Report Title	Assurance Year	Conclusion
AC2314 – Adults with Incapacity	2022-23	Internal audit has identified an overall net risk rating of **MAJOR**, with **LIMITED** assurance obtained over this area. Areas of controls are in development but have yet to be fully implemented. Efficiency is partly affected by ongoing development following the introduction of a new care management recording system – with specific service areas still identifying what needs to be recorded in the system. Procedures in respect of appointeeship, access to funds, financial guardianship and intervention are out of date and there is no evidence of review to ensure they are relevant and tried and tested for sufficiency. Reliance is

Report Title	Assurance Year	Conclusion
		largely placed on legislation and other high-level guidance, rather than locally relevant procedures and training. As a result, inconsistent practice was identified during the audit. Records are not always accessible, and the lack of clarity over procedure results in inconsistent filing, recording, and annotation of records. Some records are not on file, including legal documentation, certification of incapacity, and intended use of funds. Where changes take place, records are not consistently being updated to reflect changes. System records are incomplete. This presents risks to service delivery, and to the need to keep accurate data in compliance with data protection legislation. Where records are in place these do not always demonstrate adherence to the minimum intervention principle set out in the Adults with Incapacity (Scotland) Act. Whilst there are controls over funds received into and distributed from a centralised corporate appointee account, these funds are regularly withdrawn in cash, and a number of weaknesses were identified including an absence of checks, authorisation controls, and evidenced segregation of duties. Following withdrawals there is limited evidence of management of service users' assets. Funds are generally managed by care workers, and their activities in respect of AWI finances are not subject to regular independent review. Supporting evidence in respect of client funds management is limited and is not being reviewed and investigated where there are potential irregularities; this includes an absence of clear plans for spending, and records of use of funds, and changes from confirmed benefit entitlements. Inventories are not routinely maintained or updated, and financial assets in excess of relevant thresholds are not considered for separate management (e.g. in interest bearing accounts). The lack of control over this area means that there is substantial scope for fraud and error where funds and moveable property are being accessed and managed on others' behalf. Whilst no evidence of recent fraud or theft was identified in the audit, current controls may not prevent or identify it. There are risks to vulnerable service users' funds, and to staff involved in the management of their funds, if appropriate procedures, checks, and balances are not in place and operating effectively. Recommendations have been made to address the above risks, which Management has agreed to as part of a timebound action plan. This was discussed with Internal Audit and it considered to be propionate in the wider context of ongoing work and recognising the need to consider flexibility and efficiency as well as control

2.4 Follow up of audit recommendations

Public Sector Internal Audit Standards require that Internal Audit report the results of its activities to the Committee and establishes a follow-up process to monitor and ensure that management actions have been effectively implemented.

As at 31 July 2023 (the baseline for our exercise), 34 audit recommendations were due and outstanding:

- Four rated as Major
- 23 rated as Moderate
- Seven rated as Minor

As part of the audit recommendations follow up exercise, 19 recommendations were closed:

- Three rated as Major
- 11 rated as Moderate
- Five rated as Minor

For the remaining 15[1], all have been discussed with management and updates provided on the progress of their implementation.

Appendix 1 – Grading of Recommendations provides the definitions of each of the ratings used.

Appendix 2 – Audit Recommendations Follow Up – Outstanding Actions provides a detailed breakdown of the outstanding audit recommendations that will be taken forward and followed up as part of the next cycle.

[1] This is the position with regards to recommendations that were due as at 31 July 2023. Recommendations falling due past this date and those made as part of subsequent Internal Audit Reports will be followed up as part of the standard follow up cycle and reported to Committee session on session.

3 Appendix 1 – Grading of Recommendations

Risk level	Definition
Corporate	This issue / risk level impacts the Council as a whole. Mitigating actions should be taken at the Senior Leadership level.
Function	This issue / risk level has implications at the functional level and the potential to impact across a range of services. They could be mitigated through the redeployment of resources or a change of policy within a given function.
Cluster	This issue / risk level impacts a particular Service or Cluster. Mitigating actions should be implemented by the responsible Chief Officer.
Programme and Project	This issue / risk level impacts the programme or project that has been reviewed. Mitigating actions should be taken at the level of the programme or project concerned.

Net risk rating	Description	Assurance assessment
Minor	A sound system of governance, risk management and control exists, with internal controls operating effectively and being consistently applied to support the achievement of objectives in the area audited.	**Substantial**
Moderate	There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified, which may put at risk the achievement of objectives in the area audited.	**Reasonable**
Major	Significant gaps, weaknesses or non-compliance were identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the area audited.	**Limited**
Severe	Immediate action is required to address fundamental gaps, weaknesses or non-compliance identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the area audited.	**Minimal**

Individual issue / risk	Definitions
Minor	Although the element of internal control is satisfactory there is scope for improvement. Addressing this issue is considered desirable and should result in enhanced control or better value for money. Action should be taken within a 12 month period.
Moderate	An element of control is missing or only partial in nature. The existence of the weakness identified has an impact on the audited area's adequacy and effectiveness. Action should be taken within a six month period.
Major	The absence of, or failure to comply with, an appropriate internal control, such as those described in the Council's Scheme of Governance. This could result in, for example, a material financial loss, a breach of legislative requirements or reputational damage to the Council. Action should be taken within three months.
Severe	This is an issue / risk that is likely to significantly affect the achievement of one or many of the Council's objectives or could impact the effectiveness or efficiency of the Council's activities or processes. Examples include a material recurring breach of legislative requirements or actions that will likely result in a material financial loss or significant reputational damage to the Council. Action is considered imperative to ensure that the Council is not exposed to severe risks and should be taken immediately.

4 Appendix 2 – Audit Recommendations Follow Up – Outstanding Actions

Report	Grading	Ref	Recommendation	Original Due Date	Current Due Date	Committee Update	Status
AC2209 - Debt Recovery	**Moderate**	2.10.4	The Service should establish a comprehensive system of debt recovery performance reporting which is target based and reported regularly to relevant team leaders, service managers and Chief Officers for debt recovery escalation and decision-making purposes. The following regularly reporting should be considered: aged debt analysis, unallocated cash receipts, unresolved disputes, payment arrangements, deferred recovery action, and customers subject to cessation of service	Mar-23	Oct-23	Prioritised a number of services to receive specific reports on recovery and collection progress to enable action to be taken - e.g. commercial waste and property debts due to high volume and value. This has not covered all service income streams and we continue to expand the range of services included. Performance reporting data is still being developed and would ask that a revised date of 31/10/23 is included to enable resources to be directed to complete this.	**In progress**
AC2209 - Debt Recovery	**Moderate**	2.3.4	The Service should reconcile the Council's and the Sherriff Officers' debt records to ensure they agree and do so on a recurring basis.	Mar-23	Oct-23	Service Income team leader now has access to Sherriff Officer portal and has sight of the debts that have been transferred to SOs. SO is now providing updates on debts they have been unable to recover and these are then subject to write off processes - with team being able to update Council system to close and remove. In further discussion with the	**In progress**

Report	Grading	Ref	Recommendation	Original Due Date	Current Due Date	Committee Update	Status
						Corporate debt team action has been taken as far as we believe possible and we will continue to monitor through the performance reports, above. Once performance reporting is in place would aim to remove, therefore revised date of 31/10/23.	
AC2209 - Debt Recovery	**Moderate**	2.9.2	The Service should automate the cessation of non-statutory services which are not essential to well-being within the debtors system.	Jun-23	Dec-23	This remains work in progress due to resource limitations, a revised date of 31/12/23 is asked for to explore how we implement this.	**In progress**
AC2215 - Staff Resourcing	**Minor**	2.3.17 (a)	The Council should ensure there is clear ownership of the responsibility for performing and retaining evidence of IR35 checks on agency worker engagements.	Jul-23	Aug-23	We are currently finalising a change to the new supplier process whereby IR35 checks will be retained and the amended form/process should be published in the coming days.	**In progress**
AC2307 - Contract Management	**Moderate**	3.1.1a	The Service should review the refreshed guidance to see where more practical guidance can be provided in application, including use of visual aids for example flow charts to assist in breaking down complex information to aid ease of understanding.	Jun-23	Dec-23	We will require a little more time to finalise and reissue the guidance. We've been focussing on the refresh of our Joint Procurement Strategy and production of annual reports which has taken up capacity within the team, the additional time will	**In progress**

Report	Grading	Ref	Recommendation	Original Due Date	Current Due Date	Committee Update	Status
						ensure we can close all of these out.	
AC2307 - Contract Management	**Moderate**	3.1.2	The Service should include a revised risk matrix within the refreshed guidance, including the addition of a definition around high risk/high value, the contract management elements required for different contract types / levels of risk, and examples of these to provide a reference point for delegated procurers.	Jun-23	Dec-23	We will require a little more time to finalise and reissue the guidance. We've been focussing on the refresh of our Joint Procurement Strategy and production of annual reports which has taken up capacity within the team, the additional time will ensure we can close all of these out.	**In progress**
AC2307 - Contract Management	**Moderate**	3.1.3a	The Service should consider its approach to communicating good practice, sharing information that can increase contract manager experience and awareness, and providing assistance as and when required to develop the Council's procurement and contract management culture.	Jun-23	Dec-23	We will require a little more time to finalise and reissue the guidance. We've been focussing on the refresh of our Joint Procurement Strategy and production of annual reports which has taken up capacity within the team, the additional time will ensure we can close all of these out.	**In progress**
AC2307 - Contract Management	**Moderate**	3.1.6b	The Service should ensure that key indicators and community benefits, management information requirements, supplier contacts, and review meeting schedules are clearly set out to ensure clarity over Council expectations.	Jun-23	Dec-23	We will require a little more time to finalise and reissue the guidance. We've been focussing on the refresh of our Joint Procurement Strategy and production of annual reports which has	**In progress**

Report	Grading	Ref	Recommendation	Original Due Date	Current Due Date	Committee Update	Status
						taken up capacity within the team, the additional time will ensure we can close all of these out.	
AC2307 - Contract Management	**Moderate**	3.1.6c	The Service should consider applying a system of risk rating to contracts for monitoring and management reporting purposes to ensure that high risk contracts are reviewed more frequently by Cluster Management and at a Strategic Management Level. This should look at areas such as performance indicators and receipt of community benefits.	Jun-23	Dec-23	We will require a little more time to finalise and reissue the guidance. We've been focussing on the refresh of our Joint Procurement Strategy and production of annual reports which has taken up capacity within the team, the additional time will ensure we can close all of these out.	**In progress**
AC2307 - Contract Management	**Moderate**	3.1.5a	The Service should ensure there is clarity regarding the responsibility for and extent of record keeping required for different types of contracts and different levels of contract risk.	Jun-23	Dec-23	We will require a little more time to finalise and reissue the guidance. We've been focussing on the refresh of our Joint Procurement Strategy and production of annual reports which has taken up capacity within the team, the additional time will ensure we can close all of these out.	**In progress**
AC2211 - Transformational Programme	**Moderate**	2.5.2	Finance should liaise with budgets holders and apply MTFS savings as appropriate to H&SCP budgets.	Apr-23	Dec-23	Work is ongoing with regards to monitoring and the application of the MTFF, including sessions with SLT to address the budget. All of these points will be	**In progress**

Report	Grading	Ref	Recommendation	Original Due Date	Current Due Date	Committee Update	Status
						addressed by the time of Q2 monitoring reporting.	
AC2211 - Transformational Programme	**Moderate**	2.6.13	Where relevant, budget monitoring information should be regularly reported to groups responsible for Delivery Plan projects with sufficient detail to identify project budget underspends and pressures requiring corrective action.	Jun-23	Dec-23	Work is ongoing with regards to this recommendation and will be addressed by the time of Q2 monitoring reporting, and in line with other recommendations.	**In progress**
AC2201 - IT Infrastructure Resilience	**Major**	2.4.7 a	The Service should establish Cyber Essentials PLUS accreditation for the Council.	June-23	Oct-23	We are now a cyber essentials certified organisation. We have delayed the additional PLUS element until the device refresh programme is complete end August. This is due to the replacement of windows10 version in favour of Windows11 with a view to be PLUS in October.	**In progress**
AC2201 - IT Infrastructure Resilience	**Minor**	2.1.6	P&OD will work with D&T on the mandatory and essential elements of training and seek to ensure training is appropriate to job families. Consideration will be given to including the course as part of existing mandatory training (e.g. Information Governance course).	Apr-23	Dec-23	Although content has been agreed allocation across job families remains to be finalised.	**In progress**

Report	Grading	Ref	Recommendation	Original Due Date	Current Due Date	Committee Update	Status
AC2209 - Debt Recovery	**Moderate**	2.1.8a	Debt recovery policies and written procedures, including the Service Income policy, Corporate Debt Recovery policy, payment arrangements procedure and the write off procedure should be reviewed and updated where necessary.	Jun-23	Sep-23	Corporate Debt policy has been reviewed and moved onto the new corporate template. This has now been through the Project Board and is submitted to the August Risk Group for approval.	**In progress**

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ABERDEEN CITY COUNCIL

COMMITTEE	Audit, Risk and Scrutiny Committee
DATE	14 September 2023
EXEMPT	No
CONFIDENTIAL	No
REPORT TITLE	Internal Audit Report AC2314 – Adults with Incapacity
REPORT NUMBER	IA/AC2314
DIRECTOR	N/A
REPORT AUTHOR	Jamie Dale
TERMS OF REFERENCE	2.2

1. PURPOSE OF REPORT

1.1 The purpose of this report is to present the planned Internal Audit report on Adults with Incapacity

2. RECOMMENDATION

2.1 It is recommended that the Committee review, discuss and comment on the issues raised within this report and the attached appendix.

3. CURRENT SITUATION

3.1 Internal Audit has completed the attached report which relates to an audit of Adults with Incapacity

4. FINANCIAL IMPLICATIONS

4.1 There are no direct financial implications arising from the recommendations of this report.

5. LEGAL IMPLICATIONS

5.1 There are no direct legal implications arising from the recommendations of this report.

6. ENVIRONMENTAL IMPLICATIONS

6.1 There are no direct environmental implications arising from the recommendations of this report.

7. RISK

7.1 The Internal Audit process considers risks involved in the areas subject to review. Any risk implications identified through the Internal Audit process are detailed in the resultant Internal Audit reports. Recommendations, consistent with the Council's Risk Appetite Statement, are made to address the identified risks and Internal Audit follows up progress with implementing those that are agreed with management. Those not implemented by their agreed due date are detailed in the attached appendices.

8. OUTCOMES

8.1 There are no direct impacts, as a result of this report, in relation to the Council Delivery Plan, or the Local Outcome Improvement Plan Themes of Prosperous Economy, People or Place.

8.2 However, Internal Audit plays a key role in providing assurance over, and helping to improve, the Council's framework of governance, risk management and control. These arrangements, put in place by the Council, help ensure that the Council achieves its strategic objectives in a well-managed and controlled environment.

9. IMPACT ASSESSMENTS

Assessment	Outcome
Impact Assessment	An assessment is not required because the reason for this report is for Committee to review, discuss and comment on the outcome of an internal audit. As a result, there will be no differential impact, as a result of the proposals in this report, on people with protected characteristics.
Privacy Impact Assessment	Not required

10. BACKGROUND PAPERS

10.1 There are no relevant background papers related directly to this report.

11. APPENDICES

11.1 Internal Audit report AC2314 – Adults with Incapacity

12. REPORT AUTHOR CONTACT DETAILS

Name	Jamie Dale
Title	Chief Internal Auditor
Email Address	Jamie.Dale@aberdeenshire.gov.uk
Tel	(01467) 530 988

Internal Audit

Assurance Review of Adults with Incapacity

Status: Final
Date: 24 August 2023
Risk Level: Cluster

Report No: AC2314
Assurance Year: 2022-23

Net Risk Rating	Description	Assurance Assessment
Major	Significant gaps, weaknesses or non-compliance were identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the area audited.	**Limited**

Report Tracking	Planned Date	Actual Date
Scope issued	19-Jan-23	19-Jan-23
Scope agreed	28-Feb-23	28-Feb-23
Fieldwork commenced	24-Mar-23	9-Mar-23
Fieldwork completed	2-May-23	16-May-23
Draft report issued	12-May-23	9-Jun-23
Process owner response	19-May-23	27-Jun-23
Director response	26-May-23	12-Jul-23
Final report issued	2-Jun-23	25-Aug-23
Audit Committee	14-Sep-23 (AR&S) and 19-Sep-23 (IJB RAP)	

Distribution	
Document type	Assurance Report
Director	Sandra MacLeod, Chief Officer – Health and Social Care Partnership
Process Owner	Claire Wilson, Chief Officer, Adult Social Work
Stakeholder	Fraser Bell, Chief Operating Officer – Health and Social Care Partnership
	Andy MacDonald, Director of Customer Services
	Steve Whyte, Director of Resources
	Jonathan Belford, Chief Financial Officer
***Final only**	Paul Mitchell, Chief Finance Officer – Health and Social Care Partnership
	Katherine Paton, Service Manager
	Steven Stark, Service Manager
	Kevin Dawson, Lead for Community Mental Health, Learning Disabilities & Substance Misuse Services
	Tracey McMillan, Service Manager
	Nicola McLean, Service Manager
	Barbara Dunbar, Service Manager
	Angela Crawford, Finance Control Manager
	External Audit*
Lead auditor	Heulwen Beecroft, Auditor

Contents

1 Introduction

1.1 Area subject to review

The Adults with Incapacity (Scotland) Act 2000 provides a framework for safeguarding the welfare and managing the finances of adults (people aged 16 or over) who lack capacity due to mental illness, learning disability, dementia or a related condition, or an inability to communicate.

After due consideration of the supported person's needs and circumstances, the Health and Social Care Partnership can make a request for an assessment of capacity and use a 'Decision-Specific Screening Tool' for guidance as to whether a formal assessment is needed. A GP would then make the Mental Capacity Assessment decision for a patient. Any individual can apply to be welfare guardian. The Chief Social Work Officer of the local council can also apply where no-one else is applying and welfare guardianship is necessary. Any individual can apply to be a financial guardian, including a solicitor or an accountant. The adult's general practitioner (or other doctor) will need to carry out an examination and assessment of the adult in relation to the specific areas of decision-making for which powers are being sought. The other medical report, in the case where incapacity is caused by mental disorder, has to be from a relevant medical practitioner who has been approved under section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003.

The Adults with Incapacity (Scotland) Act 2000 introduced a system for safeguarding the welfare and managing the finances and property of adults who lack capacity to make some or all decisions for themselves. It is underpinned by principles which anyone taking action under the Act must apply when deciding which measure will be the most suitable for meeting the needs of the individual. The principles must also be used whenever decisions need to be made on behalf of the adult.

- Principle 1 – Benefit: any action or decision taken must benefit the person and only be taken when that benefit cannot reasonably be achieved without it.
- Principle 2 – Least restrictive option: any action or decision taken should be the minimum necessary to achieve the purpose. It should be the option that restricts the person's freedom as little as possible.
- Principle 3 – Take account of the wishes of the adult: in deciding if an action or decision is to be made and what that should be, account must be taken of the present and past wishes and feelings of the person, as far as they can be ascertained. The adult should be offered appropriate assistance to communicate their views.
- Principle 4 – Consultation with relevant others: In deciding if an action or decision is to be made, and what that should be, account shall be taken of the views of the nearest relative and the primary carer of the adult, the adult's named person, any guardian or attorney with powers relating to the proposed intervention, and any person whom the Sheriff has directed should be consulted, in so far as it is reasonable and practicable to do so.
- Principle 5 – Encourage the person to use existing skills and develop new skills: Any guardian, attorney, or manager of an establishment exercising functions under the Act shall in so far as it is reasonable and practicable to do so, encourage the adult to exercise whatever skills he or she has concerning property, financial affairs or personal welfare as the case may be and to develop new such skills.

The different interventions under The Adults with Incapacity (Scotland) Act 2000 are:

- Power of attorney – This must be registered with the Office of the Public Guardian and is where individuals whilst they have capacity can grant someone to act as their continuing, financial and / or welfare attorney.
- Access to Funds scheme – Applied for through the Office of the Public Guardian, allows access to the adult's bank or building society account to meet living costs. An application can be made by an individual or an organisation.
- Guardianship – Granted by the Sheriff Court, can cover property and financial matters or personal welfare.
- Intervention order – Granted by the Sheriff Court, is suitable where there is a single action or decision to be taken on behalf of the adult.

DWP appointeeship may be applied for in cases where the only funds available are state benefits / state pension, without a requirement to apply for separate Access to Funds. This is a separate type of intervention, not explicitly covered by the Act, governed by Department of Work and Pensions guidance and policy.

Part 4 of the Adults with Incapacity (Scotland) Act 2000 covers adults who live in authorised establishments (including care homes) who lack the capacity to manage their financial affairs. It provides a mechanism for managers of those establishments to manage finances on the adult's behalf. Part 4 is most likely to be used for residents with relatively small amounts of money who have no one else to lawfully manage their financial affairs. It covers resident's free assets and income and other moveable property to which they are entitled.

Due to limitations with our previous recording systems, statistical information regarding AWI figures could not be digitally obtained. However, these figures were recorded manually on a spreadsheet which gave the Health and Social Care Partnership oversight of all AWI cases in the city. There are 356 service users recorded as having ongoing funds management by the Service, including 354 who have Corporate Appointeeship, and two who have Access to Funds arrangements. The number of individuals for whom intervention agreements have been made and the number for whom the Council oversees power or attorney arrangements is not readily available from the service. The value of funds managed on behalf of Corporate Appointees is £4m, whilst for Access to funds the amounts were approximately £70k.

The Partnership also has a duty to supervise welfare guardians, including review of arrangements, provision of advice and information, and investigating complaints.

1.2 Rationale for the review

The objective of this audit is to ensure that there are evidence-based controls in place regarding funds managed on behalf of clients.

The area has not been reviewed in detail by Internal Audit, however in 2022 as part of an audit of Learning Disabilities services, report number AC2210, some variation in practice was identified, and a need for additional support for staff involved in managing funds to ensure consistency. New procedures and forms were developed to address this within the Learning Disabilities service area.

There is substantial scope for fraud and error where funds and moveable property are being accessed and managed on others' behalf. There are risks to vulnerable service users' funds, and to staff involved in the management of their funds, if appropriate procedures, checks, and balances are not in place and operating effectively.

The Service is accountable to the Care Inspectorate for the proper application of various parts of the Act, however this forms only part of any review of individual establishments, primarily focusing on care delivery. The service is also accountable to the Office of the Public Guardian, Mental Welfare Commission and the Department of Work and Pensions.

1.3 How to use this report

This report has several sections and is designed for different stakeholders. The executive summary (section 2) is designed for senior staff and is cross referenced to the more detailed narrative in later sections (3 onwards) of the report should the reader require it. Section 3 contains the detailed narrative for risks and issues we identified in our work.

2 Executive Summary

2.1 Overall opinion

The full chart of net risk and assurance assessment definitions can be found in Appendix 1 – Assurance Scope and Terms on page 16. We have assessed the net risk (risk arising after controls and risk mitigation actions have been applied) as:

Net Risk Rating	Description	Assurance Assessment
Major	Significant gaps, weaknesses or non-compliance were identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the area audited.	**Limited**

The organisational risk level at which this risk assessment applies is:

Risk Level	Definition
Cluster	This issue / risk level impacts at the Business Plan level (i.e. individual services or departments as a whole). Mitigating actions should be implemented by the responsible Chief Officer.

2.2 Assurance assessment

Internal audit has identified an overall net risk rating of **MAJOR**, with **LIMITED** assurance obtained over this area.

Areas of controls are in development but have yet to be fully implemented. Efficiency is partly affected by ongoing development following the introduction of a new care management recording system – with specific service areas still identifying what needs to be recorded in the system. Procedures in respect of appointeeship, access to funds, financial guardianship and intervention are out of date and there is no evidence of review to ensure they are relevant and tried and tested for sufficiency. Reliance is largely placed on legislation and other high-level guidance, rather than locally relevant procedures and training. As a result, inconsistent practice was identified during the audit.

Records are not always accessible, and the lack of clarity over procedure results in inconsistent filing, recording, and annotation of records. Some records are not on file, including legal documentation, certification of incapacity, and intended use of funds. Where changes take place, records are not consistently being updated to reflect changes. System records are incomplete. This presents risks to service delivery, and to the need to keep accurate data in compliance with data protection legislation. Where records are in place these do not always demonstrate adherence to the minimum intervention principle set out in the Adults with Incapacity (Scotland) Act.

Whilst there are controls over funds received into and distributed from a centralised corporate appointee account, these funds are regularly withdrawn in cash, and a number of weaknesses were identified including an absence of checks, authorisation controls, and evidenced segregation of duties. Following withdrawals there is limited evidence of management of service users' assets. Funds are generally managed by care workers, and their activities in respect of AWI finances are not subject to regular independent review. Supporting evidence in respect of client funds management is limited and is not being reviewed and investigated where there are potential irregularities; this includes an absence of clear plans for spending, and records of use of funds, and changes from confirmed benefit entitlements. Inventories are not routinely maintained or updated, and financial assets in excess of relevant thresholds are not considered for separate management (e.g. in interest bearing accounts).

The lack of control over this area means that there is substantial scope for fraud and error where funds and moveable property are being accessed and managed on others' behalf. Whilst no evidence of recent fraud or theft was identified in the audit, current controls may not prevent or identify it. There are risks to vulnerable service users' funds, and to staff involved in the management of their funds, if appropriate procedures, checks, and balances are not in place and operating effectively.

Recommendations have been made to address the above risks, which Management has agreed to as part of a timebound action plan. This was discussed with Internal Audit and it considered to be

propionate in the wider context of ongoing work and recognising the need to consider flexibility and efficiency as well as control.

2.3 Severe or major issues / risks

Issues and risks identified are categorised according to their impact on the Council. The following are summaries of higher rated issues / risks that have been identified as part of this review:

Ref	Severe or Major Issues / Risks	Risk Agreed	Risk Rating	Page No.
1.1	**Written Procedures and Training** – Procedures, although out of date, are available to assist with aspects of the service. However, within the available procedures or signposted guidance there is insufficient detail in respect of practical application and management of arrangements for Adults with Incapacity, particularly in respect of Records and Funds Management. There was no practical documented guidance or training covering day to day management of funds or assets on behalf of service users. As a result, inconsistent practice was identified during the audit, as noted in the latter elements of this report. This presents risks including fraud, reputational risk and the cost of investigation and rework / corrections.	Y	**Major**	11
1.2	**Complete and Consistent Records** – Documentation to verify client classifications is essential to demonstrate that any interventions are appropriate and are being managed correctly. However, client documents are not held consistently or consolidated in an accessible location. There is no complete central record of all AWI service users, interventions, and activities. Varying records were held by Finance, The Financial Assessments team, Adult Mental Health Administration, Care Managers / Social workers, and Care Practitioners, each with different sets of service users recorded as in receipt of AWI support. Records varied between and within systems, reports, lists and shared hard drives. Classification of the type of intervention on the care management system also varied, and records were incomplete. There is therefore a risk, particularly where there are changes in staffing, that important information will not be available when it is required. Inaccuracies in the data reduce the assurance the Service can obtain from system reports, that all adults with incapacity	Y	**Major**	12

Ref	Severe or Major Issues / Risks	Risk Agreed	Risk Rating	Page No.
	have appropriate interventions in place. The UK General Data Protection Regulation (GDPR) includes data accuracy as one of its seven key principles. There is a risk therefore of the Council breaching legislative requirements in this regard.			
1.3	**Minimum Intervention** – In contrast to Council and DWP guidance, and the 'minimum intervention' principle set out in the Adults with Incapacity (Scotland) Act, corporate appointeeships are in place in cases where incapacity has not been specifically determined by a medical practitioner. This includes cases where clients had other bank accounts – indicating that other funds, and the means or capacity to manage them, are in place. There was no indication of review by another officer prior to submission and processing of requests to manage DWP benefits on service users' behalf – limiting assurance that interventions have been appropriately assessed as necessary.	Y	**Major**	14
1.4	**Financial Controls** – Where financial interventions are appropriate and necessary, these need to be suitably controlled in order to satisfy local ACHSCP and national requirements, to protect vulnerable service users and their finances, and to protect staff responsible for their management. Whilst there are controls over funds in the corporate appointee account, weaknesses were identified including an absence of checks, authorisation controls and evidenced segregation of duties. Cash transactions present increased risk due to its portability, desirability, and the absence of an audit trail after it has been released. In the absence of appropriate controls, funds may be at increased risk of loss through fraud or error.	Y	**Major**	15
1.5	**Funds Management Records** – Supporting evidence in respect of client funds management is poor. There are no records of routine review to identify any irregularities for further review. In the absence of detailed and verified records and independent checks there is a risk that funds will not be utilised as planned or may be subject to misuse – resulting in financial loss, or a	Y	**Major**	17

Ref	Severe or Major Issues / Risks	Risk Agreed	Risk Rating	Page No.
	perception that this may be the case – resulting in reputational damage.			

2.4 Management response

The Services welcome the improvements identified by the Internal Audit team. It recognises and acknowledges that there is a requirement to strengthen and streamline the exiting processes to ensure consistency and good practice across the service and to mitigate risk. Although there is a need to update processes and procedures, it is noted that controls in place ensured no material financial loss was identified. Furthermore, all service objectives were met in relation to service delivery which puts support for people at the centre. The services have implemented a short life working group including representatives from across adult services to take forward a comprehensive action plan. Sub-groups will be tasked with addressing the recommendations from each section. The short life working group will continually review the action plan to ensure the balance of appropriate controls are in place whilst allowing flexibility in the processes which meets the varied needs of service users. This is vital in enabling choice and control by service users as outlined in the Health & Social Care Standards and that service users are not negatively impacted. Updates to guidance and training are also in progress and will be further reviewed prior to implementation to ensure areas of improvement highlighted in the audit report are addressed. All timescales identified below for completion of the actions take are considered to be proportionate with regard to the level of risk. This work will be overseen by the Process Owner.

3 Issues / Risks, Recommendations, and Management Response

3.1 Issues / Risks, recommendations, and management response

Ref	Description	Risk Rating	Major
1.1	**Written Procedures and Training** – Procedures, although out of date, are available to assist with aspects of the service. Guidance was produced over eight years ago for staff managing service users' monies under Corporate Appointeeship, Access to Funds arrangements and intervention. In the intervening period, systems and practice have changed – including implementation of a new care management system. Guidance for dealing with service users subject to Power of Attorney arrangements was out of date. Procedures from Payments control (Finance) for new Appointee requests were not dated. Government websites were referenced for specialist guidance and legislative requirements. AWI training was not formal or overseen by managers. Procedures and financial training were under development for D365, which had replaced CareFirst, which had been decommissioned and last updated in October 2022. Staff knowledge and training was limited to key individuals for information and understanding of the corporate appointee database, bank account and the reconciliation, access to funds process and access to the DWP website. Some processes may be inefficient; inordinate delays were identified in respect of setting up Access to Funds arrangements. In the majority of cases for which records were available, clients were either deceased or needs had been met in other ways before arrangements were concluded (DWP funds were used in the interim, and financial guardianship set up instead). Whilst one had died within a month of the request, for the others correspondence was four,10, 13 and 15 months after the initial requests. Delays present a risk to meeting client needs, and to the Council's reputation. Within the available procedures or signposted guidance there is insufficient detail in respect of practical application and management of arrangements for Adults with Incapacity, particularly in respect of Records and Funds Management. There was no practical documented guidance covering day to day management of funds or assets on behalf of service users. As a result, inconsistent practice was identified during the audit, as noted in the latter elements of this report. This presents risks including fraud, reputational risk and the cost of investigation and rework / corrections. **IA Recommended Mitigating Actions** The Service should document and implement procedures in respect of DWP appointeeship, Intervention Orders, Access to funds, guardianship and POA in dealing with Adults with Incapacity. The Service should ensure these are clear, efficient, provide practical guidance on day-to-day management of funds, and are subject to periodic recorded reviews. Staff required to apply the procedures should be adequately trained in their application. The Service should develop AWI staff training and procedures for key systems, D365, the corporate appointee database, access to funds process, DWP website to provide adequate cover so that key information required can be accessed and audit trails completed for client information stored. **Management Actions to Address Issues/Risks** *Agreed. Updates are in progress. Revised corporate appointeeship guidance is being updated in consultation with legal services. Procedures and guidance will be reviewed by a short life working group in consultation with colleagues across adult services, Finance, the Financial Inclusion Team, and DWP as appropriate. Thereafter procedures will be updated,*	Risk Rating	Major

Ref	Description	Risk Rating	Major
	and rolled out, including clarification of responsibilities and duties, step by step guides, and training. Mandatory training completion will be monitored by senior management, and financial training will be included in induction processes.		

Risk Agreed	Person(s)	Due Date
Yes	Chief Officer (Adult Social Work)	January 2024

Ref	Description	Risk Rating	Major
1.2	**Complete and Consistent Records** – Documentation to verify client classifications is essential to demonstrate that any interventions are appropriate and are being managed correctly. However, client documents are not held consistently or consolidated in an accessible location. There is no complete central record of all AWI service users, interventions, and activities. Varying records were held by Payments Control (Finance), the Financial Assistance team, Adult Mental Health Administration, Care Managers / Social workers, and Care Practitioners, each with different sets of service users recorded as in receipt of AWI support. Records varied between and within systems, reports, lists and shared drives. Classification of the type of intervention on the care management system also varied. Specific examples with regards to the incompleteness and inconsistency of records include: Finance records: • Finance records of care staff were incorrect in seven out of ten cases reviewed (70%). • Two of 13 clients (15%) had passed away (one three months, the other 16 months previously) and this had not been updated in Finance records. • Three of nine Appointeeship files (33%) did not include a copy of the BF56 DWP Appointee application form. • Five of nine Appointeeship files (56%) did not include a copy of the BF57 DWP confirmation of formal appointment to act on the claimant's behalf. The Service indicated these are not always received back, in contrast to the DWP website stating that you are not formally an appointee until receipt. • Although Finance had a record of the names of 'pre-active' Access to Funds clients, files had not been set up for each, and in the cases where files were available changes and delays in notification were not reflected timeously. Care system records: • In nine of 16 cases reviewed (56%), clients were not correctly recorded as an 'Adult with Incapacity' on D365 in the correct field or with relevant dates. • Four of nine client's records (44%) for cases which included both Adult with Incapacity and DWP Appointeeship did not have the relevant legal classifications recorded on D365. For one client DWP appointeeship was mentioned in the notes rather than a classification. • Two clients for whom Access to Funds arrangements were in place (100%), and three of six (50%) for whom arrangements were being put in place, did not have an 'Adult with Incapacity' legal status recorded on D365; and there were also no specific case notes to this effect. • There was no record of the care managers who had been responsible for two deceased clients.		

Ref	Description	Risk Rating	Major

- One 55 year old service user was recorded as being under the care of Children's Services.
- For seven of 15 guardianship cases (47%), Service records maintained on a spreadsheet indicated different care managers from those recorded on D365.
- D365 records in respect of two of five clients with previous local authority financial guardianships (40%) recorded this under 'cases' rather than 'legal status'.
- For those with current guardianship arrangements, eight of 15 (53%) did not have a matching 'legal status' on the system. This was however reflected in 'cases' in four instances, and 'alerts' in three instances.
- In one local authority financial guardianship case the intervention order had lapsed, and this was not reflected on D365.
- Whilst all of three clients for whom Power of Attorney was in place had a record of this on D365, only two of these had an 'Adult with Incapacity' legal status.
- Although in each of the six cases reviewed where there had been an Intervention Order, there was an 'Adult with Incapacity' legal status on D365, there was no record, case or alert specifically recording the interventions.

Care management files:

- All nine appointeeship clients records reviewed (100%) were incomplete in respect of key documents and classifications.
- Four of nine initial requests for appointeeship were not on file (44%).
- Only three of six Appointeeship files (50%) contained supporting detail of the service users' lack of capacity. Only one of these included medical certification, with the other two relying on social work appointee request documents alone.
- One of two Access to Funds clients, and a further three of six 'pre-active' clients for whom arrangements were being put in place (50%), had no medical certification on file to confirm their incapacity had been appropriately assessed.
- One of seven local authority financial guardianships (14%) had no medical certification on file.
- Service spreadsheet records in respect of welfare and financial guardianships indicated that many had expired, and there was no indication of review or follow-up either in these records or on the system.
- The amount of funds requested in an Access to Funds application was incorrect due to a transposition error (£1,975 instead of £1,795) which was not identified.

As highlighted above, there are variations in how, where and whether core records and information are recorded. There is therefore a risk, particularly where there are changes in staffing, that important information will not be available when it is required. Inaccuracies in the data reduce the assurance the Service can obtain from system reports, that all adults with incapacity have appropriate interventions in place. Whilst some assurance can be obtained through external controls – e.g. DWP and OPG checks prior to allowing access to funds, these are reliant on accurate information being provided by the Council. The UK General Data Protection Regulation (GDPR) includes data accuracy as one of its seven key principles. There is a risk therefore of the Council breaching legislative requirements in this regard.

IA Recommended Mitigating Actions

The Service should implement processes and controls to ensure consistent and complete AWI records are held in line with the GDPR accuracy principle, and these are accessible to relevant officers to avoid the risk of duplication and misalignment.

A reconciliation of existing file records against new system records should be undertaken, and corrections applied where necessary.

Ref	Description	Risk Rating	Major
	A system of review should be developed and implemented to obtain regular periodic assurance over the content and accuracy of AWI funds management records.		

Management Actions to Address Issues/Risks

Agreed. We will review options to modernise and streamline the approach, and improve access to and alignment of financial and care data to improve scrutiny. As part of this we will review utilisation of D365 more succinctly – for example classifications, record keeping, storage of documents etc. We will incorporate review of AWI records into the existing QA process and include finance, including corporate appointee accounts where these are in place.

Risk Agreed	Person(s)	Due Date
Yes	Chief Officer (Adult Social Work)	April 2024

Ref	Description	Risk Rating	Major
1.3	**Minimum Intervention –** The Council's Finance procedure for Appointeeship clearly sets out that in line with DWP guidelines: *"An appointment must never be made because it is 'convenient' either for the Secretary of State or the prospective appointee. The customer must, because of mental incapacity (or, exceptionally, severe physical disability), be incapable of managing their affairs" (Agents, Appointees, Attorneys and Deputies Guide September 2011 www.gov.uk)* The referenced document is no longer available, however current DWP guidance on becoming an appointee similarly states: *"You can apply for the right to deal with the benefits of someone who cannot manage their own affairs because they're mentally incapable or severely disabled."* In contrast, as noted at 1.2 above corporate appointeeships are in place in cases where incapacity has not been specifically determined by a medical practitioner. In the two cases reviewed where social work appointee request documents were on file, the narrative indicated that the individuals were not mentally incapable – they were at risk of financial abuse or of getting into debt. There was no indication of review by another officer prior to their submission to Finance and arrangements being set up to manage DWP benefits on their behalf. Further cases were noted during review of transactions where transfers were to clients' other bank accounts – indicating that other funds, and the means or capacity to manage them, are in place. This contrasts with the minimum intervention principle set out in the Adults with Incapacity (Scotland) Act. There is also a risk that resources are not being used efficiently, by implementing potentially unnecessary interventions.		

IA Recommended Mitigating Actions

The Service should review the appointeeship process to ensure it reflects the requirements of the scheme, and minimises intervention where possible. As part of the review the Service should ensure all interventions are subject to secondary review to ensure they are appropriate in line with policy and procedure in advance of their implementation.

Management Actions to Address Issues/Risks

Agreed in terms of review of cases to ensure correct decision making whilst allowing principles of public protection and care standards.

Ref	Description	Risk Rating	Major
	Social Workers can assess someone as lacking capacity using a variety of assessment tools. Therefore, this is not solely determined by a medical practitioner. Transfers to the corporate client account is often carried out as a way of allowing as much independence as possible for the client – but still keeping safeguards in place that they don't have access to all their money at once. Access to large amounts of money all at once can be difficult for some individuals and may lead to them spending it in a manner which may indirectly create risks. Transferring smaller amounts of money into an account enables and empowers individuals to still have a role in the management and expenditure of their money safely. This is in keeping with the principles of the Health and Social Care Standards. *However, it is recognised that improvements can be made to further clarify guidance, ensure appropriate delegations are in place, and to ensure any agreed interventions are reviewed and remain appropriate as part of the QA process.*		

Risk Agreed	Person(s)	Due Date
Yes.	Chief Officer (Adult Social Work) and Finance Control Manager	March 2024

Ref	Description	Risk Rating	Major
1.4	**Financial Controls** – Where financial interventions are appropriate and necessary, these need to be suitably controlled in order to satisfy local ACHSCP and national requirements, to protect vulnerable service users and their finances, and to protect staff responsible for their management. Whilst there are controls over funds in the corporate appointee account, a number of weaknesses were identified: Cash withdrawals: • When funds are required, a social worker will complete a 'social work appointee – client withdrawal request' and submit this to Finance. There are no secondary authorisation controls, and Finance does not have a list of authorised signatories to confirm the request has come from an approved source with appropriate delegated authority. • Funds are taken from the safe and put in envelopes, with the client name, date, and amount recorded on the front. These are taken to a public reception area, held and distributed to social workers, clients, or carers (including third-party staff and family members), nominated to collect them for each service user. • The amounts prepared for collection are recorded on a spreadsheet used for reconciling the safe balance, but this is not updated for each movement from the safe, or each collection from reception. If funds or envelopes were to go missing, it may not be identified until sometime later. • Identity documents are only checked for new visitors. A receipt should be signed by the recipient and issuer of funds, but there are no recorded checks to confirm these matches the originally nominated recipient. The receipting process was not documented as an official part of the paperwork. • A sample of ten receipts was reviewed, and in seven cases (70%) the signatures did not clearly match the nominated recipient name. Five were different names, and the Service was able to retrospectively confirm that this was appropriate in two cases. Two were insufficiently clear to confirm it was the intended recipient. There is no field on the receipt to record the name of the individual collecting the funds. • Payments are also made by BACS from the corporate bank account to individuals and suppliers on clients' behalf, but as with cash payments these are not subject to control checks. Historically, an incorrect BACS payment was made as a result of		

Ref	Description	Risk Rating	Major

mandate fraud. Whilst awareness was raised, internal controls were not revisited subsequent to this incident for improvement.

Banking and reconciliations:

- A reconciliation of the corporate appointee bank statement to database records was under development. At the time of the audit fieldwork, funds did not fully reconcile: £65,000 of differences (1.4%), some potentially dating back to 2013 when the last full reconciliation had been completed, had still to be reviewed and actions recorded. The bank balance included money not allocated to clients due to lack of client identification, information from DWP payments and from payments of funds into the account via a bank branch.
- Finance relies on correct information from social workers regarding changes to client account information, and correct and timely information from the bank and DWP to resolve the differences.
- In one instance funds had been taken in error from the appointee account for an 'access to funds' client. Whilst the Service is aware of the error, the funds had not been correctly recovered three months later.
- The corporate bank account contained funds of clients who were deceased, with no next of kin, whose money needed to be identified and returned to the Crown.

Cash transactions present increased risk due to its portability, desirability, and the absence of an audit trail after it has been released. In the absence of appropriate controls, funds may be at increased risk of loss through fraud or error.

IA Recommended Mitigating Actions

All requests for funds and payments should have clearly documented review and approval before funds are released. Segregation of duties should be in place for each stage.

The identity of funds recipients should be verified and documented. Variations should be subject to approval.

All funds movements and transfers should be documented and countersigned at the point such movements take place, with such documentation held separately from the physical funds.

Consideration should be given to whether collecting and distributing cash remains the most appropriate means of providing support to individuals.

The bank reconciliation to the corporate appointee database should be regularly completed, reviewed, and actions approved and monitored to conclusion.

Accounts of deceased clients that are still active should be reviewed for necessary actions to close.

Management Actions to Address Issues/Risks

Agreed however there is a need to consider flexibility and efficiency as well as control, and there may be scope for variation in line with the volume and value of transactions. The short life working group will review and ensure implementation of appropriate controls in line with the recommendations above whilst maintaining flexibility for the service user. Cash transactions will however remain if that is what is in the interest of the service user

Risk Agreed	Person(s)	Due Date
Yes.	Finance Control Manager (or representative)	May 2024

Ref	Description	Risk Rating	Major
1.5	**Funds Management Records** – Clear, consistent, and complete records of planned and actual income and expenditure are essential in providing assurance over appropriate stewardship of client funds. This is especially important in this service area given these clients lack capacity to review their financial activity. As appointees, staff are responsible for spending the benefit in the claimant's best interests. To provide assurance funds are being obtained for an appropriate reason it should be clearly recorded what funds will be used for – e.g. the types of expenditure that may be incurred to support and benefit the service user. There should also be records of expected income (e.g. pensions, benefits), and expenditure (e.g. care fees, regular payments, allowances etc). Actual income and expenditure can then be compared against these to ensure they are appropriate and reasonable. However, in the majority of cases for which records were available this was not the case. In five out of six cases (83%) where information was available amounts withdrawn were described as personal allowance or for clothes, food, and household items. With limited exceptions (e.g. where a third party care establishment maintained its own records) there is no record thereafter of how funds have been used to meet the service users' needs. There is currently no specified threshold for management review of larger withdrawals. An inventory should be held of clients' physical assets and updated when items are bought or sold to reduce risk of missing items whilst in the care of ACHSCP staff. With limited exceptions (e.g. where a third party care establishment maintained its own records) a formal record of inventory was not taking place. As appointees, staff are responsible for spending the benefit in the claimant's best interests and a spending plan, with receipts and associated inventory would provide assurance over this. For example, in one instance a receipt had been retained for a £199 watch – however this was not on an inventory and the receipt was in the name of a member of care home staff. Clients' funds could be spent on items for the benefit of others if there is no available documentation to verify who owns the item. Client balances and transactions were available on request from Finance, however as noted at 1.4 above these may not be up to date pending reconciliations being completed and corrections applied. Not all social workers were requesting and reviewing balance and transaction detail routinely so that any irregularities can be reviewed. Although there are annual reviews, the requirements in respect of financial review are not set out in a written procedure, resulting in variations in practice. In the absence of detailed and verified records and independent checks there is a risk that funds will not be utilised as planned or may be subject to misuse – resulting in financial loss, or a perception that this may be the case – resulting in reputational damage **IA Recommended Mitigating Actions** The Service should ensure there is a clear and consistent audit trail for all instances where funds are managed on behalf of service users. This should be subject to periodic reconciliation against other records (e.g. bank statements, cash balances, inventories, DWP data and other source documentation), and potential discrepancies escalated and the results and actions recorded. **Management Actions to Address Issues/Risks** *Agreed. There will be a review of our audit trail where money is requested, stored, and distributed. Segregation of duties will be covered by a new guidance note.* *As noted at 1.2 above we will review options to modernise and streamline the approach and improve access to and alignment of financial and care data to improve scrutiny. As part of this we will review utilisation of D365 more succinctly – for example classifications, record keeping, storage of documents etc. We will incorporate review of AWI records into the existing QA process and include finance, including corporate appointee accounts where*		

Ref	Description	Risk Rating	Major
	these are in place. Again, there does need to be some flexibility in terms of a spending plan as being too prescriptive takes away choice and control of the service user.		

Risk Agreed	Risk Agreed	Risk Agreed
Yes.	Service Manager Mental Health and Substance Misuse	February 2024

Ref	Description	Risk Rating	Moderate
1.6	**Management of Financial Assets** – Part 4 of the Adults with Incapacity Scotland Act 2000 contains a useful reference to financial thresholds for management of funds. It indicates that care home managers should not manage client finances of over £10,000. Amounts over this should be supervised by the Care Inspectorate and appropriately invested for the adult's benefit. Within the sample of cases reviewed by Internal Audit three client account balances were in excess of this threshold. The Service's ability to act in these cases is restricted, as the funds are currently managed under DWP appointeeship in a corporate account, which did not attract interest for any client and incurs charges, and access to funds. However, these balances represent a higher risk of fraud or error, and if they are not earning interest may be eroded, limiting the potential for service users to benefit from them, and potentially the amounts which they could contribute towards their care. These balances could also indicate alternative interventions may be more suitable.		

IA Recommended Mitigating Actions
The Service should ensure client accounts with balances in excess of specified thresholds are reviewed to ensure they are managed appropriately.

Management Actions to Address Issues/Risks
Agreed. We will introduce processes for early identification if funds are reaching the financial threshold.

Risk Agreed	Person(s)	Due Date
Yes	Finance Control Manager	January 2024

4 Appendix 1 – Assurance Terms and Rating Scales

4.1 Overall report level and net risk rating definitions

The following levels and ratings will be used to assess the risk in this report:

Risk level	Definition
Corporate	This issue / risk level impacts the Council as a whole. Mitigating actions should be taken at the Senior Leadership level.
Function	This issue / risk level has implications at the functional level and the potential to impact across a range of services. They could be mitigated through the redeployment of resources or a change of policy within a given function.
Cluster	This issue / risk level impacts a particular Service or Cluster. Mitigating actions should be implemented by the responsible Chief Officer.
Programme and Project	This issue / risk level impacts the programme or project that has been reviewed. Mitigating actions should be taken at the level of the programme or project concerned.

Net Risk Rating	Description	Assurance Assessment
Minor	A sound system of governance, risk management and control exists, with internal controls operating effectively and being consistently applied to support the achievement of objectives in the area audited.	**Substantial**
Moderate	There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified, which may put at risk the achievement of objectives in the area audited.	**Reasonable**
Major	Significant gaps, weaknesses or non-compliance were identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the area audited.	**Limited**
Severe	Immediate action is required to address fundamental gaps, weaknesses or non-compliance identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the area audited.	**Minimal**

Individual Issue / Risk Rating	Definitions
Minor	Although the element of internal control is satisfactory there is scope for improvement. Addressing this issue is considered desirable and should result in enhanced control or better value for money. Action should be taken within a 12 month period.
Moderate	An element of control is missing or only partial in nature. The existence of the weakness identified has an impact on the audited area's adequacy and effectiveness. Action should be taken within a six month period.
Major	The absence of, or failure to comply with, an appropriate internal control, which could result in, for example, a material financial loss. Action should be taken within three months.
Severe	This is an issue / risk that could significantly affect the achievement of one or many of the Council's objectives or could impact the effectiveness or efficiency of the Council's activities or processes. Action is considered imperative to ensure that the Council is not exposed to severe risks and should be taken immediately.

5 Appendix 2 – Assurance Scope and Terms of Reference

5.1 Area subject to review

The Adults with Incapacity (Scotland) Act provides ways to help protect adults, aged 16 or over, who are or may become, incapable of looking after their own welfare or finances. This may be because of a mental health problem, learning disability, dementia, or other difficulties in communication. After due consideration of the supported person's needs and circumstances, the Health and Social Care Partnership can make a request for an assessment of capacity and use a 'Decision-Specific Screening Tool' for guidance as to whether a formal assessment is needed. A GP would then make the Mental Capacity Assessment decision for a patient.

The act allows other people (including e.g. family members, main carers, or the local authority) to make decisions on behalf of those adults, subject to authorisation and other safeguards, and following 5 key principles.

- Principle 1 – Any action or decision taken must benefit the person and only be taken when that benefit cannot reasonably be achieved without it.
- Principle 2 – Least restrictive option, any action or decision taken should be the minimum necessary to achieve the purpose. It should be the option that restricts the person's freedom as little as possible.
- Principle 3 – Take account of the wishes of the person, in deciding if an action or decision is to be made and what that should be, account must be taken of the present and past wishes and feelings of the person, as far as this may be ascertained.
- Principle 4 – Consultation with relevant others, take account of the views of others with an interest in the person's welfare.
- Principle 5 – Encourage the person to use existing skills and develop new skills.

The different interventions are:

- Power of attorney – This must be registered with the Office of the Public Guardian and is where individuals whilst they have capacity can grant someone to act as their continuing, financial and / or welfare attorney.
- Access to Funds scheme – Applied for through the Office of the Public Guardian, allows access to the adult's bank or building society account to meet living costs. An application can be made by an individual or an organisation.
- Guardianship – Granted by the Sheriff Court, can cover property and financial matters or personal welfare.
- Intervention order – Granted by the Sheriff Court, is suitable where there is a single action or decision to be taken on behalf of the adult.

DWP appointeeship may be applied for in cases where the only funds available are state benefits / state pension, without a requirement to apply for separate Access to Funds.

Part 4 of the act covers adults who live in authorised establishments (including care homes) who lack the capacity to manage their financial affairs. It provides a mechanism for managers of those establishments to manage finances on the adult's behalf. Part 4 is most likely to be used for residents with relatively small amounts of money who have no one else to lawfully manage their financial affairs. It covers resident's free assets and income and other moveable property to which they are entitled.

The Health & Social Care Partnership is involved with a number of Adults With Incapacity in the area. In a number of cases the Service is required to handle the service user's finances. The Health & Social Care Partnership is still to confirm the number of each type of arrangement, and overall estimated value of funds managed on service users' behalf.

The Partnership also has a duty to supervise welfare guardians, including review of arrangements, provision of advice and information, and investigating complaints.

Rationale for review

The objective of this audit is to ensure that there are evidence based controls in place regarding funds managed on behalf of clients.

The area has not been reviewed in detail by Internal Audit, however in 2022 as part of an audit of Learning Disabilities services, report number AC2210, some variation in practice was identified, and a need for additional support for staff involved in managing funds to ensure consistency.

There is substantial scope for fraud and error where funds and moveable property are being accessed and managed on others' behalf. There are risks to vulnerable service users' funds, and to staff involved in the management of their funds, if appropriate procedures, checks, and balances are not in place and operating effectively.

The Service is accountable to the Care Inspectorate for the proper application of various parts of the Act, however this forms only part of any review of individual establishments, primarily focusing on care delivery.

5.2 Scope and risk level of review

This review will offer the following judgements:

- An overall **net risk** rating at the Cluster level.
- Individual **net risk** ratings for findings.

5.2.1 Detailed scope areas

As a risk-based review this scope is not limited by the specific areas of activity listed below. Where related and other issues / risks are identified in the undertaking of this review these will be reported, as considered appropriate by IA, within the resulting report.

The specific areas to be covered by this review are:

- Adults with Incapacity policies and procedures
- Management, decision making, application of policy and procedure, and record keeping in respect of Adults with Incapacity and associated interventions.
- Records and management of service users' funds
- Records and management of service users' personal assets

5.3 Methodology

This review will be undertaken through interviews with key staff involved in the process(es) under review and analysis and review of supporting data, documentation, and paperwork. To support our work, we will review relevant legislation, codes of practice, policies, procedures, guidance.

Due to flexible working arrangements, the majority of this review will be undertaken remotely. Any site visits required will be planned and risk assessed. We remain flexible in the face of the rapidly changing risk environment. Where our resourcing or access to the client is impacted further by COVID-19, we will adapt our audit methodology to balance the risks and assurance output and will work in co-operation with key contacts to understand the impact of the situation as it evolves.

5.4 IA outputs

The IA outputs from this review will be:

- A risk-based report with the results of the review, to be shared with the following:
  - Key Contacts (see 1.7 below)
  - Audit Committee (final only)
  - External Audit (final only)

5.5 IA staff

The IA staff assigned to this review are:

- Heulwen Beecroft, Auditor **(audit lead)**
- Colin Harvey, Audit Team Manager
- Jamie Dale, Chief Internal Auditor **(oversight only)**

5.6 Council key contacts

The key contacts for this review across the Council are:

- Sandra MacLeod, Chief Officer (ACHSCP)
- Fraser Bell, Chief Operating Officer (ACHSCP)
- Paul Mitchell, Chief Finance Officer (ACHSCP)
- Katharine Paton, Service Manager (ACHSCP)
- Claire Wilson, Chief Officer, Adult Social Work, (ACHSCP)
- Steven Stark, Service Manager, (RCH)
- Kevin Dawson, (NHS Grampian)
- Tracey McMillan, Service Manager, (ACHSCP)
- Nicola McLean, Service Manager (ARI)
- Barbara Dunbar, Service Manager, (ACHSCP)

5.7 Delivery plan and milestones

The key delivery plan and milestones are:

Milestone	Planned date
Scope issued	19-Jan-23
Scope agreed	28-Feb-23
Fieldwork commences	24-Mar-23
Fieldwork completed	2-May-23
Draft report issued	12-May-23
Process owner response	19-May-23
Director response	26-May-23
Final report issued	2-Jun-23