Report

Internal Audit Annual Opinion
Edinburgh Integration Joint Board

28 September 2018

Executive Summary

1. This purpose of this paper is to refer the Edinburgh Integration Joint Board (EIJB) Internal Audit annual opinion which is included as Appendix 1 for the year ended 31 March 2018 from the EIJB Audit and Risk Committee to the Board for review and noting. It also updates the Board on the arrangements being put in place within the Edinburgh Health and Social Care Partnership to respond to internal audit findings and scrutinise progress in delivering agreed management actions.

2. The 2017/18 annual opinion reflects that Internal Audit considers that significant enhancements are required to the EIJB control environment and governance and risk management frameworks and is therefore reporting a significant enhancement 'red' rated opinion, with our assessment towards the middle of this category.

Recommendations

3. The Integration Joint Board is asked to note:

   i. That there is a number of areas where further work is needed to close internal audit actions and directs the Chief Officer to provide a detailed action plan to the next Audit and Risk Committee.

   ii. the final 'significant enhancements' red rated Internal Audit opinion for the year ended 31 March 2018; and

   iii. the arrangements in place in the Partnership to scrutinise audit activity and provide assurance to the EIJB, the City of Edinburgh Council and NHS Lothian.

Background

4. It is the responsibility of the EIJB Chief Internal Auditor to provide an independent and objective annual opinion on the adequacy and effectiveness of

the EIJB's control environment, and governance and risk management frameworks in line with the requirements of Public Sector Internal Audit Standards.

5. The annual opinion is provided to the EIJB Audit and Risk Committee and should be used to inform the EIJB Annual Governance Statement. The 2017/18 opinion was presented to the IJB Audit and Risk Committee on 23 July 2018, and subsequently referred to the Board for noting.

6. It is recognised within the Partnership that a different approach to the implementation of audit actions was required. Consequently the Chief Officer has now established an "Assurance Oversight Group", whose purpose is to scrutinise progress against agreed management actions and, in turn, to provide assurance to key stakeholders.

Main report

7. The Internal Audit opinion (attached at appendix 1) is based on the outcomes of three audits included in the EIJB 2017/18 Internal Audit annual plan; the outcomes of relevant Partnership reports referred to the EIJB by the City of Edinburgh Council Governance, Risk, and Best Value Committee and the NHS Lothian Audit Committee; and the status of open Internal Audit findings.

8. The opinion is a component part of the annual assurance provided to the EIJB, as there are a number of additional assurance sources that the Committee should consider when forming their own view on the design and effectiveness of the control environment and governance and risk management frameworks.

9. In response to the weaknesses identified in the opinion, the Chief Officer has now established an Assurance Oversight Group. This will form a key plank of the assurance process and has a wide ranging membership, both from within the Partnership and from colleagues in Council and NHS departments with responsibility for delivering elements of the plans. The group held its inaugural meeting on 29th August and will agree a work plan over the coming months. It has currently established one sub group, chaired by the Chief Finance Officer, which has been tasked with agreeing the detailed management actions which will support delivery of the findings of the report on the purchasing budget. This sub group ensure that an action plan is in place by 21st December 2018.

Key risks

10. Covered in section 38 of the main paper.

Financial implications

11. There are no financial implications for the EIJB as a consequence of this report.

Implications for Directions

12. There are no specific implications for directions arising from this report.

Equalities implications

13. There are no equalities impacts.

Sustainability implications

14. No direct sustainability implications.

Involving people

15. Covered in section 43 of the main paper.

Impact on plans of other parties

16. Covered in section 44 of the main paper.

Background reading/references

Public Sector Internal Audit Standards

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Appendices

Appendix 1	Internal Audit annual opinion

Report

Internal Audit Annual Opinion 2017/18

IJB Audit and Risk Committee

23 July 2018

Executive Summary

1. This report details Internal Audit's annual opinion for the Edinburgh Integration Joint Board (EIJB) for the year ended 31 March 2018.
2. Internal Audit considers that significant enhancements are required to the EIJB control environment and governance and risk management frameworks and is therefore reporting a 'red' rated opinion (see Appendix 1), with our assessment towards the middle of this category.
3. Our opinion is based on the outcomes of three audits included in the EIJB 2017/18 Internal Audit annual plan; the outcomes of relevant Partnership reports referred to the EIJB by the City of Edinburgh Council Governance, Risk, and Best Value Committee and the NHS Lothian Audit Committee; and the status of open Internal Audit findings.
4. This report is a component part of the annual assurance provided to the EIJB, as there are a number of additional assurance sources that the Committee should consider when forming their own view on the design and effectiveness of the control environment and governance and risk management frameworks.
5. This report is prepared as per the requirements detailed in the Public Sector Internal Audit Standards (PSIAS).

Recommendations

6. It is recommended that the Committee note the final 'significant enhancements' red rated Internal Audit opinion for the year ended 31 March 2018.

Background

7. The Public Sector Internal Audit Standards (PSIAS) provide a coherent and consistent internal audit framework for public sector organisations. Adoption of the PSIAS is mandatory for internal audit teams within UK public sector organisations, and PSIAS require annual reporting on conformance.
8. The objective of Internal Audit is to provide a high quality independent audit service to the EIJB in accordance with PSIAS requirements, that provides

assurance over the control environment established to manage the EIJB's key risks and their overall governance and risk management frameworks.

9. Internal Audit assurance is provided to the EIJB by its two partners, the City of Edinburgh Council (the Council) and NHS Lothian (NHSL), with a total of four audits completed annually (three by the Council and one by NHSL). The role of Chief Internal Auditor for the EIJB is performed by the Council's Chief Internal Auditor.

10. NHSL use a different classification for their Internal Audit findings in comparison to the Council. Details of these classifications and their alignment are included at Appendix 2.

11. It is the responsibility of the Chief Internal Auditor to provide an independent and objective annual opinion on the adequacy and effectiveness of the EIJB's control environment and governance and risk management frameworks in line with PSIAS requirements. The opinion is provided to the EIJB Audit and Risk Committee, and should be used to inform the EIJB Annual Governance Statement.

12. The Internal Audit plan for 2017/18 was based on the March 2017 EIJB risk register which included 6 High and 6 Medium rated risks where audit assurance could be provided. It was agreed by the EIJB Audit and Risk Committee that assurance should be provided annually on High risks with coverage of Medium risks on a rolling 3 year basis. The 2017/18 IA annual plan was approved by the Audit and Risk Committee in June 2018.

13. The IA plan was rebased and approved by the Audit and Risk Committee in December 2017 following a request by the Partnership to review the key financial controls supporting the social care purchasing budget. Consequently, this review was added to the plan and two existing plan reviews consolidated. Details of the audits completed as part of the rebased plan are included at Appendix 3.

14. Where control weaknesses are identified, Internal Audit findings are raised, and management agree recommendations to address the gaps identified. However, it is the responsibility of management to address and rectify control weaknesses via timely implementation of the agreed management actions.

15. The IA definition of an overdue finding is any finding where all agreed management actions have not been implemented by the final date agreed by management and recorded in Internal Audit reports.

Main report

Internal Audit Opinion

16. Internal Audit considers that significant enhancements are required to the EIJB control environment and governance and risk management frameworks and is therefore reporting a 'red' rated opinion (see Appendix 1), with our assessment towards the middle of this category.

17. This opinion is subject to the inherent limitations of internal audit (covering both the control environment and the assurance provided over controls) as set out in Appendix 4.

18. Internal Audit is not the only source of assurance provided to the EIJB, and there are a number of additional assurance sources (for example, external audit) that the Committee should consider when forming their own view on the design and effectiveness of the EIJB control environment and governance and risk management frameworks.

Basis of Opinion

19. Our opinion is based on the outcomes of three audits included in the rebased EIJB 2017/18 Internal Audit annual plan; the outcomes of relevant Partnership audits completed by the Council and NHSL; and the status of open Internal Audit findings.

Audit Outcomes

20. Assurance was provided on all 6 High and 3 of the Medium rated risks included in the March 2017 EIJB risk register by completion of the three EIJB audits, and Partnership audits performed and referred to the EIJB by the Council and NHSL respectively. Further detail is included at Appendix 5. The remaining Medium rated risks will be covered on a rolling three-year basis, unless any substantive changes are made to the risk register.

21. A total of 66 Internal Audit findings have been raised (29 High; 26 Medium; and 11 Low) across the three audits performed for the EIJB and audits referred to the EIJB by the Council's Governance, Risk, and Best Value Committee (nine) and the NHSL Audit and Risk Committee (two). Further detail is included at Appendix 3, table 1.

22. All three EIJB audits have been completed and include a total of 8 High and 1 Medium rated findings. Further detail is included at Appendix 3, table 2.

23. A total of nine reports were referred to the EIJB Audit and Risk Committee by the Council's Governance, Risk, and Best Value Committee, that have either a direct impact on core IJB activities, or an indirect impact on supplementary IJB activities. These reports included a total of 50 findings (19 High; 22 Medium; and 9 Low). Further detail is included at Appendix 3, table 3.

24. NHSL also referred a total of 2 reports, with a total of 7 findings raised (2 Critical / High; 3 Medium / Significant; and 2 Low / Important) rated findings raised. Further detail is included at Appendix 3. Table 4.

Status of Internal Audit Findings

25. As at 31 March 2018, the total number of open Internal Audit findings that relate to reviews completed across the 2017/18 EIJB and the Partnership annual plans was 34 (10 High; 20 Medium; and 4 Low). Note that this does not include the 9 findings raised in the in three draft 2017/18 EIJB audit reports.

26. Of these, 28 (82%) comprising 7 High; 17 Medium; and 4 Low were overdue as agreed management actions were not completed by the agreed implementation date. Further detail is included at Appendix 3, table 5.

Comparison to Prior Year

27. A disclaimer opinion was reported in 2016/17 as capacity constraints resulted in the inability to complete sufficient reviews to provide assurance on 5 of the 6 Medium rated EIJB risks (based on the June 2016 EIJB Risk Register), resulting in an inability to conclude on the EIJB's control environment and governance and risk management frameworks.

28. However, the 2016/17 annual opinion did include details of the number of findings raised and reported to the EIJB in the year to 31 March 2017.

29. Whilst the total number of audits referred to the EIJB by the Council's GRBV and NHSL Audit and Risk Committees in 2017/18 has decreased by 50% in comparison to 2016/17, with a reduction in the number of findings raised (from 88 to 50), the number of High rated findings raised has increased by circa 58% from a total of 12 in 2016/17 to 19 in 2017/18. This is offset by a decrease in the number of Medium and Low rated findings raised.

30. We have also noted an increasing trend in the percentage of open IA findings that are overdue as at 31 March (82% in 2017/18 in comparison to 74% in 2016/17). There has also been an increase in the number of High rated findings that are now overdue (70% in 2017/18 in comparison to 67% in 2016/17). It should be noted that the majority of overdue findings relate to reports referred to the EIJB by the Council. Further detail on open and overdue findings is included at Appendix 3, table 5.

Internal Audit Independence

31. PSIAS require that Internal Audit must be independent and internal auditors must be objective in performing their work. To ensure conformance with these requirements, both the Council and NHSL Internal Audit teams have established processes to ensure that both team and personal independence is consistently maintained and that any potential conflicts of interest are effectively managed.

32. Neither audit team considers that we have faced any significant threats to our independence during 2017/18, nor do we consider that we have faced any inappropriate scope or resource limitations when completing our work.

33. Internal Audit independence for NHS Lothian was confirmed in the Internal Audit Annual Report and Opinion 2017/18 that was presented to the NHS Lothian Audit and Risk Committee on Monday 18 June.

34. City of Edinburgh Council Internal Audit independence will be confirmed in the City of Edinburgh Council Internal Audit Opinion and Annual Report for the Year Ended 31 March 2018 to be presented at the Governance Risk and Best Value committee on 31 July 2018.

Conformance with Public Sector Internal Audit Standards

35. The City of Edinburgh Council Internal Audit function has not conformed with PSIAS requirements during 2017/18 for the following reasons:

- There has been insufficient follow-up of Internal Audit findings between April 2015 and October 2017 to monitor and ensure that management actions have been effectively implemented; and
- Resourcing challenges within the Internal Audit team has impacted completion of the two internal quality assurance reviews included in the 2017/18 Internal Audit annual plan to ensure consistency of audit quality.

36. It should be noted that these instances of non-conformance have had no direct impact on the quality of internal audit reviews completed in 2017/18.

37. The NHSL Internal Audit team has fully conformed with PSIAS requirements during 2017/18. This is confirmed in the Internal Audit Annual Report and Opinion 2017/18 that was presented to the NHS Lothian Audit and Risk Committee on Monday 18 June.

Key risks

38. If Internal Audit findings are not implemented, the EIJB will remain exposed to the risks detailed in Internal Audit reports. Internal Audit findings are raised as a result of control gaps or deficiencies identified during reviews and therefore inherently impact upon compliance and governance.

Financial implications

39. There are no financial implications for the EIJB as a consequence of this report.

Implications for Directions

40. There are no specific implications for directions arising from this report.

Equalities implications

41. There are no equalities impacts.

Sustainability implications

42. No direct sustainability implications

Involving people

43. The Internal Audit plan on which this opinion is based, is derived from the EIJB from risk register. In preparing the risk register, the Risk function consulted widely with senior management from the Integration Board, NHS Lothian and the City of Edinburgh Council. The Risk register also includes input from members of the Board and the Board's Audit Committee.

Impact on plans of other parties

44. The Internal Audit reports brought to the attention of the Committee, that support this opinion, come from 3 different sources:

- Audits completed for the EIJB as part of its Internal Audit Plan for 2017/18. These audits were performed by either the Council's or the NHSL Internal Audit teams under the supervision of the EIJB's Chief Internal Auditor
- Audits completed by the Council Internal Audit team for the City of Edinburgh Council and referred to the EIJB Audit & Risk Committee by the City of Edinburgh Council's Governance, Risk & Best Value Committee.
- Audits completed by the NHSL Internal Audit team for NHS Lothian and made available to the EIJB's Audit & Risk Committee by NHS Lothian's Audit & Risk Committee.

45. Reports in the first category require to be incorporated into the work programmes of both Internal Audit teams and may require City of Edinburgh Council Internal Audit team members to work within the NHS as well as in their own environment.

Background reading / references

46. Public Sector Internal Audit Standards

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Appendices

Appendix 1	**Internal Audit opinion types**
Appendix 2	**Classifications Applied to Internal Audit Findings**
Appendix 3	**Summary of Internal Audit reports that form the basis of the**

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Appendix 1 - Internal Audit opinion types

The PSIAS require the provision of an annual Internal Audit opinion, but do not provide any methodology or guidance detailing how the opinion should be defined.

Professional judgement is exercised in determining the appropriate opinion, and it should be noted that in giving an opinion, assurance provided can never be absolute

We consider that there are 5 possible opinion types that could apply to the EIJB. These are detailed below:

1 'Adequate' *An adequate and appropriate control environment and governance and risk management framework is in place enabling the risks to achieving organisation objectives to be managed*	**2 'Generally adequate but with enhancements required'** *Areas of weakness and non-compliance in the control environment and governance and risk management framework that that may put the achievement of organisational objectives at risk*
3 Significant enhancements required *Significant areas of weakness and non-compliance in the control environment and governance and risk management framework that puts the achievement of organisational objectives at risk*	**4. 'Inadequate'** *The framework of control and governance and risk management framework is inadequate with a substantial risk of system failure resulting in the likely failure to achieve organisational objectives*
5. 'Disclaimer' *Inability to complete sufficient reviews and gain sufficient evidence to be able to conclude on the adequacy of the framework of Governance, Risk Management and Control.*	

Appendix 2 - Classifications Applied to Internal Audit Findings

City of Edinburgh Council	
Rating	**Assessment rationale**
Critical	A finding that could have a: • ***Critical*** impact on operational performance; or • ***Critical*** monetary or financial statement impact; or • ***Critical*** breach in laws and regulations that could result in material fines or consequences***;*** *or* • ***Critical*** impact on the reputation or brand of the organisation which could threaten its future viability.
High	A finding that could have a: • ***Significant*** impact on operational performance; or • ***Significant*** monetary or financial statement impact; or • ***Significant*** breach in laws and regulations resulting in significant fines and consequences***;*** *or* • ***Significant*** impact on the reputation or brand of the organisation.
Medium	A finding that could have a: • ***Moderate*** impact on operational performance; or • ***Moderate*** monetary or financial statement impact; or • ***Moderate*** breach in laws and regulations resulting in fines and consequences; or • ***Moderate*** impact on the reputation or brand of the organisation.
Low	A finding that could have a: • ***Minor*** impact on the organisation's operational performance ; or • ***Minor*** monetary or financial statement impact; or • ***Minor*** breach in laws and regulations with limited consequences; or • ***Minor*** impact on the reputation of the organisation.
Advisory	A finding that does not have a risk impact but has been raised to highlight areas of inefficiencies or good practice.

NHS Lothian	
Management Action Rating	**Definition**
Critical	The issue has a material effect upon the wider organisation.
Significant	The issue is material for the subject under review.
Important	The issue is relevant for the subject under review.
Minor	The issue is a housekeeping point for the subject under review.

Appendix 3 - Summary of Internal Audit reports that form the basis of the 2017/18 Internal Audit Opinion and Open Internal Audit Findings

1. Total Findings Raised		No of Findings Raised			
	No of Audits	High	Medium	Low	Totals
EIJB Audit Reviews	3	8	1	-	9
City of Edinburgh Council Audit Reviews	9	19	22	9	50
NHS Lothian Audit Reviews	2	2	3	2	7
Total 2017/18	**14**	**29**	**26**	**11**	**66**
Total 2016/17	**20**	**12**	**40**	**36**	**88**

2. EIJB Audit Reviews	No of Findings Raised			
	High	Medium	Low	Totals
Health and Social Care Partnership Purchasing Budget Management	4	-	-	4
Review of Social Care Commissioning	1	1	-	2
Performance Target Data	3	-	-	3
Total 2017/18 – 3 reports	**8**	**1**	**-**	**9**
Total 2016/17 – 4 reports	**4**	**5**	**2**	**11**

Appendix 3 - Summary of Internal Audit reports that form the basis of the 2017/18 Internal Audit Opinion and Open Internal Audit Findings

3. Reports referred by City of Edinburgh Council Governance, Risk and Best Value Committee

		No of Findings Raised			
	*Impact	High	Medium	Low	Totals
Care Homes Assurance Review	Direct	4	12	4	20
Social Work Centre Bank Account Reconciliations	Direct	2	-	-	2
Edinburgh Alcohol and Drug Partnership Contract Management	Direct	1	2	1	4
Asset Management Strategy	Indirect	-	3	2	5
Starters (referred March 18)	Direct	2	1	-	3
Leavers Process (referred Dec 17)	Direct	4	1	1	6
Property Maintenance (referred Dec 17)	Indirect	2	1	1	4
IT Disaster Recovery (referred Dec 17)	Direct	1	-	-	1
Review of External Security (referred Dec 17)	Direct	3	2	-	5
Total 2017/18 – 5 reports		**19**	**22**	**9**	**50**
Total 2016/17 – 15 reports		**8**	**21**	**5**	**34**

***Impact Definition**

Direct – Audits performed by the City of Edinburgh Council / NHS Lothian where control gaps identified have a direct impact on core IJB activities

Indirect – Audits performed by the City of Edinburgh Council / NHS Lothian where control gaps identified have an impact on ancillary IJB activities.

Appendix 3 - Summary of Internal Audit reports that form the basis of the 2017/18 Internal Audit Opinion and Open Internal Audit Findings

4. Reports identified by NHS Lothian IA as being of interest to the EIJB

		Findings Raised			
	*Impact	Critical	Significant	Important	Totals
Budget Management and Financial Recovery Planning	Direct	-	1	2	3
Whistleblowing	Direct	2	2	-	4
Total 2017/18 – 2 reports		**2**	**3**	**2**	**7**
Total 2016/17 – 8 reports		**-**	**14**	**29**	**43**

5. Open and Overdue Internal Audit Findings

	Number of findings				
	Critical	High/ Critical	Medium/ Significant	Low/ Important	Total
EIJB	-	2	4	-	6
City of Edinburgh Council	-	8	16	4	28
NHS Lothian	-	-	-	-	-
Total 17/18	**-**	**10**	**20**	**4**	**34**
Overdue 17/18	**-**	**7 (70%)**	**17 (85%)**	**4 (100%)**	**28 (82%)**
Total 16/17	**-**	**3**	**23**	**9**	**35**
Overdue 16/17	**-**	**2 (67%)**	**18 (78%)**	**6 (67%)**	**26 (74%)**

Appendix 4 - Limitations and responsibilities of Internal Audit and management responsibilities

The opinion is based solely on the internal audit work performed for the financial year 1 April 2017 to 31 March 2018. Work completed was based on the terms of reference agreed with management for each review. However, where other matters have come to our attention, that are considered relevant, they have been taken into account when finalising our reports and the annual opinion.

There may be additional weaknesses in the EIJB control environment and governance and risk management frameworks that were not identified as they were not included in the 2017/18 EIJB annual internal audit plan; were excluded from the scope of individual reviews; or were not brought to Internal Audit's attention. Consequently, management and the Committee should be aware that the opinion may have differed if these areas had been included, or brought to Internal Audit's attention.

Control environments, no matter how well designed and operated, are affected by inherent limitations. These include the possibility of poor judgment in decision-making; human error; control processes being deliberately circumvented by employees and others; management overriding controls; and the impact of unplanned events.

Future periods

The assessment of controls relating to the Council is for the year ended 31 March 2017. Historic evaluation of effectiveness may not be relevant to future periods due to the risk that:

- the design of controls may become inadequate because of changes in operating environment, law, regulation or other; or
- the degree of compliance with policies and procedures may deteriorate.

Responsibilities of Management and Internal Audit

It is Management's responsibility to develop and effective control environments and governance and risk management frameworks that are designed to prevent and detect irregularities and fraud. Internal audit work should not be regarded as a substitute for Management's responsibilities for the design and operation of these controls.

Internal Audit endeavours to plan its work so that it has a reasonable expectation of detecting significant control weaknesses and, if detected, performs additional work directed towards identification of potential fraud or other irregularities. However, internal audit procedures alone, even when performed with due professional care, do not guarantee that fraud will be detected. Consequently, internal audit reviews should not be relied upon to detect and disclose all fraud, defalcations or other irregularities that may exist.

Appendix 5 – Coverage of EIJB Risks

Inherent rank (Residual rank)	Risk	Auditable risk	Rating (H/M/L)	Assurance requirement	2017/18 Coverage
1 (3)	There is a risk that a lack of downstream capacity will reduce the Partnership's ability to reduce hospital delays.	YES	H	●	CEC Care Homes Assurance Review EIJB - Review of Social Care Commissioning
2 (7)	There is a risk that a lack of capacity and poor systems in the community are impacting on timely access to care.	YES	H	●	EIJB - Review of Social Care Commissioning
3 (4)	There is a risk that the current levels of GP capacity is unsustainable and will reduce with negative consequences for care.	YES	H	N/A	NHSL IA are conducting an audit on workforce planning with a particular emphasis on GP Sustainability.
4 (2)	There is a risk that performance targets are not achieved resulting in reputational damage.	YES	H	●	EIJB - Review of Social Care Commissioning EIJB – Performance Target Data
5 (1)	There is a risk that the high vacancy levels within District Nurses will impact on safe delivery of care.	YES	H	●	EIJB - Review of Social Care Commissioning
6 (5)	The strategic approach and methodology to procure, evaluate and monitor key contracts of 3rd parties is ineffective.	YES	H	●	Edinburgh Alcohol and Drug Partnership Contract Management Health and Social Care Partnership Purchasing Budget Management
7 (15)	There is a risk that legislation is interpreted differently by the 3 parties (CEC, NHS and IJB) leading to disruption of delivery and directions.	NO	N/A	N/A	N/A

Inherent rank (Residual rank)	Risk	Auditable risk	Rating (H/M/L)	Assurance requirement	2017/18 Coverage
8 (13)	A lack of a well understood, sustainable delegated resource (budget and financial model) increases the risk that the IJB doesn't meet budgets and fails to generate the required level of savings and efficiencies.	YES	M	●	Health and Social Care Partnership Purchasing Budget Management Social Work Centre Bank Account Reconciliations
9 (14)	The NHS and Council are not able to deliver on the directions flowing from the Strategic Plan and/or within the associated directed resource.	YES	M	●	Health and Social Care Partnership Purchasing Budget Management EIJB - Review of Social Care Commissioning
10 (6)	A lack of a defined and collaborative approach with 3rd sector and other partners may lead to a negative impact on the delivery of the strategic outcomes.	YES	M	●	None
11 (16)	There is a risk that the statutory duties of the IJB as set out in the 2014 Act are unmanageable and the decisions made by the IJB Board are secondary to those of NHS Lothian and the Council meaning the IJB Board has limited authority to influence its' collective outcomes.	NO	N/A	N/A	N/A
12 (8)	There is a risk that the corporate capital asset planning / arrangements are not sufficiently responsive to enable delivery of the Strategic Plan.	YES	M	●	CEC Care Homes Assurance Review
13 (9)	There is a risk that there is a lack of knowledge, experience and stability of the IJB Board.	YES	M	●	None
14 (10)	Volatility in IJB membership could change the strategic direction of the IJB.	NO	N/A	N/A	N/A

Inherent rank (Residual rank)	Risk	Auditable risk	Rating (H/M/L)	Assurance requirement	2017/18 Coverage
15 (17)	Welfare Reform has a negative impact on service users which could adversely impact the preventative agenda with a consequential increase in demand on IJB services.	YES	M	●	None
16 (11)	The financial uncertainty of Brexit may negatively affect the financial position of the IJB.	NO	N/A	N/A	N/A
17 (12)	There is a risk that the NHS and/or Council have a financial catastrophe which means the parties must renegotiate the budget for the delegated functions.	NO	N/A	N/A	N/A
18 (18)	The governance structure of the IJB and its partners' means there is a risk of conflicts of interest between the needs of the IJB and individuals place of employment. This could be a barrier to effective decision making which results in inefficiencies in the delivery of services.	NO	N/A	N/A	N/A
19 (19)	The IJB has limited ability to influence the decision making of services hosted elsewhere in Lothian without the consent of other partners meaning there is risk that the IJB cannot drive strategy and operations to help meet its' objectives/outcomes.	NO	N/A	N/A	N/A

Key to frequency of audit work

Assurance Requirement Rating	Frequency
●	Annual
●	Every three years
●	No further work

Appendix 7 - Reports Supporting the 2017/18 Internal Audit Opinion

1. Health and Social Care Partnership Purchasing Budget Management
2. Review of Social Care Commissioning
3. Performance Target Data
4. Care Homes Assurance Review
5. Social Work Centre Bank Account Reconciliations
6. Alcohol and Drug Partnership Contract Management
7. Asset Management Strategy

Appendix 6

Internal Audit

Internal Audit Annual Report and Opinion 2017/18

June 2018

Contents

1. Introduction

The Scottish Public Finance Manual (SPFM) requires that:

"An annual audit assurance is provided to the Accountable Officer through the professional opinion of the Head of Internal Audit (or equivalent) on the adequacy and effectiveness of the internal control system and the extent to which it can be relied upon. That opinion is contained in an annual report from the Head of Internal Audit to the organisation's Audit Committee, and forms part of the assurance required by the Accountable Officer to enable them to sign a Governance Statement to be provided alongside the accounts for which they are directly responsible."

The Public Sector Internal Audit Standards (PSIAS) require that:

"The Chief Audit Executive (Head of Internal Audit) must deliver an annual internal audit opinion and report that can be used by the organisation to inform its governance statement."

"The annual internal audit opinion must conclude on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control."

1.1 To meet the SPFM and PSIAS requirements, this Annual Report summarises our conclusions and key findings from the internal audit work undertaken at NHS Lothian during the year ended 31 March 2018, including our overall opinion on NHS Lothian's internal control system (as related to our work completed and the three key areas of governance, risk and internal control).

Acknowledgement

1.2 We would like to take this opportunity to thank all members of management and staff for the help, courtesy and co-operation extended to us during the year.

2. Internal audit work performed

Scope and responsibilities

Management

2.1 It is management's responsibility to establish a sound internal control system. The internal control system comprises the whole network of systems and processes established to provide reasonable assurance that organisational objectives will be achieved, with particular reference to:

- risk management;
- the effectiveness of operations;
- the economic and efficient use of resources;
- compliance with applicable policies, procedures, laws and regulations;
- safeguards against losses, including those arising from fraud, irregularity or corruption; and
- integrity and reliability of information and data.

Internal audit

2.2 Internal Audit assists management by examining, evaluating and reporting on the controls, based on internal audit's risk assessment, in order to provide an independent assessment of the adequacy of the internal control system. To achieve this, Internal Audit should:

- analyse the internal control system and establish a review programme;
- identify and evaluate the controls which are established to achieve objectives in the most economic and efficient manner;
- report findings and conclusions and, where appropriate, make recommendations for improvement;
- provide an opinion on the reliability of the controls in the system under review; and
- provide an assurance based on the evaluation of the internal control system within the organisation as a whole.

Planning process

2.3 In order to provide an annual assurance statement supporting the Governance Statement, we consider NHS Lothian's activities and systems, as aligned to key risks, within the scope of our internal audit reviews.

2.4 Our internal audit plans are designed to provide the Audit and Risk Committee with assurance that NHS Lothian's internal control system is effective in managing NHS Lothian's key risks and value for money is being achieved. Our plans are therefore linked to the NHS Lothian Corporate Risk Register.

2.5 Internal Audit has a three-year strategic Internal Audit Plan which agreed in consultation with senior management and formally approved by the Audit & Risk Committee, alongside annual internal audit plans.

2.6 The Annual Internal Audit Plan is subject to revision throughout the year to reflect changes in NHS Lothian's risk profile.

2.7 We have planned our work so that we have a reasonable expectation of detecting significant control weaknesses. However, internal audit can never guarantee to detect all fraud or other irregularities and cannot be held responsible for internal control failures.

2.8 Our internal audit activity is planned in accordance with the capacity and capability within the internal audit team and is managed to an agreed internal audit budget. Internal audit do not undertaking testing of all NHS lothian internal controls.

Coverage achieved

2.9 The Internal Audit Plan comprises 725 days per annum. During the year we flexed the plan to take account of emerging risks and additional requests, with the Audit and Risk Committee updated during the year. The Internal Audit Plan originally contained 22 reviews. We have completed 19 of these original reviews during 2017/18, with three reviews being deferred into the 2018/19 internal audit plan due to timing of the planned review and ongoing work at NHS lothian. Information on these reviews are included within the Internal audit quarterly progress report submitted to each Audit and Risk Committee and have been approved by Committee. In addition we have also undertaken additional internal audit activity in year:

Additional review	Comments
Whistle blowing allegation regarding unscheduled care waiting times	Following receipt of an allegation regarding potential manipulation of figures relating to the 4-hour waiting time target for Accident and Emergency internal audit conducted a detail review of waiting times figures, processes, and culture across four A&E sites in Lothian. Fieldwork was undertaken in October and November 2017 and reported to the December 2017 Board. Our review identified a number of higher risk findings including compliance with Scottish Government guidance, the NHS Lothian SOP alongside wider organisational culture considerations. As a result of the whistleblowing Scottish Government also commissioned an independent investigation. NHS Lothian took the recommendations extremely seriously, immediately taking action to improve the controls and devising a detailed action plan. This was owned by the Deputy Chief Executive with support from the SMT.
Whistle blowing allegation regarding procurement of MRI scanners	We were requested by the Director of Finance to undertake a review of the arrangements in place and decision making process in regards to the procurement of MRI scanners, following receipt of a whistle blowing. This has been reported to the Director of Finance and the whistleblowing champion.

2.10 We can confirm that no restrictions were placed on our work by management.

2.11 During the year one member of the internal audit team unfortunately passed away following a long term illness. As a result the internal audit programme was re-allocated within the existing team, with some work re-profiled to accommodate the in-year requests for internal audit assistance, and additional resource utilised from graduate trainees within NHS Lothian, for a period of two days per week for eight weeks, and resource from Grant Thornton, also for a period of six weeks. This has ensured that sufficient work was still undertaken across the areas of: governance; risk management and control to inform my annual report and opinion.

Reports

2.12 We have prepared a report for each of the internal audit reviews completed and presented these reports to the Audit and Risk Committee.

2.13 Where relevant, all reports contained management action plans detailing responsible officers and implementation dates. The reports were fully discussed and agreed with management prior to submission to the Audit and Risk Committee.

2.14 We made no critical or significant recommendations that were not accepted by management.

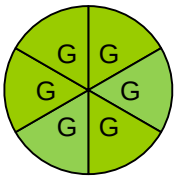
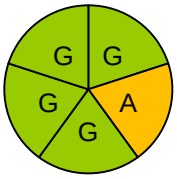
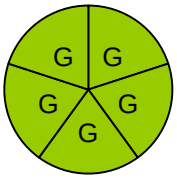
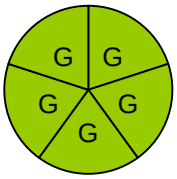
3. Summary of reports by control objective and action grade

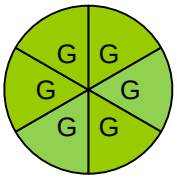
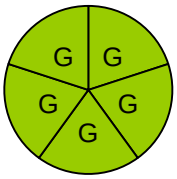
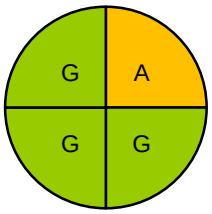
19 internal audit reports have been issued in 2017/18, as summarised in the below tables.

In addition to the reports detailed below we issued a report in regards to the controls, processes and governance in place within NHS Lothian related to the 4 hour emergency care standard, which arose as a result of a whistle blowing allegation, which did not follow the standard internal audit report format.

For our standard internal audit reporting format an updated rating system was introduced from December 2017 onwards, and we have split the reports in to those issues pre and post December 2017:

Pre-December 2017:

Review	Control objective assessment	No. of issues			
		Critical	Significant	Important	Minor
Volunteers expenses		-	-	5	-
Equality and diversity		-	2	3	1
Financial ledger		-	-	2	1
Hospital laundry		-	2	1	1

Review	Control objective assessment	No. of issues			
		Critical	Significant	Important	Minor
Volunteer Recruitment and reimbursement		-	-	5	-
Property transaction monitoring		-	-	1	1
Private Patient Funds		-	1	1	3

Post December 2017:

	Control objective – level of assurance					Critical	High	Medium	Low
Fixed Assets	Significant	Significant	Significant	Significant	Significant	-	-	-	1

	Control objective – level of assurance				Critical	High	Medium	Low
Consultants' Job Planning	Moderate	Modrate	Significant	Moderate	1	1	6	-
	Moderate	Significant	No Assurance	Moderate				

	Control objective – level of assurance						Critical	High	Medium	Low
Information Governance	Significant	Moderate	Significant	Moderate	Significant	Significant	-	1	2	1

	Control objective – level of assurance				Critical	High	Medium	Low
Waiting Times – Monitoring and Reporting of Elective Care Performance	Significant	Limited	Significant	Limited	-	2	-	1

	Control objective – level of assurance				Critical	High	Medium	Low
Network Management	Significant	Limited	Significant	Significant	-	1	-	1

	Control objective – level of assurance					Critical	High	Medium	Low
Mandatory Training	Moderate	Significt	Significant	Moderate	Significant	-	-	2	1

	Control objective – level of assurance					Critical	High	Medium	Low
IT applications	Moderate	Moderate	Significant	Moderate	Significant	-	-	3	1

	Control objective – level of assurance						Critical	High	Medium	Low
Medicines Management on Wards	Significant	Significant	Moderate	Significant	Moderate	Moderate	-	1	3	3

	Control objective – level of assurance					Critical	High	Medium	Low
Healthcare Governance: Child Protection Services	Significant	Significt	Significant	Significant	Significant	-	-	-	-

	Control objective – level of assurance					Critical	High	Medium	Low
Use of Nursing Midwifery Workload and Workforce Planning Tools	Moderate	Moderate	Moderate	Moderate	Limited	-	1	5	1

	Control objective – level of assurance				Critical	High	Medium	Low
Complaints Management	Significant	Moderate	Significant	Significant	-	1	4	1
	Moderate	Moderate	Limited	Significant				

	Control objective – level of assurance					Critical	High	Medium	Low
Midlothian IJB - Transformational Funding	Significant	Limited	Significant	Limited	Significant	-	2	-	1

The definitions used to grade reports, control objectives and individual actions are set out in Appendix 2.

Commentary

3.2 During the year we identified certain higher risk findings across our work.

3.3 In each case we have agreed a management response to these recommendations, and the action is being implemented. Throughout the year we follow up on the implementation of internal audit recommendations and can report good progress by management in implementing recommendations.

3.4 The one area we outlined no assurance was related to a specific control objective on consultant job planning. A good discussion took place at the April Audit and Risk Committee, attended by the Medical Director and the Medical Director is taking a series of actions to address the control deficiencies identified. We are comfortable that these control weaknesses are not fundamental to NHS Lothian's overall control environment.

3.5 Lastly, as referenced our work on unscheduled care identified a number of actions which although specific to NHS Lothian had wider organisational considerations for example: the use of NHS Lothian SOPs and the interpretation and application of these compared to national guidance, the creation of local procedures and how these are interpreted and followed over time and cultural style and working. Since the identification of these issues this has been a key priority for NHS Lothian with immediate action taking place alongside a detailed short-medium term action plan. A key aspect of this plan is the work of organisational development in supporting teams and embedding the NHS Lothian culture and values throughout.

3.6 Given the wider NHS Lothian nature of these issues, the profile and potential reputational risks we have identified this work within our annual opinion, set out in Section 5.

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4. Performance of Internal Audit

Independence

4.1 PSIAS require us to communicate on a timely basis all facts and matters that may have a bearing on our independence.

4.2 We can confirm that the staff members involved in each 2017/18 internal audit reviews were independent of NHS Lothian's operational processes and their objectivity was not compromised in any way.

Conformance with Public Sector Internal Audit Standards

4.3 The Chief Internal Auditor has completed an internal quality assessment of the service provided by the internal audit service, using guidance issued by H M Treasury.

4.4 The results of this assessment confirm that the internal audit service conforms to the Public Sector Internal Audit Standards, which are based on the International Standards for the Professional Practice of Internal Auditing. A summary of the results is provided at Appendix 1.

Performance against Internal Audit performance indicators

4.5 We have a suite of internal audit performance indicators which we track and formally report to the Audit and Risk Committee quarterly, and are in the process of assessing these and updating these to ensure they remain relevant for 2018/19. Focus on ensuring achievement of all KPIs will continue to be a focus for 2018/19, and any proposed changes or updates to KPIs will be brought to the Audit and Risk Committee for approval.

5. Overall internal audit opinion

Basis of opinion

5.1 The internal audit service at NHS Lothian is required to provide the Audit and Risk Committee with assurance on the systems of internal control. In giving an opinion it should be noted that assurance can never be absolute. The most that the internal audit service can provide is reasonable assurance that there are no major weaknesses in the whole system of internal control.

5.2 In assessing the level of assurance to be given, internal audit has taken into account:

- All reviews undertaken as part of the 2017/18 internal audit plan including the additional requests during the year;
- Matters arising from previous reviews and the extent of management's follow-up action; and
- The effect of any significant changes in NHS Lothian's objectives or systems.

Internal Audit Opinion

5.3 Overall, Internal Audit's work indicates that NHS Lothian has a framework of controls in place that provides **reasonable assurance** regarding the effective and efficient achievement of the organisation's objectives and the management of key risks.

5.4 However we would highlight particular areas of risk around NHS Lothian's unscheduled care arrangements as identified in our report presented to the NHS Lothian Board in December 2017. Particular risks related to compliance with national guidance and NHS Lothian's SOP, recording and reporting of accurate data, and certain organisational culture considerations. Subsequent to our report NHS Lothian management has implemented a revised SOP and taken a number of actions to address the control deficiencies identified. A further independent review was undertaken on behalf of the Scottish Government which is due to report in 2018/19 and Management has reiterated their commitment to take forward the additional actions in this report, particularly in respect of governance, culture and working practices.

5.5 Sufficient arrangements are in place, in the areas Internal Audit has reviewed, to promote value for money and secure regularity and propriety in the administration and operation of NHS Lothian controls.

Chief Internal Auditor

18 June 2018

Appendix 1 – Summary of Internal Quality Assurance Assessment

We are required by Public Sector Internal Audit Standards to disclose the outcome of our regular internal and external quality assessments. The table below summarises the outcome of our most recent internal quality assessment, in which we have assessed the extent to which our internal audit methodology conforms to the standards.

Standard	Does not conform	Conforms	Improvements identified
Purpose & positioning			
• Remit		✔	
• Reporting lines		✔	
• Independence		✔	
• Other assurance providers		✔	
• Risk-based plan		✔	✔
Structure & resources			
• Competencies		✔	
• Technical training & development		✔	✔
• Resourcing		✔	
• Performance management		✔	
• Knowledge management		✔	
Audit execution			
• Management of the IA function		✔	
• Engagement planning		✔	
• Engagement delivery		✔	
• Reporting		✔	
Impact			
• Standing and reputation of IA		✔	✔
• Impact on organisational delivery		✔	
• Impact on governance, risk and control		✔	

Overall, the Internal Audit service conforms to the requirements of the PSIAS.

We have identified a small number of actions, which will continue to improve the overall effectiveness and consistency with which our methodology is applied. In particular:

- Thinking about Internal Audit training and CPD activities for the team to endure their knowledge remains up to date and they build greater understanding of good practices in internal audit and emerging internal audit tools and techniques

- How we continue to focus on root cause in our internal audit work and ensuring our recommendations actively support management in mitigating/minimising risks. Linked to this a focus on ensuring our recommendations add value to NHS Lothian management and the NHS Lothian control environment helping to identify areas of under-control as well as over-control and inefficiency.

We are happy to provide Audit & Risk Committee members with further details of the information set out above and the assessment process, if required.

Appendix 2 - Definition of ratings

A points system is used for deriving ratings for each control objective within audit reports, with the system based on the number and significance of control issues raised within audit reports. An updated system was introduced from December 2017 onwards, and we have detailed both the Pre December 2017 and Post December 2017 rating systems below.

Pre December 2017

Management Action Ratings

Action Ratings	Definition
Critical	The issue has a material effect upon the wider organisation – 60 points
Significant	The issue is material for the subject under review – 20 points
Important	The issue is relevant for the subject under review – 10 points
Minor	This issue is a housekeeping point for the subject under review – 5 points

Control Objective Ratings

Action Ratings	Definition
Red	Fundamental absence or failure of controls requiring immediate attention (60 points and above)
Amber	Control objective not achieved - controls in place are inadequate or ineffective (21 – 59 points)
Green	Control objective achieved – no major weaknesses in controls but may be scope for improvement (20 points or less)

Post December 2017

Findings and management actions ratings

Finding Ratings	Definition
Critical	A fundamental failure or absence in the design or operating effectiveness of controls, which requires immediate attention
High	A key control failure has been identified which could be either due to a failure in the design or operating effectiveness. There are no compensating controls in place, and management should aim to implement controls within a calendar month of the review.
Medium	A control failure has been identified which could be either due to a failure in the design or operating effectiveness. Other controls in place partially mitigate the risk to the organisation, however management should look to implement controls to fully cover the risk identified.
Low	Minor non-compliance has been identified with the operating effectiveness of a control, however the design of the control is effective

Report ratings and overall assurance provided

Report Ratings	Definition	When Internal Audit will award this level
No assurance	The Board cannot take any assurance from the audit findings. There remains a significant amount of residual risk.	The controls are not adequately designed and / or operating effectively and immediate management action is required as there remains a significant amount of residual risk(for instance one Critical finding or a number of High findings)
Limited assurance	The Board can take some assurance from the systems of control in place to achieve the control objective, but there remains a significant amount of residual risk which requires action to be taken.	This may be used when: • There are known material weaknesses in key control areas. • It is known that there will have to be changes that are relevant to the control objective (e.g. due to a change in the law) and the impact has not been assessed and planned for. The controls are deficient in some aspects and require management action (for instance one 'high' finding and a number of other lower rated findings)

Moderate assurance	The Board can take reasonable assurance that controls upon which the organisation relies to achieve the control objective are in the main suitably designed and effectively applied. There remains a moderate amount of residual risk.	In most respects the “purpose” is being achieved. There are some areas where further action is required, and the residual risk is greater than “insignificant”. The controls are largely effective and in most respects achieve their purpose with a limited number of findings which require management action (for instance a mix of ‘medium’ findings and ‘low’ findings)
Significant assurance	The Board can take reasonable assurance that the system(s) of control achieves or will achieve the control objective. There may be an insignificant amount of residual risk or none at all.	There is little evidence of system failure and the system appears to be robust and sustainable. The controls adequately mitigate the risk, or weaknesses are only minor (for instance a low number of findings which are all rated as ‘low’ or no findings)

Appendix 7

The City of Edinburgh Council

Internal Audit

EIJB1701 – Health and Social Care Partnership Purchasing Budget Management

Final Report

20 July 2018

Contents

This internal audit review is conducted for the Edinburgh Integration Joint Board under the auspices of the rebased 2017/18 internal audit plan approved by the Audit and Risk Committee in December 2017. The review is designed to help the Edinburgh Integration Joint Board assess and refine its internal control environment. It is not designed or intended to be suitable for any other purpose and should not be relied upon for any other purpose. The Edinburgh Integration Joint Board accepts no responsibility for any such reliance and disclaims all liability in relation thereto.

The internal audit work and reporting has been performed in line with the requirements of the Public Sector Internal Audit Standards (PSIAS) and as a result is not designed or intended to comply with any other auditing standards.

Although there is a number of specific recommendations included in this report to strengthen internal control, it is management's responsibility to design, implement and maintain an effective control framework, and for the prevention and detection of irregularities and fraud. This is an essential part of the efficient management of the Edinburgh Integration Joint Board. Communication of the issues and weaknesses arising from this audit does not absolve management of this responsibility. High and Critical risk findings will be raised with senior management and elected members as appropriate

1. Background and Scope

Background

In April 2014, The Scottish Government enacted new legislation, the Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) that required all Health Boards and Local Authorities in Scotland to integrate their health and social care services for adults.

This resulted in the creation of the Edinburgh Joint Integration Board (EIJB) which is responsible for commissioning; directing; and governing; the activities of the Edinburgh Health and Social Care Partnership (the Partnership). The Partnership comprises NHS Lothian, and the City of Edinburgh Council who work together to deliver health and social care services for adults across the City.

Four localities were established across Edinburgh in May 2017 to enable delivery of Partnership services, with emphasis on anticipatory planning for people's care needs and their long-term support in the community. Each locality is responsible for establishing and managing the resources required to support service delivery, including financial planning and management.

Directions

The Act places an obligation on Integration Joint Boards to issue directions to the Partnership to ensure effective implementation of health and social care strategic plans. To date, the EIJB has issued the following financial directions to the Partnership.

1. **EIJB Direction 2 – Integrated structure** - the City of Edinburgh Council and NHS Lothian are directed to complete the implementation of Phase 2 of the integrated structure; including final assessment of budgetary position and establishment of budgets held on a locality basis; and
2. **EIJB Direction 3 – Key processes**
    - (b) redesign the referral process including the integration of Social Care Direct; and
    - (f) review and simplify the Funding Allocation System used to calculate indicative budgets

Partnership Budget

The total Partnership budget for 2017/18 was £500M (2016/17 £676M). Of this, the total budget for social care services was £239M (2016/17 £190M), with the purchasing budget set at £148M (2016/17 £143M).

Social care services are predominantly delivered by the Council, with an approved purchasing budget for these services agreed at the start of each financial year. The main drivers of purchasing budget spend are:

- In house services – provision of in house services by the Partnership by CEC and NHS employees;
- Care at Home Contracts – provision of services with 3rd party suppliers to provide home care services;
- Block – provision of service via 3rd party suppliers with contracts based on pre-agreed volumes;
- Individual Service Funds (ISFs) – value of the care package is paid to a provider chosen by the client who then agrees with the provider how the care will be delivered;
- Direct Payments (DPs) – direct payment made to client who then arranges their own support; and
- Spot – spot purchasing of home care services from external 3rd parties when required.

Service Delivery and Technology Systems

The Partnership is supported in social care service delivery by a number of established Council teams, for example; Business Support; Transactions; ICT Solutions; and Strategy and Insight. A full list of the teams contacted during the course of our audit review is included at Appendix 3 – Partnership Support Teams.

The Partnership manages and records delivery of social care on Swift, an established Council care management database introduced in April 2006. All client information (for example assessment and personal support plans information) is recorded on Swift via the AIS (Adults Integrated Solutions) front end application. Swift also records financial data in relation to client financial assessments and external provider charges, and generates care payments and charges via an Oracle payment system interface. The system also supports service delivery planning and ongoing performance reporting.

Client assessment information is also maintained on the NHS 'TRAK' Patient Database, whilst the NHS 'Hospital Dashboard – Tableau' system is used to monitor hospital discharges where subsequent social care support may be required.

Scope

This review was added to the 2017/18 EIJB internal audit plan following identification of a forecast overspend on the Partnership's home care purchasing budget of £12m for the 2017/18 financial year as at 31 August 2017. Initial analysis performed by finance confirmed that this appeared to be driven by increased demand for services and failure to deliver approved savings under the Health and Social Care Transformation Programme.

Our review assessed the adequacy and effectiveness of controls established across the Partnership to support service delivery by the Localities and demand management in line with approved financial budgets. Our full terms of reference are included at Appendix 5.

A separate review of Social Care Commissioning has been completed as part of the EIJB 2017/18 Internal Audit plan.

2. Executive summary

Total number of findings

Critical	-
High	4
Medium	-
Low	-
Advisory	-
Total	**4**

Summary of findings

The forecast overspend on the Partnership's home care purchasing budget (£12M at 31 August 2017) has been addressed by obtaining £4.2M of recurring funding from the social care fund, and an additional one-off contribution of circa £7m from the Council.

Whilst this additional funding resolves the Partnership's 2017/18 budget position, it does not address the underlying root causes that contributed to the overspend. Council Finance senior management has advised that the Partnership has not achieved social care service delivery in line with agreed budgets since 2014/15, and attribute this to lack of strategic action to offset increasing ISF / DP growth (£16.6M in 2015/16 and £25.5M in 2017/18) and care at home demand; inability to deliver approved budget savings; and lack of implementation of both internal and external audit recommendations on both business and financial controls.

Our review has confirmed that Partnership management has not delivered against the financial directions (2 and 3) issued by the EIJB to the partnership organisations (the Council and NHSL), and identified four areas where significant and systemic operational and financial control weaknesses have adversely impacted upon purchasing budget spend. Consequently, four High rated findings have been raised.

Whilst noting that delivery against financial direction has not been achieved, it is acknowledged that the Partnership has been impacted by significant changes at senior management level, with three changes at Chief Officer level in the last year. A new senior management team has now been appointed and will focus on reviewing the current operational arrangements supporting service delivery.

The first High rated finding notes that as the Partnership's operating structure had not been finalised, financial budgets (including the locality purchasing budget) had not been devolved / allocated across the localities (as at December 2017), and that the client and cost data maintained in Swift was not aligned with the localities operating model. As a result, the Partnership has not yet met the requirements of the second EIJB direction (Integrated Structure), which required the establishment of locality budgets, and locality managers have been unable to effectively manage locality purchasing costs and budgets.

Management has advised that a 'purchasing realignment group' has been established and is working towards allocation of Partnership budgets across the localities by June 2018.

Our second finding notes that there is currently no funding allocation model used across the Partnership as required by the third EIJB direction (Key Processes – part f). resulting in non-compliance with the requirements of the Social Care (Self-directed Support) (Scotland) Act 2013, as the range of care

options prescribed by the Act cannot be accurately costed to support client choices. This issue was raised as a High rated finding in our Self-directed Support Option 3 review completed in August 2016, and has not yet been resolved.

This finding also reflects weaknesses in the design of financial controls that should be applied end to end processes to ensure that care packages are accurately and consistently costed with variances appropriately approved; care payments are stopped upon cessation of the service; and that all charges for additional services are completely and accurately applied. This finding also highlights a lack of controls within the Swift system enabling care costs to be overwritten, and a lack of segregation of duties when processing Individual Service fund and Direct Payment payments that should be immediately addressed.

The scale and complexity of the operational structure and lack of understanding of holistic processes, responsibilities, and accountabilities of the teams supporting delivery of social care is reflected in our third finding. This finding highlights that end to end procedures supporting service delivery have not been established; the significant number of hand offs between teams involved; and high volumes of manual workarounds applied.

The need to implement a framework to support contract and grant management across the Partnership, with focus on improving controls supporting ongoing supplier and contract management is reflected in our fourth finding. Our main concerns here are that there are no clearly established delegated authorities supporting issue of contracts; contracts are currently being issued in the name of a former employee; contracts are not consistently priced; there is no clearly defined operational guidance supporting use of spot contracts; and no monitoring performed to confirm that the volume and cost of spot contracts is reasonable. Management has advised that a new Partnership contracts manager has recently been appointed who will be responsible for progressing work in these areas.

Effective financial and budget management is also an important element of commissioning, as budgets generally constrain capacity to deliver services. A separate review of social care commissioning (EIJB1702) was completed in June 2018, and the outcomes reported separately. The findings raised in the commissioning review in relation to maturity of social care commissioning; management capacity; and the need for clarity on roles and responsibilities should be considered in the context of addressing the findings raised in this report.

Management Response

Whilst Partnership and Customer senior management recognise the need to address the financial control weaknesses identified, a wider review of both strategic (for example options in relation to Swift) and current operational service delivery arrangements is required, with appropriate project management resource and capacity to support this process.

In the interim, a Partnership working group will be established / existing working groups refreshed. This group will include Partnership senior management and representation from Finance; Customer; ICT; and Strategy and Insight. The group will ensure that these findings are included in the wider service delivery review, and incorporated into an overarching plan that focuses on delivery of strategic and operational service delivery solutions, with initial focus on addressing the supplier and contract management issued raised in Finding 4.

The Partnership working group will be established by the Chief Finance Officer by **28 September 2018** and the plan produced by **21 December 2018**. The plan will then be reviewed by IA to confirm that it addresses all findings raised in this report, and individual IA findings raised to support subsequent IA follow-up to ensure that the control gaps identified have been effectively addressed.

In the interim, control gaps that expose the Partnership to significant financial risk, or gaps that can be remediated in the short to medium term will be addressed. Management responses in relation to these and agreed implementation dates are included in the detailed findings at Section 3 below.

3. Detailed findings

1. Purchasing Budget Allocation

Findings
Whilst an overall Partnership purchasing budget has been established, the budget had not been appropriately devolved / allocated across the localities as at December 2017. Additionally, care package cost data maintained on the Swift system is not aligned with the localities operating model, and no locality financial management information is currently available. Locality Management has advised that they are aware of these issues. Finance senior management confirmed that a draft report was presented to the Partnership senior management team in April highlighting the need for alignment of financial budgets; income and cost centres with the localities operating model. The draft report notes that this exercise is a significant undertaking as it requires amendments to the general ledger; Swift; and other core financial systems. We understand that a 'purchasing realignment group' has been established to resolve allocation of budgets across the localities by June 2018. If this can be resolved in June, locality reporting and budget management will be effective from quarter 2 2018/19.

Business Implication	Finding Rating
• Failure to deliver against EIJB direction 2, which requires that budgets should be established and maintained on a locality basis; and • Locality managers are unable to monitor actual in comparison to planned spend for their localities; and • Budget overspends are not identified in a timely manner.	**High**

Action plans	
Recommendation	**Responsible Officer**
1. A detailed financial budget allocation delivery plan should be developed with defined timescales for each stage of the implementation of the locality operating model budgets. 2. A consistently applied budget monitoring process should be clearly defined, documented, implemented, and communicated to all budget managers within the Locality operating model; with training provided to budget managers on how budgets should be managed. 3. The budget monitoring process should include, but not be restricted to: • Agreement on how overspends should be managed against increasing demand for services; • Responsibility for ongoing oversight of locality budgets and upward reporting to relevant governance forums / committees; and	Chief Finance Officer

4. A detailed plan should be developed and implemented, to ensure that the Swift system is updated so that H&SC Swift system care costs and recharges are aligned with and set against the relevant locality budgets.	
Agreed Management Action	**Estimated Implementation Date**
These recommendations will be addressed within scope of the strategic management action detailed in the Executive Summary at Section 2.	

2. Financial Controls

Findings

Our review identified a number of significant financial control gaps across the teams supporting delivery of social care by the Partnership, and the processes they apply:

1) Funding allocation model

There is currently no funding allocation model established within the Partnership to ensure that budgets for packages of care are established and monitored based on an ongoing assessment of client needs.

Additionally, there is no evidence to confirm that each of the self-directed support options have been fully discussed with clients, and that they are given the opportunity to choose from the available self-directed support options.

This issue was raised as a High rated finding in our Self-directed Support Option 3 'Communication of the budget' review completed in August 2016, and has not yet been resolved.

2) Delegated financial authorities

No clear delegated financial authorities have been established for approval of the cost of care packages or spot purchase contracts.

Our review established that a number of interim financial guidance documents have been issued, and that there is a lack of clarity re the actual authorisation limits that should be applied. Further details of the guidance that has been issued is included at Appendix 2 .

Additionally, the Service Matching Unit (SMU) is processing packages of care initiated by hospital occupational therapists with no independent approval of costs by localities. It was not possible to identify the total volume and costs of these care packages, as it is understood that there is no unique identifier allocated to these cases to confirm their source.

Review of approval of personal support plans for a sample of 20 Individual Service Fund (ISF) and Direct Payment (DP) cases in comparison to the approval limits included within interim financial approval process and the national care home nursing care rate (included within the two documents provided by management as being the current authorisation limits applied as detailed within appendix 2) identified:

- at least five cases that were not appropriately approved within the specified limits; and
- a further four cases where the personal support plan was signed off by either a Hub or Cluster Manager where the cost of care exceeded the £2K per week limit specified. We were unable to confirm whether additional levels of authorisation were required for these costs, as this was not detailed in the interim procedures.

3) Charging Policy / Procedures

Charging policies to support consistent and accurate pricing and charging of social care services provided to clients in addition to their assessed needs have not been finalised. Whilst the Transaction

Team confirmed draft charging procedures have been prepared, Partnership Senior Management has confirmed that there is currently no owner of charging policies and procedures,

Information regarding paying for care and the financial assessment process is available on the Council's external website at Care and Support at Home, however we could not establish who owns this web content and whether the charges specified are accurate. The details provided are not aligned with the information published on the Orb (refer: receiving care and support at home guidance dated 2013-14 which specifies a rate for £12.50 per hour for any chargeable services.

We did confirm that client charges are being applied on Swift, however, the completeness and accuracy of charges applied could not be confirmed due to lack of an established charging policy detailing the costs to be applied for additional services.

In addition; the Transactions Team confirmed that if an 'allocated worker' has incorrectly indicated whether an element of the support (to be provided) is chargeable, this results in the client either being billed in error or not at all. The Transactions Team indicated that they are not able to assess the completeness and accuracy of the billing report which is produced from the Swift System.

4) Cessation of and reduction in service

Notification of cessation of and reduction in service is not provided by Social Workers to Business Support in a timely manner, resulting in reliance on external providers to advise of changes in service, and overpayments that must be reclaimed retrospectively from the relevant providers.

All changes should be advised to Business Support by Social Workers via updated case notes on Swift. Notification can also be provided by General Practitioners and hospitals via a share point portal.

This process is not operating effectively partly due to the backlog of locality client reviews and issues regarding the timely update of the SharePoint portal.

Our sample testing identified two overpayments to the value of £14k that had not been reclaimed from external providers.

5) Swift system controls

Standard care cost rates specified in the 'guide to price' owned by the Partnership's contracts team are not hard coded into the Swift system to ensure consistent costing of care packages. Our review also confirmed that care costs can be manually entered into Swift.

Additionally, there are no established system approval controls to prevent unauthorised creation or cancellation of services; or changes to the nature or cost of existing services.

Review of a sample of 20 provider rates noted on Personal Support Plans (10 ISFs; and 10 DPs) by the allocated Social Worker and approved by their line managers identified a number of differences between rates detailed in the guide to price; the rates recorded in Swift; and the rates noted on the support plans

We have been unable to confirm whether pricing approval controls are available within Swift, and have not been activated.

6) Payment Controls

A number of significant control gaps were identified in relation to the payment processes applied by Business Support and the Social Care Finance Transactions Team that require to be addressed, most notably key person dependency and lack of segregation of duties within the Transactions Team.

Business Support - invoice processing and subsequent payment run

- Significant volumes of queries are raised by Business Support on invoices received from suppliers where they do not include client names or reference numbers, and often include unusual service rates;

- Business Support have only a one hour window to review and process Care at Home invoices on Swift (we understand that this is attributable to a unique one hour window in Swift when invoice headers for Neighbourhood Care at Home Contract Providers can be created - the 'AGEN' hour) impacting their ability to address all invoice queries prior to payment;
- Checks carried out on pre-payment reports are minimal due to transaction volumes and resource constraints; and
- Business support highlighted that a number of providers charged higher rates over the festive period, that were not subject to formal approval.

Individual Service Funds (ISFs) – Transactions Team

- There is lack of segregation of duties and key person dependency associated with ISF payment processing as one employee is solely responsible for updating service details (including payments) on Swift, and the processing; reviewing; and approving the ISF payment run;
- There is no one else within the team with the knowledge and skills to perform these tasks and the responsible (part time) employee currently manages their annual leave to avoid the timing of payment runs;
- The team confirmed that varying rates are being agreed with ISF providers that are not aligned with the 'guide to price' owned by the contracts team;
- Checks carried out on pre-payment reports are minimal due to transaction volumes and resource constraints and
- Retrospective adjustments are required where a change to the nature or cost of the service provided, or a change in level of client contribution is not advised and processed in a timely manner, resulting in inaccurate payments to providers that have to be subsequently adjusted.

Direct Payments – Transactions and Business Support Teams

Direct Payments can either be loaded on to a payment card or paid directly into the client's bank account. A review of client expenditure is performed to ensure that clients appropriately disburse funds to meet their assessed needs. Review of this process confirmed that:

- the Transactions team experienced difficulty in identifying new DP cases from Swift workflows as social workers use inconsistent narrative to describe the package of care;
- Checks carried out on pre-payment reports by the Transactions team are minimal due to transaction volumes and resource constraints;
- Reviews of quarterly client paper returns by Business Support (for funds paid directly into client bank accounts) to confirm appropriateness of expenditure for clients not using loaded payment were delayed by a quarter;
- There is no clearly defined methodology supporting sample selection and review of client paper returns within Business Support; and
- The Direct Payment reclaim figure for 2017/18 (reclaim of inappropriate expenditure by clients) was £1.5M.

It is understood that the Business Support is in the process of transferring clients who receive funds directly into their bank accounts on to prepaid cards, enabling more effective real time monitoring of client expenditure, and that submission of paper returns for funds paid directly into client accounts are moving from quarterly to six-monthly.

Business Implication	Finding Rating
• Non-compliance with the requirements of the Social Care (Self-directed Support) (Scotland) Act 2013;	High

• Financial decisions are made outwith approved authority levels; • Variations in cost of care are not appropriately authorised; • Income is not maximised • Clients are incorrectly charged for contributions to service provision; • Ineffective supplier management and overpayments for services provided; • Inconsistent pricing applied to packages of care; • Packages of care are overpriced; • Potential risk of fraud; • Inaccurate payments; and • Direct Payment reclaims are not processed	

Action plans

Recommendation	Responsible Officer
1) A funding allocation model or alternative solution should be designed and implemented to ensure that clients are provided with details of their budget when considering their options, (as per legislative requirements), with evidence of budget discussion recorded on Swift; 2) Delegated financial authorities should be established and implemented across the Partnership. These will include (but should not be restricted to) responsibility for approval of care package costs originated from all sources; and details of approval for spot purchase contracts. A process should also be established and implemented to ensure that evidence of approval in line with delegated authorities is recorded and retained. An appropriate owner of delegated authorities should be established and timeframes established for their ongoing review and refresh; 3) A charging policy for services provided should be established and implemented across the Partnership. This should specify the charges to be applied for additional services provided. A process should be established to confirm that these charges are consistently applied. Charges currently published on the Council's website and on the Orb should be updated to reflect the revised charging policy, and refreshed in line with ongoing review and refresh of the policy. An appropriate owner of the charging policy should be established and timeframes established for its ongoing review and refresh; 4) A process should be established to ensure that Business Support are advised re cessation of or reduction in services in a timely manner, either by social workers or third party providers; 5) Agreed provider rates should be automatically built into the Swift system. Where the 'alternative cost' field requires to be used, additional authorisation should be obtained in line with agreed delegated authorities. 6) Financial controls available within Swift System should be reviewed and implemented (where feasible) to ensure care costs either cannot be overwritten, or (where they are overwritten) a clear audit trail is available for review.	4) 8 and 10 Neil Jamieson, Senior Manager, Customer 12) John Arthur, Senior Manager, Business Support

7) A communication should be sent to all providers specifying that invoices should include client names; reference numbers; and accurate hourly service rates charged; 8) Appropriate sample based checks should be performed on pre-payment run reports to confirm the completeness and accuracy of invoices processed by all teams responsible for payments; 9) Business Support should escalate any rates applied by providers that are not aligned with agreed rates to management for approval in line with delegated authorities; 10) Key person dependency and segregation of duties issues within the Transactions team should be addressed immediately; 11) A standard process should be established to ensure that Direct Payment cases are clearly recorded on Swift with a unique identifier, enabling the Transactions team to easily identify them for inclusion in payment runs; and 12) A risk based approach should be designed; implemented; and consistently applied to support ongoing review of client paper based returns for Direct payments within the Business Support team, with all instances of inappropriate expenditure escalated for immediate reclaim.	
Agreed Management Action	**Estimated Implementation Date**
1. Management has advised that they will 'risk accept' this recommendation on the basis that the Partnership is compliant with the spirit of SDS legislation as funding is being allocated on the basis of the SDS legislation and is therefore compliant with the spirit of the legislation. There is recognition that the evidence of conversations in relation to allocation of funding should be recorded and this will be addressed as part of the review of the Swift system. 4. Process is in place for Care homes. Providers submit form with returns to identify changes of circumstances which would affect charging levels (e.g. hospitalisation). No further action required. Transactions would expect that service authorisation would be achieved prior to the activity for financial assessment, otherwise the calculation would be inaccurate. This is a requirement of social workers. Actions will be addressed as part of wider strategic recommendation for the Partnership. Early investigations are in place to determine the legitimacy of the charging team sitting within Business Support, and whether it would be more appropriate to bring this service within Transactions. Due to inappropriate data base use by services in the past, some areas (Transactions Community Alarm Team) make it difficult to ascertain eligibility to continued service. Whilst this risk is mitigated by checks and balances, confident adherence will not be in place until this service is processed within SWIFT and linked to all other social services. 8. A quality control framework for sample based checking that is aligned with the process applied to checking benefits payments will be developed (with support from the Quality Control team) and implemented. We will aim for the process to be implemented and operational by 21 December 2018, with a three month period to embed and final closure by 29 March 2019.	1. N/A 4. 31 January 2019 for decision re charging team; and 29 March 2019 for SWIFT replacement 8. 29 March 2019 10. 31 October 2018 12. 28 September 2018 for IA follow-up

10. The Transactions team have recently decided to apply additional resource to support this function immediately. As well as this, the Team Manager and Customer Manager will be looking across the entire team structure to ensure that segregation of duties is addressed sufficient resilience exists by cross training individuals to participate in the process. 12. The backlog has been addressed and the review process changed to review the full population of client returns every 6 months with effect from January 2018. Recommendations 1 – 3; 5 – 7; 9; and 11 will be addressed within scope of the strategic management action detailed in the Executive Summary at Section 2.	

3. Operational structure and processes

Findings

Our review confirmed that a significant number of Council teams are involved in supporting the Partnership with delivery of social care.

No holistic social care processes and supporting operational procedures have been established to ensure effective service delivery. The processes applied within individual teams are often complex, involving use of both Council and NHS systems; involve a significant number of hand offs between teams; and involve high volumes of manual workarounds.

A review of a sample of social care operational processes applied by the teams involved, confirmed that they are performed inconsistently and often without a full understanding of their overall purpose or objective, and that the volume of briefing emails issued detailing changes to procedures causes confusion for the teams performing the processes. Additionally, a number of links to procedural documentation on the Orb are broken, or documents have been removed and not replaced. Further detail is provided below:

1. Locality Processes and Procedures

Draft Hub Standard Operating Procedures were created in December 2017 and have not yet been finalised. These provide a high-level overview of locality service delivery and are not supported by current detailed operational procedures.

2. Service Matching Unit (SMU)

- End to end SMU procedures have not been fully reviewed and refreshed since 2012. The SMU Business manager did provide evidence of standalone procedures and process maps that had been reviewed and revised, however these were unclear, and have not been incorporated into end to end procedural documentation.
- Controls in relation to approval of packages of care by hospital Occupational Therapists (OTs) are unclear. The SMU Business Manager was unaware that there had been a 'verbal instruction' received from a locality manager which enabled SMU staff to process all service requests received from occupational therapists without approval. When this issue was identified, the SMU Business Manager issued an instruction to the SMU team limiting the number of hours that could be processed without approval to 18 hours, until the process is clarified.
- Additionally, an inconsistent approach was evident in relation to requests for care received from hospitals, and those received from Social Care Direct (SCD) or social workers, as hospital requests are not supported by a client assessment.

  For hospital requests, SMU issues a memo to the third-party care provider asking them to contact the allocated worker directly if they require further information on client needs. Additionally, no

process documentation was evident detailing the process to be applied when sharing personal, sensitive client information with third-party providers.

3. Social Care Direct (SCD)

- The need to review and update SCD processes supporting screening and allocation of care referrals to service areas was highlighted by Internal Audit in October 2015, as processes applied were inconsistent and did not include 'trigger points' to ensure that clients remained informed of progress with their cases.

  SCD processes have not yet been updated, and an SCD options appraisal (being completed by Strategy and Insight); that would improve how referrals are received, recorded, and responded to across the localities is understood to be 'ongoing'.

  Additionally, existing SCD processes have been criticised by the Care Inspectorate and a number of issues were highlighted within the internal Partnership quality assurance report in December 2017.

- Our review also established instances where SCD are copying and pasting client information received from hospitals into the Swift system / Assessment of Needs Forms;

4. Client Review Process

There is currently a significant backlog of client reviews to be completed across the localities; and completed reviews are not recorded consistently on Swift to support a clear audit trail between the review and subsequent changes to the nature and cost of care. Specifically:

- The 'Adult Care Service Reviews' procedure was last updated in December 2015. The procedure notes that the outcomes of the reviews would recorded in the 'My Steps to Support Review Tool' on the Swift / AIS system or in a Case note titled 'Review Outcome' for ease of identification; and
- There was evidence supporting completion of client reviews in Swift, however, the outcomes and decisions are not always consistently recorded in the Outcomes' and 'Decisions' tabs within the system. Some review outcomes were included within case notes; however, these outcomes /decisions were not always clear due to the volume of information included within the case notes.

5. Technology Issues

A number of the social care process require creation of documents such as the Assessment of Needs through a mail merge function within the Swift system. This functionality does not work with Microsoft 2016, resulting in employees reverting to Microsoft 2013 to generate these documents. CGI has advised that this is unsustainable as Microsoft 2013 will become unsupported. No detailed timeframes have been confirmed.

Business Implication	Finding Rating
• End to end processes supporting service delivery risks are not clearly understood and are not effectively managed; • Poor quality service for clients; • For care requests received from hospitals, providers may not fully understand the needs of the client and client needs may not be met; • Clients are not effectively matched with the most appropriate service provider; • Incorrect client data is copied into the Swift system and populated in Assessment of Needs Forms;	**High**

• Potential breach of General Data Protection Requirements (effective 25 May 2018) if there is no established process supporting provision of client information to third parties in a secure and compliant manner; • Review outcomes are not identified and required changes in levels of care not communicated to care providers and associated costs revised; • There is no clear link from assessments through to revised personal support plans; changes in care provided; and the associated cost; • Current processes supporting generation of key documents via the mail merge process are unsustainable.	
Action plans	
Recommendation	**Responsible Officer**
1) A review of holistic social care processes should be performed from point of origination / referral to ongoing review and payment processes; and new processes designed and implemented. These processes should include (but not be restricted to) responsibilities and accountabilities and hand offs between the teams involved. Key controls and checks to be performed to confirm that service delivery is consistently recorded in Swift, costed, and processed completely and accurately should also be included in process documents; 2) The process for recording client reviews in Swift should be specifically documented; implemented and consistently applied; and 3) ICT should be formally engaged to ensure that an alternative solution is found for the generation of key client documents via Swift; prior to support for Microsoft 2013 being removed.	
Agreed Management Action	**Estimated Implementation Date**
These recommendations will be addressed within scope of the strategic management action detailed in the Executive Summary at Section 2.	

4. Supplier and Contract Management

Findings

A number of significant and systemic control weaknesses have been identified in relation to supplier and contract management where third-party providers are used to provide social care services.

1. Contract Authorisation

The register of 'Proper Officers' held by the Council's Committee Services Team has not been updated to reflect the Partnerships delegated authority for signing contracts under the Council's Scheme of Delegation. A number of contracts continue to be issued with manual signatures, and it is unclear whether these signatories have the required authority.

Additionally, a significant number of contracts (mainly Care at Home Contracts) are being issued with the electronic signature of a former employee. This issue was immediately escalated to the Interim Chief Officer when identified (5 January 2018) and has not yet been fully resolved. Appendix 4 – Timeline – Electronic Signatures includes details of the issue and progress and actions implemented to date.

2. Contracts Team

The Partnership contracts team is responsible for procurement; agreeing rates with on contract and spot service providers; monitoring supplier performance; and also own the 'guide to price' which specifies the cost of services provided.

Review of the contracts team established that:

- they currently have no established operational processes and procedures;
- no clear approval and change management process has been established to support changes to the cost of services detailed in the guide to price. The rates included on the Orb are noted as April 2018 rates, however there is no clear audit trail supporting how these costs were established and approved;
- the 'guide to price' is not aligned with the service costs included in the Swift system;
- there is no defined ownership of and review of agreed third party supplier rates charged for cost of care, and no established maximum limits for off contract 'spot' purchases;
- no monitoring is performed on Individual Service Fund (ISF) care providers to ensure that clients are receiving the expected level of care. Effective monitoring of ISFs was raised as a High rated finding in the Personalisation and SDS (Self-Directed Support) – Stage 3 audit report issued in June 2015.
- Quarterly returns are received from ISF providers detailing how funds received have been disbursed on client care, but are not reviewed due to lack of resources. The Individual Service Fund Agreements request providers to submit quarterly returns, however, there are no detailed procedures specifying the checks to be performed; or when payments should be delayed (as specified in the Payment section of Provider agreements issued by the Contracts Team);

  Consequently, reliance is placed on client complaints or case reviews to identify instances where clients are not receiving the level of service specified within personal support plans. A review of 10 ISFs confirmed that six monthly case reviews had not been completed for 60% of our sample;

3. Care at Home Contract

No formal process has been established to ensure that 'on contract providers' contact the Partnership to advise when the client has been unable or unwilling to accept the service for four consecutive weeks.

The current Care at Home Contract enables 'on contract providers' to continue to receive automatic payments (90% of the client's personal budget) during any length of temporary client absence (section 4.3.5), but does not include a formal definition of 'temporary'.

The contract also specifies (section 4.5.2) that if a client is unable or unwilling to accept the Service for four consecutive weeks and / or the provider believes that they can no longer meet the client's needs, then the provider should contact Social Care Direct to request a review.

Business Support identified one client who was in hospital for more than 3 months, where the provider had been paid £9K. Due to the backlog of reviews, it was unclear whether a review had been requested by the provider and not completed. Business Support persuaded the provider to refund part of the payment, however, the provider was under no contractual obligation to do so.

4. Spot Contracts

Discussions with the teams involved in matching assessments to providers confirmed that a significant volume of spot contracts are issued to meet increasing demand for care. Review of processes supporting the issue of spot contracts confirmed that:

- review of a sample of Spot contracts issued on behalf of Partnership by the Service Matching Unit and Transactions team identified four different variations of the same contract that included different clauses. There is currently no established owner for the content of these contracts;

- there is no clear guidance available detailing when spot contracts should be used. Current practice is that where a package of care cannot be matched to an existing provider and no guide price is available for the service, then a spot contract should be used;
- no management information is available detailing the volume of spot contracts issued, as use of spot contracts and their associated costs are not recorded using a unique identifier in Swift;
- there is no established guidance on acceptable spot contract rates.
- review of a sample of spot contracts established that they do not consistently specify the rate applied for the cost of care. 60% of our sample of spot contracts simply included a weekly total;
- Electronically signed spot contracts are not consistently returned to business support by providers enabling subsequent validation of contract rates against invoices received prior to payment.

Business Implication	Finding Rating
• Contracts may not be legally enforceable; • The contracts team is not operating and supporting the Partnership effectively; • Inconsistent pricing applied to packages of care; • Inability to confirm that client care needs are being effectively met by ISF service providers; • Overpayment to 'on contract' where service has not been provided to clients for four consecutive weeks; • Excessive use of spot contracts that are not appropriately priced; • Inconsistent terms in spot contracts issued; and • Spot contract rates are not validated prior to invoice payment;	**High**

Action plans

Recommendation	Responsible Officer
A new framework to support management of contracts and grant across the partnership should be designed and implemented. This should include (but not be restricted to) the following areas: 1) Authorities for issuing contracts should be agreed across the Partnership and the register of proper officers updated to reflect the outcomes of this review; 2) Revised authorities for contract approval should be communicated and implemented across the Partnership; 3) A solution should be implemented to prevent issue of electronically signed contracts by former employees; 4) A process should be established to ensure that contract delegated authorities are revised to reflect all new starts and leavers; 5) A formal owner of contract authorities should be established and timeframes agreed for their ongoing review; 6) Procedures should be established to support the operation of the Partnership contracts team; 7) The 'guide to price' should be reviewed and updated to reflect current cost of care (including agreed third-party supplier and spot contract rates), with changes communicated across the Partnership. This document should be used as a single source of truth for pricing.	

Costs of care per the guide to price should be updated in the Swift system. An appropriate owner of delegated authorities should be established and timeframes established for their ongoing review and refresh. A change management process should be established to support all future guide to price changes in line with approved delegated authorities, ensuring that the changes are also updated on Swift in a timely manner; 8) A process should be established to ensure that quarterly provider ISF returns are reviewed to confirm that clients are receiving the expected level of care. The process should include a clear escalation procedure where it is identified that clients are not receiving the expected level of care. The review performed should be a risk based sampling approach, with all results and actions taken clearly documented and retained; 9) The process for delaying payments to ISF providers should be clearly documented, and should include effective engagement with providers specifying ISF payments have been withheld; 10) A process should be established to ensure that the Partnership is advised of all instances of client hospitalisation that lasts for more than four weeks, so that appropriate payment adjustments can be agreed with on contract providers; 11) The spot contract template should be reviewed and refreshed, with support from Legal, to ensure that the content of all contracts issued is consistent, and includes specification of rates applied for cost of care in line with the guide to price. A formal owner of the contract template should be established and timeframes agreed for ongoing review of the content; 12) Guidance should be established detailing when spot contracts can be used, and communicated across the partnership. This guidance should include the requirement to use a unique identifier or field (if possible) on Swift to ensure that spot contracts can be easily identified; 13) Management information detailing the volume and value of spot contracts issues should be produced (at least monthly) and provided to budget managers; and 14) A process for review and retention of spot contracts should be established, enabling rates applied to be agreed to invoices processed by Business Support prior to invoice payment.	
Agreed Management Action	**Estimated Implementation Date**
These recommendations will be addressed within scope of the strategic management action detailed in the Executive Summary at Section 2.	

Appendix 1 - Basis of our classifications

Finding rating	Assessment rationale
Critical	A finding that could have a: • ***Critical*** impact on operational performance; or • ***Critical*** monetary or financial statement impact; or • ***Critical*** breach in laws and regulations that could result in material fines or consequences***; or*** • ***Critical*** impact on the reputation or brand of the organisation which could threaten its future viability.
High	A finding that could have a: • ***Significant*** impact on operational performance; or • ***Significant*** monetary or financial statement impact; or • ***Significant*** breach in laws and regulations resulting in significant fines and consequences***; or*** • ***Significant*** impact on the reputation or brand of the organisation.
Medium	A finding that could have a: • ***Moderate*** impact on operational performance; or • ***Moderate*** monetary or financial statement impact; or • ***Moderate*** breach in laws and regulations resulting in fines and consequences; or • ***Moderate*** impact on the reputation or brand of the organisation.
Low	A finding that could have a: • ***Minor*** impact on the organisation's operational performance; or • ***Minor*** monetary or financial statement impact; or • ***Minor*** breach in laws and regulations with limited consequences; or • ***Minor*** impact on the reputation of the organisation.
Advisory	A finding that does not have a risk impact but has been raised to highlight areas of inefficiencies or good practice.

Appendix 2 – Financial approval guidance applied across the Partnership

- An interim financial approval process (Purchasing budget - financial approval process and budget monitoring) was established in February 2016 and has not been reviewed. This document details the authorisation levels required to approve specific service types;
- Interim guidance (Assessment and Support Planning Guide) was issued in May 2017 and specified that the authorisation levels for seniors/first line social work mangers was to be increased from £400 to £574 in line with the national care home residential home rate. A further change was implemented in June 2017; to £667 (the national care home nursing care rate);
- A briefing paper on the changes for social workers (New Hospital Processes and Standards 290517) was prepared by Cluster managers and issued via email in June 2017; and
- Whilst the June 2017 increase was reflected in Swift questionnaires, the May 2017 Interim guidance was not updated to reflect this change.

The Interim guidance was forward to Internal Audit by a number of managers as evidence of the current procedure applied across the Partnership. When IA queried the national care home rate used in April 2018 the “New Hospital Processes and Standards 290517” paper was provided.

Appendix 3 – Partnership Support Teams

The table below provides details of teams involved in supporting delivery of social care who were engaged as part of the audit. Please note that this list is not exhaustive and may not be fully complete.

Team	Service Area	Location	Role and Responsibilities
Locality Managers	HSCP	Locality Offices	Lead and manage all locality services delegated to the Edinburgh Health and Social Care Partnership.
Locality Hubs Managers	HSCP	Locality Offices	The Hub is a new operating model which assumes the role and remit of a number of different services, including Intermediate Care, Reablement and Sector Initial Intervention teams and what were previously hospital social workers. Hub teams work directly with the services detailed below to develop effective, person-centred care pathways, and are responsible for monitoring and reducing delayed discharge. • Early intervention, • < 6weeks (level of care required) • Reablement • Intermediate Care • Step up and Step down • Range of voluntary organisations
Locality Cluster Managers	HSCP	Locality Offices	Responsible for a range of community and hospital based services providing assessment and care management services; community and district nursing; AHP services; and homecare services including the following: • Complex and continuing care • > 6weeks (level of care required) • Care Homes, Care at Home, Social Work assessment and support • District Nursing, Therapies • Older People's Mental Health • Carer support, respite services • Hosted services, pharmacy
Locality Mental Health &	HSCP	Locality Offices	Responsible for the performance, efficiency and development of the locality integrated mental health and substance misuse service:

Team	Service Area	Location	Role and Responsibilities
Substance Misuse Manager			• Social work assessment and support, Mental Health Officer team, • Alcohol and drug prevention and rehabilitation services
Locality Development Manager	HSCP	Locality Offices	Developed Draft Hub Standard Operating Procedures.
Allocated Workers	HSCP	Locality Offices	Allocated workers include: • Senior Social Workers Responsible for the management of all social work teams; allocation of assessments; reviews; and other tasks across the community and hospital sites. • Social Workers • Occupational therapist • Community Care Assistant Responsible for assessments; support planning; and review of people in hospital and in the community. A number of allocated workers were contacted during the course of the audit review to clarify key stages of the end to end process.
Social Care Direct	Resources	Waverley Court	All service referrals are processed through the Social Care Direct team. SCD, who log all referrals onto data systems and progress new referrals to Locality Hub
Service Matching Unit	HSCP	Locality Offices	Matches requests for Care at Home Services to third party providers.
Contracts Team	HSCP	Waverley Court	Responsible for negotiating contracts; monitoring supplier performance; and management of agreed third party provider rates.
Business Support	Resources	Waverley Court / Locality Offices	Business Support provides a business partnering approach between Business Support and services promoting joint working to provide a strong and strategic centre supporting frontline services across the four localities. Responsibilities include: • Personal Support Plans • Spot Contracts • Payment of Invoices and • Direct Payments Quarterly Returns

Team	Service Area	Location	Role and Responsibilities
Customer Transactions Team	Resources	Waverley Court	The transaction team supports the partnership by processing, issuing, and reviewing: • Individual Service Funds • Direct Payments • Care Home Contracts • Spot Contracts • Payment of Invoices and • Individual Service Funds Quarterly Returns
Strategy and Insight	Chief Executive's	Waverley Court	Provide management information / performance reports.
Finance	Resources	Waverley Court	Provides Financial and Budgetary Support to HSCP
ICT Solutions	Resources	Waverley Court	Provides IT support for the Swift system
Financial Systems	Resources	Waverley Court	Maintain user access to the Council's Frontier System (used for budget monitoring) and user information in respect of budget monitoring reports.
Quality Assurance Service	Safer and Stronger Communities	Waverley Court / Locality Offices	Currently supporting Locality teams in completing quality assurance assessments on their key processes; (i.e. screening, allocation, workload management, assessment, service matching, review, etc) which had been graded as being unsatisfactory by the Care Inspectorate and Healthcare Improvement Scotland as part of their Older People's Inspection of 2016.

Appendix 4 – Electronic Signatures Timeline

Our review established that there were a number of third party contracts being issued on behalf of the Partnership that included the electronic signature of a Senior Manager who had left the organisation in December 2017.

The contract production process involves manually entering information into Swift which is then 'merged' into the standard contract documentation.

The electronic signature is embedded in the Swift system and is automatically applied via 'print' functionality. Contract documentation is then either printed or saved onto a local drive before being issued (either by post or through SharePoint) to the third-party provider.

A timeline of events from initial discovery of the issue to date is detailed below:

Date	Description of events
05 January 2018	Internal Audit site visit to the Service Matching Unit (SMU) identified that 'SMU Spot Contracts were being issued to third party providers with the signature of former Senior Manager.
09 January 2018	Internal Audit met with SMU Business Manager who noted that the required change to the spot contracts would need to be completed through the Contracts Team. SMU Business Manager also noted that there would be other documents which held the Electronic Signature of Senior Managers.
09 January 2018	Internal Audit contacts SMU Business Manager and Contracts Officer to advise of the issue and to request that the signatures be updated. Advised via email by Contracts Officer that: "… it is the responsibility of the team using the spot documentation to arrange for the signature updates and that this would not be undertaken by the Contract team who are not involved with Spot Contracts".
09 January 2018	Internal Audit wrote to Interim Chief Officer to highlight the issue and note that there may be other documents issued with historic electronic signatures.
10 January 2018	Interim Chief Officer issues instruction to all relevant staff regarding the use of the electronic signatures. <u>Action to be taken</u> The email noted that the use of the electronic signature should 'cease immediately' and that electronic signatures should only be used by a) current employees; and b) appropriately authorised individuals, i.e. consistent with standing orders.
10 January 2018	SMU Business Support Manager contacts ICT Solutions (Swift Team) with change request form to remove the electronic signature from relevant spot contracts. <u>Action to be taken</u> ICT Solutions (Swift Team) to remove signature from spot contracts.
10 January 2018	SMU Business Support Manager contacts each of the four 'Locality Managers' to request that they agree to the use of their 'electronic signature' for the Locality that they are responsible for.

Date	Description of events
10 January 2018	Locality Manager notes that a check is required to ensure that the use of Locality Managers signatures is compliant with Standing Orders. Action to be taken The Senior Accountant, (Finance) was copied in to advise.
10-12 January 2018	Correspondence between the ICT Solutions (Swift Team) and the SMU Business Manager which highlighted difficulties in changing the electronic signature; as the document had been created in a 'bespoke format' and requests that staff manually "delete" the electronic signature from the document until the "issue can be fixed". Action to be taken SMU staff to manually 'delete' the electronic signature of the member of staff who has left the organisation from the 'spot contract'.
17-23 January 2018	SMU Business Manager advises Internal Audit of the interim process within the NE Locality and provides email evidence of some of the difficulties in the 'signing off' of the spot contracts which is causing slight delays.
30 January 2018	Internal Audit met with SMU Business Manager to discuss the interim process and discuss some of the difficulties that the team are having. Advised that one Locality manager had a 'question over the legality of using electronic signatures on spot contracts' and that the Cluster Managers in a separate Locality were signing off the spot contracts in the interim.
01 February 2018	Internal Audit contacted the Locality Manager's to establish whether there has been a decision on the SMU spot contract process.
01 February 2018	Internal Audit contacted two Cluster Managers who had previously been identified as signing off SMU spot contracts in the absence of the Locality Manager in order to establish the process being followed.
02 February 2018	Hub Manager NW Locality provides confirmation (via email) of the checks undertaken prior to signing off the SMU Spot Contract.
07 February 2018	Update provided by IA to the Interim Chief Officer which notes that there are ongoing challenges re the authorisation and signature of the contracts which is resulting in delays in obtaining care services from third party providers.
07 February 2018 **07 February 2018 cont.**	Operations Manager (Risk and Compliance) noted that contact had been made with SMU who confirmed that there are no outstanding 'spot purchasing' delays and provided details of interim arrangements in NW. Also noted that the Locality Managers Forum for 8th February had been cancelled and that the process for 'spot contracts' would be added to the agenda for the following week. Action to be taken The four Locality Managers to agree a process for the signing of SMU spot contracts at Locality Forum of 15 February 2018.
07 February 2018	SMU Business Manager requests confirmation from the Operations Manager (Risk and Compliance) of the process to be followed within NE Locality.

Date	Description of events
	Also requests confirmation that the current process followed in SE & SW can continue, i.e. can the electronic signature (of the Senior Manager still in post) continue to be used. Operations Manager (Risk and Compliance) confirms that there is a requirement for all localities to agree on a consistent process and that the proposed process would be discussed at the Locality Managers Forum on 15 February 2018.
07 February 2018	Executive Assistant to Health and Social Care NW Locality Manager confirms that there are no delays in the signing of Spot Purchase Contracts in NW but that there are delays in NE and that the Locality Manager is addressing these.
07 February 2018	Cluster Manager NW confirms that the process noted by the Operations Manager (Risk and Compliance) is the process being followed.
07 February 2018	IA updated the Interim Chief Officer re lack of response from Locality Managers to previous audit correspondence of 01 February. Interim Chief Officer requested that Internal Audit contact the Operations Manager (Risk and Compliance) to take forward. This was completed and a meeting was held on 13 February 2018.
08 February 2018	IA established during site visit to Business Support area office that there are spot contracts issued via a completely different process from the spot purchase contracts which are processed by SMU although both sets of contracts are headed with the same form number / title. In terms of the signature; these spot contracts are printed in hard copy and signed by a Senior Manager and the third-party provider prior to the services being added to the Swift system; rather than being electronically signed by the Locality Manager.
09 February 2018	Three spot purchase contracts which were identified through a Business Support process walkthrough were queried with the SMU Business Manager as to why these spot contracts bypassed the SMU Team. The SMU Business Manager confirmed that one case was for a short-term emergency therefore the spot purchase was appropriate; but that she felt that the remaining two cases should have been processed by the SMU Team.
12 February 2018	The SMU Business Manager provides IA with a breakdown of the difference in the spot purchase contract process between SMU, the Assessors (i.e. Allocated Worker) and Business Support Staff.
13 February 2018	Meeting held between Internal Audit and Operations Manager (Risk and Compliance) to discuss the current position with the electronic signing of the SMU spot contracts. Internal Audit advised of the separate spot contract process established from Business Support site visit of 08 February 2018 (see note above). Operations Manager (Risk and Compliance) advised IA of the proposed interim spot contract process to be discussed at the Locality Managers Forum subject to Locality Managers agreement.
15 February 2018	IA attended the Locality Managers Forum with the Operations Manager (Risk and Compliance), Business Services Manager and each of the Locality Managers. Operations Manager (Risk and Compliance) discussed the proposed interim spot contract process. Locality Managers noted that they would require time to review the

Date	Description of events
	proposed process documentation presented at the meeting and that a decision would be made at the following weeks Locality Managers Forum. The SE Locality Manager noted that she was unaware that the electronic signature was being used for the signing of the SMU Spot Contracts. Email issued from Operations Manager (Risk and Compliance) to Locality Managers 16 February to confirm agreed actions from the meeting and request that a decision on the paper be made by 21 February 2018.
21 February 2018	Internal Audit identified during a walkthrough of the Individual Service Funds (ISFs) process within the Transactions Team (Resources) that the electronic signature for the former Senior Manager was still in use.
26 February 2018	Meeting held between Internal Audit and Operations Manager (Risk and Compliance) to discuss the current position with the electronic signing of the SMU spot contracts. The Operations Manager had advised that feedback had been received from three out of the four Locality Managers as one Manager was not available at the time. Operations Manager advised that she was meeting SMU Business Manager 27 February 2018 and Interim Chief Officer 28 February 2018 to discuss the new interim process.
27 February 2018	Internal Audit informs Operations Manager that ISFs are being electronically signed by former Senior Manager within the Transactions Team (Resources). Internal Audit met with the Transactions Team Manager to advise that Operations Manager had been informed and that the Operations Manager would be in contact regarding the proposed interim process.
27 February 2018	The Transactions Team Manager advised that there are thirteen Residential Care Home contracts and seven Financial Assessment documents and letters which are still using the electronic signature of the former Senior Manager.
27 February 2018	The Transactions Team Manager provides email evidence of correspondence issued to Locality Managers dated 19 January 2018 and 16 February 2018. A response was received to the email dated 16 February from the SE Locality Manager.
27 February 2018	Phone call from Operations Manager notes that ICT Solutions (Swift Team) have advised that a member of the team who has now left the Council had created the SQL signatures using Matrix Code. Replacement of the documents would be a complicated process as the 'whole programme' would need to be recreated. An acceptable work around is to be put in place. Locality Manager has noted that she is unaware that the electronic signatures were being used.
01 March 2018	The Transactions Team Manager confirmed that the list of Residential Care Home contracts and Financial Assessments had been passed to the Operations Manager and ICT Solutions (Swift Team) to be actioned (once process is agreed).
05 March 2018	Email correspondence between the Operations Manager and SE Locality Manager to obtain current position regarding the electronic signature on Care Home Contracts.

Date	Description of events
	SE Locality Manager advised that she is liaising with Transactions Team Manager regarding this issue.
16 April 2018	Transaction Team Manager contacted Internal Audit to advise that she had been in contact with the contracts Team and Legal regarding the use of electronic signatures. Legal have advised that the contracts can be produced with a named person who is a Designated Signatory printed on the contracts without the need to have a signature. However, the Transitions Team Manager noted that there is no current list of signatories in place. The Transactions Team Manager has noted that she is currently having to remove the former Senior Manager's Signature from the contracts and manually sign each one.
16 April 2018	IA met with Interim Chief Officer and Operations Manager as part of initial audit close out meeting and advised them of the email received from the Transactions Team Manager. The Operations Manager agreed to take this forward.
17 April 2018	IA met with Transactions Team Manager to discuss the closure of the audit review and the issue she had raised in respect of the electronic signatures. The Transactions Team Manager advised that she is not a Designated signatory but that there is no current list of Designated Signatories in place. It was established that ISFs were still being issued in the former Senior Manager's name. The Transactions Team Manager advised that this process would stop that day.
17 April 2018	Email from IA to the Interim Chief Officer (HSCP) and Head of Customer Services and IT to advise of current position. It was suggested that a meeting be held by all relevant parties to discuss and agree a way forward. Both the Interim Chief Officer (HSCP) and Head of Customer agreed that this was the correct approach.
20 April 2018	Operations manager has set up a 'Short Life Working Group' with the first meeting to be held on 23 April 2018 with the following members of the group required to attend: • SE Locality Manager (HSCP) • Operations Manager (HSCP) • ICT/Swift - Systems Development Team Lead (Resources) • Transaction Team Manager (Resources) • SMU Business Manager (HSCP) • Business Support – Business Services Manager and / or Business Support Manager. (Resources) <u>Action to be taken</u> Objective: to produce 'end to end' interim flow processes for Chief Officer and Head of Customer Services and IT approval.
23 April 2018	Short life working group meeting held.
26 April 2018	Operations Manager issued draft "Interim Purchase Budget Management Process for Localities" document to IA for comment. IA Comments were returned to the Operations Manager
02 May 2018	Operations Manager issues the "Interim Purchase Budget Management Process

Date	Description of events
	for Localities" to all Cluster and Hub Managers within H&SCP via email.
08-09 May 2018	ICT Solutions issue newly formatted draft contract documentation for consultation to Short Life Working Group. Action to be taken Short Life Working Group to provide confirmation that the newly formatted draft contract documentation can go 'Live' within the Swift system.
09 May 2018	IA contacted Legal Services to obtain confirmation of advice provided. Legal Services confirm that no written advice had been supplied to H&SCP IA met with Senior Solicitor who advised that "all contracts must be signed by 'Proper Officer's' who have the 'delegated authority' to sign contracts on behalf of H&SCP. A register of proper officers is held by the "Committee Services" team.
09-10 May 2018	IA contacted Committee Services and requested sight of "Proper Officers' register. Governance Manager confirmed that the Interim Chief Officer has delegated authority through the Council's Scheme of Delegation; however, the register required to be updated in terms of subsequent delegation of authority by the Interim Chief Officer.
10 May 2018	At an introductory meeting with the newly appointed Chief Officer; IA updated Interim Chief Officer of current issue regarding delegated authority.
14 May 2018	Interim Chief Officer requests clarification from IA of the detail of the current issue which was provided via email. Operations manager contacted IA to confirm the detail of the delegated authority issue and provided the Interim Chief Officer with a detailed note of the issue. Interim Chief Officer confirmed that new Chief Officer and Chief Finance Officer will determine a way forward with the process.
17 May 2018	Operations Manager has advised IA that Legal advice has now been obtained. A letter requires to be produced by the Chief Officer for each of the 'Proper Officers' to give them the appropriate delegated authority to sign contracts. Once issued the letters require to be forwarded to Committee Services to allow them to update the 'Proper Officers' register. At this stage only, the Spot Contracts; Care Home Contracts and Individual Service Funds will be updated with the Interim Process / Delegated authority. An analysis requires to be undertaken to identify any other contracts or documents that are electronically signed. The above process requires to be discussed and agreed with the Partnership's Chief Officer.
24 May 2018	Operations Manager issued email to Committee Services which includes Delegated Authority Letters for both Locality and Cluster Managers within the Partnership.

Appendix 5 – Terms of Reference

Health and Social Care – Purchasing Budget Management

To: Michelle Miller, Interim Chief Officer, Edinburgh Health and Social Care Partnership
Stephen Moir, Executive Director of Resources

From: Lesley Newdall, Chief Internal Auditor Date: 23rd October 2017

Cc: Wendy Dale, Strategic Commissioning Manager, Edinburgh Health and Social Care
Moira Pringle, Interim Chief Finance Officer, Edinburgh Integration Joint Board
Hugh Dunn, Head of Finance
Nicola Harvey, Head of Customer
Laurence Rockey, Head of Strategy and Insight
Health and Social Care Locality Managers.

This review has been added to the 2017/18 internal audit plan at the request of the Interim Chief Officer, Health and Social Care, and the Head of Finance.

Background

The Edinburgh Health and Social Care Partnership (City of Edinburgh Council in partnership with NHS Lothian) is responsible for delivering care and meeting support needs across the City through the recently established Localities model.

The Partnership is committed to reducing delays and waiting times for assessment, care, treatment, and support, and providing the right care at the right time in the right place. Consequently, treatment and support should (where possible) be delivered in homes or in homely settings in the community, and hospital admissions minimised. Where hospital admission is necessary, this should take place in a timely way.

Four localities have been established to deliver these services with emphasis on anticipatory planning for people's care needs and their long-term support in the community.

Locality services are delivered via Hubs and Clusters. Hubs respond to initial service requests, avoid the need for hospital admission, and support the return home of people who have been in hospital. Clusters provide longer term care services and focus on prevention and early intervention,

Each locality is responsible for establishing and managing the resources required to support service delivery, including financial planning and management.

At 31st August, the forecast overspend on Health and Social Care home care purchasing was £12m for the 2017/18 financial year. Supporting analysis confirms that this appears to be driven by increased demand for services and failure to deliver approved savings under the Health and Social Care Transformation Programme.

The main drivers of increased purchasing costs are:

- In House – provision of in house services by the Partnership via CEC and NHS employees,
- Block – provision of service via 3rd party suppliers with contracts based on pre-agreed volumes,
- Individual Service Funds (ISFs) - value of the care package is paid to a provider chosen by the client who then agrees with the provider how the care will be delivered,
- Direct Payments (DPs)– direct payment made to client who then arranges their own support, and
- Spot – spot purchasing of home care services from external 3rd parties when required.

Scope

Our review will assess the adequacy and effectiveness of controls established across Health and Social Care to support service delivery by the Localities and demand management in line with approved financial budgets, and will provide assurance over the following key Corporate Leadership Team (CLT) and Finance Risks:

- CLT (High): Health and Social Care - through either lack of CEC resource and/or provider capacity, the Council may be unable to secure appropriate contracts with its providers or deliver appropriate services as directed by the Integration Joint Board (IJB) As a result, we may be unable to deliver our own commitments as part of the Health and Social Care Partnership's strategic plan
- Finance (Medium): Approved savings, including procurement-related savings, are not delivered and/or risks and pressures not managed, resulting in service or Council-wide overspends

We will assess the design adequacy and operating effectiveness of the key controls supporting the processes detailed below:

1. Review and prioritisation of initial requests for assessment,
2. Management of waiting lists,
3. Completion, review, and approval of initial assessments, support plans, and future reviews, including costs,
4. Completeness and accuracy of care packages and costs recorded on Swift,
5. Cessation or reduction of service,
6. Completeness and accuracy of charging and payments made to clients and third-party suppliers, and
7. Ongoing budget management.

An early priority will be to review arrangements for assessment and authorisation of ISFs and DPs where increases in financial commitments are most material.

Approach

Our audit approach is as follows:

- Obtain an understanding of the processes detailed above through discussions with key personnel, review of systems documentation and walkthrough tests;
- Identify the key risks associated with these processes;
- Evaluate the design of the controls in place to address the key risks; and
- Test the operating effectiveness of the key controls.

Limitations of Scope

The following areas are specifically excluded from the scope of our review:

- Adequacy of the agreed 2017/18 Health and Social Care budget – this was subject to review by Internal Audit in May 2016.
- Compliance with the requirements of the (Self-directed Support) (Scotland) Act 2013 – whilst our scope will not assess full compliance with all requirements of the Act, any instances of non compliance identified from our testing will be raised.

The sub-processes and related control objectives included in the review are:

Sub - process	Control Objectives
1. Review and prioritisation of initial service requests	• There is a clearly defined process for recording, assessing, and responding to all requests for assessments received. • The process includes guidance on how requests should be prioritised and a clear escalation process for critical or emergency requests and use of ‘spot’ contracts. • The process has been communicated across all Localities and is consistently applied.

Sub - process	Control Objectives
	• All requests are correctly prioritised in line with applicable guidance. • Prioritisation of requests is subject to management review and approval. • Requests are then either added to the waiting list, or assessment progressed.
2. Management of waiting lists (including provision of Performance Management Information)	• Localities operate waiting lists within approved tolerance limits. • There is a clearly defined process supporting client transfers from the waiting list to service providers. • The process has been communicated across all Localities and is consistently applied. • Waiting list management information (MI) is provided to all Locality managers on an ongoing basis, and consolidated MI provided to H&SC Senior Management. • MI is reviewed and discussed at Locality and H&SC management meetings and appropriate action taken to address any concerns.
3. Completion, review, and approval of initial assessments, support plans, and future reviews, including costs,	• There is a clearly defined process for completion of initial assessments, support plans and future reviews, including calculation of the cost of care. • Initial and ongoing care assessments are consistently performed and the outcomes recorded. • Clear guidance on cost of care calculation is available and consistently applied. • Cost of care is accurately calculated. • All SDS options (arranged and manged by the Council; ISFs; and DPs) are discussed with the client, • Where clients have requested provision of chargeable services, the associated charges are communicated and included in the cost of care. • There are clearly defined delegation and authorisation controls which identify the financial thresholds at which commitments should be escalated to more senior managers for authorisation. • Assessments, proposed care packages, and costs of care are consistently and thoroughly reviewed and approved by the relevant manager, with evidence of review retained There is an established process for dealing with assessment backlogs. • Volumes of assessment backlogs are monitored by Locality managers and H&SC Senior Management.
4. Completeness and accuracy of care packages and costs recorded on Swift	• Details of the care package to be provided (including costs) are completely and accurately recorded on the Swift system. • Any subsequent changes made (and associated costs) are also recorded on Swift.

Sub - process	Control Objectives
	• There is a clear audit trail in Swift demonstrating that all care packages and costs have been reviewed and approved by managers.
5. Cessation of Service	• There is a clearly defined process supporting cessation or reduction of services on a temporary or permanent basis, • The process has been communicated across all Localities and is consistently applied. • Swift records are updated to record the change in service.
6. Completeness and accuracy of charging and payments made to clients and third-party suppliers	• All payments made (arranged and manged by the Council; ISFs; and DPs) have been checked to Swift prior to payment to confirm accuracy. • All charges to be applied to clients have been identified and completely and accurately invoiced, • All payments made to block 3rd party suppliers are in line with contractual terms and conditions. • Block payments are only authorised where service delivery volumes have been achieved. • Payments to spot 3rd party suppliers are only made when supported with payment requests that have been authorised in line with applicable authorities or standing orders.
7. Ongoing budget management	• Locality managers have clear visibility of their devolved care purchasing budgets. • Budgets are regularly monitored and reviewed and considered when making decisions in relation to demand and management of waiting lists. • Budget transfers are performed to address emerging overspends. • H&SC senior management have clear visibility of the total H&SC purchasing budget. • H&SC regularly review the purchasing budgets and develop appropriate strategies, and agree and implement actions to deal with any significant variances.

Internal Audit Team

Name	Role	Contact Details
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Karen Sutherland	Internal Auditor	karen.sutherland@edinburgh.gov.uk 0131 469 3451 (x 43451)

Key Contacts

Name	Title	Role	Contact Details
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Lyn McDonald	Health and Social Care Operations Manager	Key contact	07540 334 800
Patrick Jackson	Locality Manager, South West	Key contact	0131 453 9010
Angela Lindsay	Locality Manager, North East	Key Contact	0131 469 3927
Marna Green	Locality Manager, North West	Key Contact	0131 553 8318
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John Connarty	Senior Manager – Business Partnering, Finance, Resources	Key Contact	0131 469 3188
Karen Dallas	Principal Accountant, (Health and Social Care), Finance, Resources	Key Contact	0131 529 7937
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Jon Ferrer	Quality, Governance & Regulation Senior Manger	Key Contact	0131 553 8396
Katie McWilliam	Strategy Planning & Quality Manager, Older People	Key Contact	0131 553 8382
Liz Davern	Team Manager, Transactions Social Care Finance, Customer, Resources	Key Contact	0131 553 8232

Timetable

Fieldwork Start	6th November 2017
Fieldwork Completed	24th November 2017
Initial Discussion – Draft Observations	30th November 201
Submission of Draft Report	8th December 2017
Response from Auditee	15th December 2017
Final Report to Auditee	22nd December 2017

Follow Up Process

Where reportable audit findings are identified, the extent to which each recommendation has been implemented will be reviewed in accordance with estimated implementation dates outlined in the final report.

Evidence should be prepared and submitted to Audit in support of action taken to implement recommendations. Actions remain outstanding until suitable evidence is provided to close them down.

Appendix 1: Information Request

It would be helpful to have the following available prior to our audit or at the latest our first day of field work:

- Details of the following processes and procedures:
  - Review and prioritisation of service requests;
  - Completion of initial and ongoing care assessments;
  - Calculation of all service support care package costs;
  - Delegated authorisation limits for financial commitments arising from care assessments;
  - Recording care packages and costs on Swift;
  - Payments process for all support services (both invoiced and non-invoiced);
  - Charging process;
  - Cessation of service and removal from Swift
- Details of waiting lists tolerances (e.g. maximum length of waiting lists; maximum time spent on waiting lists).
- Management information on waiting lists across the last year

This list is not intended to be exhaustive; we may require additional information during the audit which we will bring to your attention at the earliest opportunity.

City of Edinburgh Council

Internal Audit

Edinburgh Integration Joint Board - Review of Social Care Commissioning

Final Report

20 July 2018

EIJB1702

Contents

This internal audit review is conducted for the Edinburgh Integration Joint Board under the auspices of the rebased 2017/18 internal audit plan approved by the Audit and Risk Committee in December 2017. The review is designed to help the Edinburgh Integration Joint Board assess and refine its internal control environment. It is not designed or intended to be suitable for any other purpose and should not be relied upon for any other purpose. The Edinburgh Integration Joint Board accepts no responsibility for any such reliance and disclaims all liability in relation thereto.

The internal audit work and reporting has been performed in line with the requirements of the Public Sector Internal Audit Standards (PSIAS) and as a result is not designed or intended to comply with any other auditing standards.

Although there is a number of specific recommendations included in this report to strengthen internal control, it is management's responsibility to design, implement and maintain an effective control framework, and for the prevention and detection of irregularities and fraud. This is an essential part of the efficient management of the Edinburgh Integration Joint Board. Communication of the issues and weaknesses arising from this audit does not

absolve management of this responsibility. High and Critical risk findings will be raised with senior management and elected members as appropriate

1. Background and Scope

Background

The Edinburgh Integration Joint Board (EIJB) was established under the Public Bodies Joint Working Act 2014 (the Act) and is responsible for commissioning health and social care services in Edinburgh for delivery by the Health & Social Care Partnership (The Partnership) established between the City of Edinburgh Council and NHS Lothian.

To ensure that the health and social care services are effectively delivered by the Partnership, it is essential that there is an established process to forecast and monitor demand, and that sufficient capacity is available enabling access to the services provided.

Commissioning is the approach applied by local authorities when planning and resourcing public services (including social care) with the objective of achieving the best possible outcome for the community, whilst meeting current and future client needs. Commissioning should ensure that personalised approaches are provided to meeting needs across all services, and should achieve best value whilst complying with applicable legislation.

A number of demand and capacity assessments and plans have been developed throughout the lifetime of the EIJB; the Partnership and predecessor organisations. These include the Joint Strategic Needs Assessment (2015) and the Partnership Strategic Plan 2016-2019 (created in March 2016).

The EIJB has issued a total of 21 directions (the Directions) to the Partnership that are intended to provide clarity about the changes required in the design and delivery of services. The Directions document notes that the approach to be applied in Edinburgh is focused on 'shifting the balance of care by increasing the range and capacity of community based services' with Principle E focussing on 'making best use of capacity across the whole system'. The document also notes (at section 3 – financial control) that the EIJB 'faces significant financial challenges in 2017/18 and future years, due to the ongoing difficult national economic outlook.

Also included in the Directions document are the recommendations made by the Care Inspectorate (CI) in their May 2017 report. The full report is available at: Joint Inspection of Adult Health and Social Care Services May 2017.

A number of the EIJB directions specifically refer to service demand and capacity, whilst some CI recommendations make specific reference to commissioning. Further detail is included at Appendix 2.

In November 2017, Partnership management presented a 'Statement of Intent' to the EIJB Board. This noted that delivery of health and social care in Edinburgh had been in a period of transition since April 2016, and highlighted a number of governance and operational areas where immediate attention was required, including commissioning for five priority service areas: Older People; Primary Care; Mental Health; Learning Disabilities; and Physical Disabilities.

A detailed Health & Social Care Improvement Programme was then developed in December 2017 to address the issues noted in the statement of intent. Specific actions include undertaking a detailed capacity planning exercise as well as developing commissioning plans across the five priority service areas which robustly analyse and assess demand, capacity, investment choices and associated risks.

Additionally, the 'Whole System Delay' report presented to the EIJB Board on 2 March 2018 highlighted the significant social care commissioning challenges faced by the Partnership, noting that at the end of January 2018:

- 220 people were awaiting hospital discharge;
- 120 of these were waiting for a domiciliary care package; 60 waiting for a care home place; and 40 waiting to be assessed;
- 1,600 people in the community were waiting for a care needs assessment;
- 950 people in the community were waiting for a domiciliary care package; and
- 5 out of the 7 external 'Care at Home' providers used by the Partnership had been suspended to low scoring in regulatory assessments, preventing them from providing care at home services, with a further provider unable to support new clients due to capacity limitations.

Scope

The objective of this review was to assess the adequacy of design of the controls established within the Partnership in relation to demand forecasting and monitoring and capacity and access management, with focus on the process established to:

- Understand and assess current levels of service provision;
- Assessing current demand;
- Forecasting and planning for future demand;
- Influencing and managing future demand;
- Assessing and managing internal and external capacity;
- Understanding and managing imbalances between demand and capacity.

We also considered overall management, governance and oversight arrangements in place.

2. Executive summary

Total number of findings

Critical	-
High	1
Medium	1
Low	-
Advisory	-
Total	**2**

Summary of findings

Partnership social care commissioning processes are not fully established and as mature as would be expected by this point in the Partnership lifecycle, and existing processes do not adequately meet the requirements of the EIJB Directions or address the CI recommendations raised in their May 2017 report.

The Partnership's Statement of Intent confirms that both Partnership management and the EIJB are aware of the significant demand pressures and challenges impacting service delivery. These challenges will be addressed by the Partnership's Improvement Programme which includes plans to develop full strategic commissioning plans for Older People; Mental Health; Learning and Physical Disabilities by December 2018, however further time will be required to develop commissioning plans and processes across the full range of social care services provided.

To ensure that there is sufficient capacity to support future social care demand, it is essential that effective commissioning is performed on an ongoing basis, and appropriate forecasting models and reporting tools developed and implemented to support this process.

It is also important to ensure that commissioning processes are performed and managed by teams that are adequately resourced with the appropriate level of skills and experience, and that all roles; responsibilities and accountabilities for commissioning across the Partnership (including linkages with and hand offs across teams) are documented; communicated; and clearly understood.

Consequently, one High and one Medium rated findings have been raised. Our detailed recommendations are included at section 2 - Detailed Findings.

Effective financial and budget management is also an important element of commissioning, as budgets generally constrain capacity to deliver services. A separate review of the Health and Social Care purchasing budget (EIJB1701) was also completed in June 2018, and the outcomes reported separately. The findings raised in the purchasing budget review in relation to purchasing budget allocation; financial controls; operational structure and processes; and supplier and contract management should also be considered in the context of addressing the known social care commissioning challenges.

Management Response

Whilst Partnership senior management recognise the need to address the weaknesses identified in commissioning processes, a wider review of both strategic and current operational commissioning processes is required, with appropriate project management resource and capacity to support this process.

The Commissioning Lead Officer role for the Partnership is currently being recruited, and the new Lead Officer will be responsible for reviewing and redesigning (where required) the established commissioning process with support from Partnership executive management.

To achieve this, a Partnership working group will be established / existing working groups refreshed by the new Head of Commissioning that will include Partnership senior management and representation from Finance; ICT; and Strategy and Insight. The group will ensure that the findings raised in this report are incorporated into an overarching plan that focuses on delivery of strategic and operational commissioning solutions.

3. Detailed Findings

1. Maturity of social care commissioning

Finding
Social care commissioning processes are not fully established and as mature as would be expected by this point in the Partnership lifecycle, and existing commissioning processes do not adequately meet the requirements detailed in the EIJB Directions, or the recommendations made by the Care Inspectorate in their May 2017 report. This is recognised by Partnership management, and working groups and action plans have been established as part of the improvement programme to ensure that this is addressed. New draft commissioning plans have been developed for five priority service areas: Older People; Primary Care; Mental Health; Learning Disabilities; and Physical Disabilities; and were discussed by the EIJB Board in April 2018. Detailed commissioning plans for these areas are scheduled to be completed by December 2018. This timeframe reflects the scale and complexity of the work to be performed. However, it is essential to ensure that there is also sufficient focus on ensuring that effective commissioning processes are established and maintained across all social care services. This was recognised by the interim Partnership management team and has been included in the Improvement Programme.

Business Implications	Findings Rating
• Client social care needs cannot be effectively met; • EIJB directions requirements are not achieved; • Delivery of social care services is not achieved within budget; and • Adverse reputational impacts for the Partnership and EIJB	High

Action plans	
Recommendation	**Responsible Officers**
1. A new social care commissioning model should be designed and implemented covering all social care services provided by the Partnership. This should include (but should not be restricted to) the ability to: • Analyse the current level of services provided at the appropriate levels (e.g. for the full service; and by individual localities; clusters and hubs);	

• forecast future demand for services at appropriate levels based on accurate demographics; historic growth analysis; and realistic future growth assumptions; • analyse current and future internal and external provider capacity; • assess current financial performance against budget; and • estimate future funding requirements based on forecast demand and cost of care. 2. The management information currently provided to support commissioning should be reviewed and refreshed to ensure that it includes all relevant information to support effective service delivery, and is accurately aligned with the localities operating model; and 3. Demand management strategies should be developed and implemented to support effective risk based management of social care waiting lists, whilst ensuring that urgent cases are prioritised.	
Agreed Management Action	**Estimated Implementation Date**
These recommendations will be addressed within scope of he strategic management action detailed in the Executive Summary at Section 2.	

2. Management Capacity and Roles and Responsibilities

Finding	
Whilst permanent appointments to the roles of Chief Officer; Head of Operations; and Chief Finance Officer have now been made, the Partnership has faced significant challenges in terms of turnover; extended vacancies and interim appointments at senior management level during the last twelve months. Additionally, employees with extensive knowledge of client demographics and commissioning are scheduled to leave the Partnership in June 2018. Our discussions with Partnership managers also highlighted that the roles and responsibilities of strategy; planning; quality and locality Managers in relation commissioning are not clearly understood. The findings raised in our audit of the Health and Social Care purchasing budget highlighted the need to ensure that the budgeting processes are aligned to reflect the localities operating model; and that holistic social care delivery processes and procedures are established across all teams involved in delivering the service. The report also highlighted a number of control gaps in the processes applied by the Partnership's contracts team that need to be addressed.	
Business Implications	**Findings Rating**
Insufficient commissioning skills and experience within the Partnership to support effective commissioning and delivery of the improvement plan.	**Medium**
Action plans	
Recommendation	**Responsible Officers**
1. The commissioning structure across the partnership should be reviewed and refreshed to ensure that: there is sufficient capacity; skills; and	

experience within the partnership to support delivery of the commissioning plans as per the Improvement Plan and support ongoing commissioning processes; 2. Support for the commissioning process required from the Council and NHS Lothian should be quantified and agreed; 3. The review should consider the responsibilities of the existing contracts team in relation to commissioning; 4. The revised structure should be implemented; and 5. A post implementation review should be performed by management once the new structure has embedded to confirm that it is operating effectively.	
Agreed Management Action	**Estimated Implementation Date**
These recommendations will be addressed within scope of he strategic management action detailed in the Executive Summary at Section 2.	

Appendix 1 - Basis of our classifications

Finding rating	Assessment rationale
Critical	A finding that could have a: • ***Critical*** impact on operational performance; or • ***Critical*** monetary or financial statement impact; or • ***Critical*** breach in laws and regulations that could result in material fines or consequences***; or*** • ***Critical*** impact on the reputation or brand of the organisation which could threaten its future viability.
High	A finding that could have a: • ***Significant*** impact on operational performance; or • ***Significant*** monetary or financial statement impact; or • ***Significant*** breach in laws and regulations resulting in significant fines and consequences***; or*** • ***Significant*** impact on the reputation or brand of the organisation.
Medium	A finding that could have a: • ***Moderate*** impact on operational performance; or • ***Moderate*** monetary or financial statement impact; or • ***Moderate*** breach in laws and regulations resulting in fines and consequences; or • ***Moderate*** impact on the reputation or brand of the organisation.
Low	A finding that could have a: • ***Minor*** impact on the organisation's operational performance; or • ***Minor*** monetary or financial statement impact; or • ***Minor*** breach in laws and regulations with limited consequences; or • ***Minor*** impact on the reputation of the organisation.
Advisory	A finding that does not have a risk impact but has been raised to highlight areas of inefficiencies or good practice.

Appendix 2 – References to relevant EIJB Directions and Recommendations from the Joint Inspection of Services for Older People

Direction	Title	Page	Narrative
EDI_2017/18_1	Locality working	7	'work with local people and community organisations to increase the resilience and **capacity** of communities to promote wellbeing and support their members to live independently'
EDI_2017/18_4	Primary care	13	build and expand GP premises to increase **capacity** to meet increasing demand as already agreed,
EDI_2017/18_5	Older people	16	finalise **capacity** plans and prepare detailed proposals for implementation; consider whether care at home contract delivers **capacity**. Note: Capacity plan was to be completed by 31/10/17
EDI_2017/18_6	Unscheduled care	19	Purpose - To reduce the number of unplanned hospital admissions and support the shift in the balance of care by developing **easily accessible** community based alternatives to hospital admission for the frail elderly.
DI_2017/18_7	Learning disabilities	21	finalise the costed **capacity plan** for people with learning disabilities
EDI_2017/18_9	Sensory impairment	26	Purpose - To ensure that people with sensory impairments can **access** the services they need and supported to take control over their own health and wellbeing.
EDI_2017/18_13	Community based mental health	33	develop business case to support the **capacity** required for community rehabilitation
EDI_2017/18_14	Substance misuse services	36	strengthen the **capacity** of community detox
EDI_2017/18_18	Engagement with partners and stakeholders	43	develop and implement an engagement strategy to promote collaborative working with all stakeholders across the partnership. This will support the involvement of citizens, staff and partners from the third, independent and statutory sectors in all stages of the **commissioning cycle** from service planning and design through to delivery and review;
Appendix C Recommendation 9	Recommendations from the joint	56	The partnership should work with the local community and other stakeholders to develop

Direction	Title	Page	Narrative
	inspection of services for older people report published in May 2017		and implement a cross-sector market facilitation strategy. This should include a risk assessment and set out contingency plans. (A market facilitation strategy sets out in detail the partnership's priorities for the **commissioning** of services)
Appendix C Recommendation 10		**56**	The Partnership should produce a revised and updated **joint strategic commissioning plan** with detail on: • how priorities are to be resourced • how joint organisational development planning to support this is to be taken forward • how consultation, engagement and involvement are to be maintained • fully costed action plans including plans for investment and disinvestment • based on identified future needs • expected measurable outcomes.
Appendix C Recommendation 12		**56**	The partnership should ensure that there are clear pathways to **accessing** services

Appendix 3 – Terms of Reference

City of Edinburgh Council
Terms of Reference – Review of Demand, Access and Capacity Management

To: Michelle Miller;

From: Lesley Newdall / Paul McGinty
Chief Internal Auditor/Principal Audit Manager

Introduction and Background

Edinburgh Integration Joint Board (EIJB) is responsible for the planning and commissioning of health and social care services in Edinburgh as delegated by City of Edinburgh Council and NHS Lothian. The Edinburgh Health & Social Care Partnership (EHSCP) is responsible for the operational delivery of these services.

The provision and delivery of health and social care services in Edinburgh is a high profile and fundamentally important aspect of CEC's overall operations. The combined health and social care budget is over £670m and covers a wide range of services.

The significance and importance of health and social care is also reflected in the fact that EIJB has a dedicated Internal Audit service and plan (provided jointly by the Chief Internal Auditors of CEC and NHS Lothian) with reporting directly to the Governance, Risk and Best Value (GRBV) Committee of EIJB.

The original 2017/18 Internal Audit plan for EIJB (February 2017) included three reviews to be undertaken by CEC Internal Audit. These focused on (1) Capacity of Health & Social Care Provision (2) Access to Health & Social Care Provision and (3) District Nursing Provision. This proposed coverage was driven directly by the Internal Audit plan risk assessment for EIJB and the content of the EIJB risk register. In overall terms, the proposed coverage reflected the importance of effective capacity planning and delivery of access to community care services.

A subsequent update to the plan by the CEC Chief Internal Auditor in December 2017 (agreed with the EIJB Audit & Risk Committee) refocused and streamlined the proposed coverage into a combined review of Health & Social Care Provision focusing on both *capacity* and *access*. Specific coverage of District Nursing Provision was deferred.

Scope

The scope of this review will therefore be to assess the current framework of control arrangements in place across the EHSCP with respect to capacity, demand and access management. Our work will consider the adequacy of control arrangements in relation to how management:

- Understand and assess current 'as is' service provision
- Assess and consider current demand levels
- Understand and plan for future demand levels
- Seek to influence and manage future demand levels
- Assess and manage internal and external capacity
- Understanding and seek to manage imbalances between demand and capacity

Our work will also consider overall governance and oversight arrangements in place.

Limitations of Scope

Given the scale and complexity of EIJB / Health & Social Care Partnership operations, we have not undertaken detailed compliance or process control testing at this stage but have focused on assessing the overall framework of control in place.

Approach

Our approach will involve:

- Meeting with relevant management to record and understand the control and process arrangements in place across the areas outlined above
- Assessing the adequacy of overall control arrangements in place (at a high level initially)
- Capturing our assessment of current arrangements in a structured control framework template.

Internal Audit Team

Name	Role	Contact Details
Lesley Newdall	Head of Internal Audit	Lesley.Newdall@edinburgh.gov.uk
Paul McGinty	Principal Audit Manager	paul.mcginty@edinburgh.gov.uk

Key Contacts

Name	Title	Role	Contact Details
Michelle Miller	Chief Officer	Key Contact	Michelle.Miller@edinburgh.gov.uk

Indicative Timetable

Planning Meeting / Initial Meeting	8 Feb 2018
Fieldwork Start	W/c 12 Feb
Fieldwork Completed	W/c 9 April
Draft report to Auditee	W/c 16 April
Response from Auditee	W/c 23 April
Final Report to Auditee	W/c 30 April
Final report available	W/c 30 April

Internal Audit

Edinburgh IJB – Performance Target Data

May 2018

Internal Audit Assurance assessment:

Objective One	Objective Two	Objective Three
No Assurance	No Assurance	Significant Assurance

Timetable

Date closing meeting held: 23 April 2018

Date draft report issued: 14 May 2018

Date management comments received: 20 June 2018

Date Final report issued: 20 June 2018

This report has been prepared for NHS Lothian in our capacity as NHS Lothian Internal Auditors and will be shared with Edinburgh IJB's Internal Audit team and the IJB's Audit & Risk Committee. It has been supported by officers from the IJB, NHS Lothian, and the City of Edinburgh Council.

1. Introduction

1.1. The Public Bodies (Joint Working) (Scotland) Act 2014 created an obligation for Integration Joint Boards (IJBs) to issue directions to the Councils and NHS boards in relation to delegated areas of responsibility. The Edinburgh IJB is responsible for the issuing of direction to the City of Edinburgh Council and NHS Lothian.

1.2. As at 20 April 2018 the Edinburgh IJB has issued 21 Directions to the City of Edinburgh Council and NHS Lothian relevant to its overall strategic objectives. Most of the directions are divided is separate objectives.

1.3. The monitoring of the directions' performance is a responsibility of the IJB Board and its relevant committees. The relevant committees in this case were the Strategic Planning Group (SPG) and the Performance & Quality Subgroup (P&Q).

Scope

1.4. This audit sought to establish whether performance objectives have been set for each of the directions' objectives under review and whether performance was monitored by a relevant Board committee at an adequate frequency. It also considered whether the data used to report the performance objectives was accurate and reflected the baseline data.

Acknowledgements

1.5. We would like to thank all staff consulted during this review, for their assistance and cooperation.

2. Executive Summary

Summary of Findings

2.1. The table below summarises our assessment of the risks and the adequacy and effectiveness of the controls in place to meet each of the risk areas agreed for this audit. Definitions of the ratings applied to each action are set out in Appendix 1.

No.	Control Objectives	Assurance Level	Number of findings			
			Critical	High	Medium	Low
1	There are clear and effective performance objectives for each EIJB direction which are well articulated and relate back to the Directions	No Assurance	-	1	-	-
2	All relevant performance objectives are being reported to the EIJB Board in a timely manner based on data collected and analysed	No Assurance	-	2	-	-
3	The reported performance objectives are based on complete and accurate information which has been subjected to appropriate validation/data assurance	Significant Assurance	-	-	-	-
TOTAL			**-**	**3**	**-**	**-**

Conclusion

2.2. The area under review comprised 3 control objectives, of which 2 received No Assurance, and 1 received Significant Assurance.

2.3. Timescales and performance objectives have not been clearly stated for all relevant directions. Also, reporting arrangements for directions have not always been stated, i.e. which committee should receive information, who should provide it, and how often it should be provided. In addition, performance information is not always reported to committee with the required frequency. However, performance information provided to the IJB's Board and sub-committees agrees to base data held within NHS Lothian and City of Edinburgh Council electronic systems.

Main Findings

2.4. We identified three key findings for improvement during the review:

- Having performance objectives for each direction enables more effective performance monitoring by the IJB Board. However an analysis of the 136 direction objectives showed that, of the 127 which should contain a timescale, 89 (70.1%) do not. In addition, of the 83 objectives which should have performance measures stated 59 (71.1%) did not.
- Of the 136 direction objectives, 109 (80.1%) did not state the committee which would receive performance information, 109 (80.1%) did not state the frequency of reporting, and 116 (85.3%) did not state the person responsible for providing the information.
- Of the 136 direction objectives, 27 (19.9%) have stated the committee that performance information will be reported to and how frequently. Of these, only 9 (33.3%) have stated performance objectives. However, an analysis of the minutes and papers of the Strategic Planning Group and the Performance & Quality Subgroup from March 2017 to January 2018 showed that only 6 (66.7%) of these 9 direction objectives had performance information reported about them with the required frequency.

2.5. Of the 21 Directions reviewed, 9 do not state either the timescales, the performance measures, the source of the performance management information, or have information provided to committee with the required frequency; these Directions are Unscheduled Care, Learning Disabilities, Sensory Impairment, Long-Term Conditions, Diabetes, and Workforce Development. In addition, none of the individual Directions have stated all four of these requirements.

2.6. Performance management information reported to committee was complete, accurate and timely and reflected the data held within NHS Lothian's and the City of Edinburgh Council's management information systems based on our sample testing.

2.7. Our two previous audits within the IJB were Performance Targets & Reporting (March 2017) and Directions (August 2017) which had a total of 6 recommendations. At the time of this audit, 5 of these recommendations had still not been fully implemented even though they all had an implementation date of 30 September 2017, and 4 of them had a High rating and one had a Low rating. By not implementing these recommendations in a timely manner there is an increased risk that there is ineffective oversight by the IJB.

3. Management Action Plan

Control objective 1.1: Performance objectives not stated for all Directions. **Associated risk of not achieving the control objective: Effective performance objectives are not in place for all directions.**	**High**

Observation and risk

Edinburgh IJB is responsible for issuing directions to City of Edinburgh Council and NHS Lothian for its delegated areas of responsibility, in order to fulfil its strategic aims. At the time of the audit, 21 directions have been issued in total for 2017-18. These directions comprise a total of 136 objectives.

Having performance objectives for each direction enables more effective performance monitoring by the IJB Board. However an analysis of the 136 direction objectives showed that, of the 127 which should contain a timescale, 89 (70.1%) do not. In addition, of the 83 objectives which should have performance measures stated, 59 (71.1%) did not; for example, the directions for long-term conditions and diabetes.

If effective performance objectives are not clearly stated for all relevant directions there is an increased risk that the IJB Board will not be able to monitor their implementation.

Recommendation

All current and future directions should have clear, effective performance objectives which will enable the implementation of directions to be effectively monitored by the IJB Board.

Management Response

The need for clearly stated performance objectives is agreed.

The context of the development of the performance framework provides an explanation for the way that many of the directions have been expressed. The framework, developed in 2016, focused on two main areas:

- the findings of the inspection of older people's services in 2016 – specifically the pressures around assessment and review waiting lists and people waiting for packages of care
- responding to the introduction of national performance indicators by the Ministerial Strategic Group.

Regular performance reporting was developed and implemented to support these priorities, with contributions from Strategy and Insight, NHS Lothian's analytical team, and LIST. Performance monitoring and management by SMT and the IJB's Performance and Quality

Subgroup was based on this framework, and work to support this included the development and implementation of the whole system dashboard on Tableau. Until early in 2018, the directions had not been the focus for performance management, and had not been developed in that context. Work had been undertaken to consider how progress against the directions could be assessed and this showed that many of the indicators in the performance framework were directly relevant for many of the directions, and so the existing framework provided an indirect means of assessing progress with the directions. <u>The Management Action</u> Current directions will be reviewed and revised to ensure that they state clear and effective performance objectives.	
<u>Responsibility</u>: Colin Briggs, Director of Strategic Planning (NHS Lothian)	<u>Target date:</u> 31 December 2018

Control objective 2.1: Not all directions have stated which committee will receive performance objective statistics, how frequently these are provided and who will provide them. **Associated risk of not achieving the control objective: Reporting arrangements have not been clearly stated for all directions.**	**High**

Observation and risk

The IJB Board should be provided with assurance that the directions are being implemented in a timely manner. As such it is vital that the reporting requirements for each direction are explicitly stated, including which committee performance information will be reported to, who will report it, and how frequently it will be reported.

Of the 136 direction objectives, 109 (80.1%) did not state the committee which would receive performance information, 109 (80.1%) did not state the frequency of reporting, and 116 (85.3%) did not state the person responsible for providing or collating the information.

If reporting arrangements for each direction are not clearly stated there is an increased risk that the IJB Board will not be able to gain assurance that directions are being implemented in a timely manner.

Recommendation

All current and future directions should clearly state their reporting arrangements, which should include which committee performance information will be reported to, who will report it, and how frequently it will be reported.

Management Response

The IJB's Performance and Quality subgroup, and Health and Social Care's Senior Management Team have previously had the role of considering all performance reports; with the IJB considering a specific subset. Arrangements for performance scrutiny have been reviewed with the outcome being that the directions will form the focus of performance monitoring, and that the Strategic Planning Group, instead of the Performance and Quality Subgroup will take the lead on considering performance.

The Management Action

Reporting requirements for each direction will be explicitly stated, including which committee performance information will be reported to, who will report it, and how frequently it will be reported.

Responsibility:	Target date: 31 December 2018

Colin Briggs, Director of Strategic Planning (NHS Lothian)	

Control objective 2.2: Not all performance objective statistics are being reported to IJB committees with the required frequency. **Associated risk of not achieving the control objective: Performance information for directions it not always reported in a timely manner.**	**High**
Observation and risk Performance information for directions should be reported to relevant IJB committees on a regular basis so that IJB non-executives and others can determine if directions are going to be implemented fully and on time. Of the 136 direction objectives, 27 (19.9%) have stated the committee that performance information will be reported to and how frequently. Of these, only 9 (33.3%) have stated performance objectives. However, an analysis of the minutes and papers of the Strategic Planning Group and the Performance & Quality Subgroup from March 2017 to January 2018 showed that only 6 (66.7%) of these 9 direction objectives had performance information reported about them with the required frequency; for example, for reducing delayed discharges, and reducing occupied bed days. If the reporting of performance information is not performed with the required frequency there is an increased risk that directions are not implemented in a timely manner.	
Recommendation Performance information for directions should be reported with the frequency stated in the directions.	
Management Response Agreed. The Management Action Performance reporting will now be done on the basis of the directions, and will be reported to relevant IJB committees on a regular basis to ensure that the implementation of the directions can be monitored effectively.	
Responsibility: Colin Briggs, Director of Strategic Planning (NHS Lothian)	Target date: 31 December 2018

Appendix 1 - Definition of Ratings

Findings and management actions ratings

Finding Ratings	Definition
Critical	A fundamental failure or absence in the design or operating effectiveness of controls, which requires immediate attention.
High	A key control failure has been identified which could be either due to a failure in the design or operating effectiveness. There are no compensating controls in place, and management should aim to implement controls within a calendar month of the review.
Medium	A control failure has been identified which could be either due to a failure in the design or operating effectiveness. Other controls in place partially mitigate the risk to the organisation, however management should look to implement controls to fully cover the risk identified.
Low	Minor non-compliance has been identified with the operating effectiveness of a control, however the design of the control is effective

Report ratings and overall assurance provided

Report Ratings	Definition	When Internal Audit will award this level
No assurance	The Board cannot take any assurance from the audit findings. There remains a significant amount of residual risk.	The controls are not adequately designed and / or operating effectively and immediate management action is required as there remains a significant amount of residual risk(for instance one Critical finding or a number of High findings)
Limited assurance	The Board can take some assurance from the systems of control in place to achieve the control objective, but there remains a significant amount of residual risk which requires action to be taken.	This may be used when: • There are known material weaknesses in key control areas. • It is known that there will have to be changes that are relevant to the control objective (e.g. due to a change in the law) and the impact has not been assessed and planned for. The controls are deficient in some aspects and require management action (for instance one 'high' finding and a number of other lower rated findings)

Moderate assurance	The Board can take reasonable assurance that controls upon which the organisation relies to achieve the control objective are in the main suitably designed and effectively applied. There remains a moderate amount of residual risk.	In most respects the "purpose" is being achieved. There are some areas where further action is required, and the residual risk is greater than "insignificant". The controls are largely effective and in most respects achieve their purpose with a limited number of findings which require management action (for instance a mix of 'medium' findings and 'low' findings)
Significant assurance	The Board can take reasonable assurance that the system(s) of control achieves or will achieve the control objective. There may be an insignificant amount of residual risk or none at all.	There is little evidence of system failure and the system appears to be robust and sustainable. The controls adequately mitigate the risk, or weaknesses are only minor (for instance a low number of findings which are all rated as 'low' or no findings)

Appendix 2 – Analysis of Individual Directions

Key:

No Direction sub-objectives have this	Some Directions sub-objectives have this	All Direction sub-objectives have this	Not applicable

Direction Title	Timescale stated	Performance measures stated	Source stated	Performance measures reported with the required frequency
Direction 1 Locality Working				
Direction 2 Integrated Structure				
Direction 3 Key processes				
Direction 4 Primary care				
Direction 5 Older People				
Direction 6 Unscheduled Care				
Direction 7 Learning Disabilities				
Direction 8 Physical Disabilities				
Direction 9 Sensory Impairment				
Direction 10 Long term Conditions				
Direction 11 - Diabetes				
Direction 12 Unpaid carers				
Direction 13 Community Based mental health				
Direction 14 Substance misuse services				
Direction 15 Palliative and end of life care				
Direction 16 Prevention and early intervention				
Direction 17 Technology enabled care				
Direction 18 Engagement with partners and stakeholders				

Direction 19 Workforce development				
Direction 20 Property Strategy				
Direction 21 ICT to support integrated working				

The City of Edinburgh Council

Care Homes Assurance Review: Internal Audit; Health and Safety; and Information Governance

Health & Social Care

Care Homes Reviews – Thematic Report

Final Report

11th February 2018

Contents

1. Background and Scope

Background

Following successful completion of an Internal Audit assurance programme across the schools managed by Communities and Families in 2015/16 and 2016/17, it was decided that a 'centre based' assurance review would be included in the 2017/18 annual plan (approved by the Governance Risk and Best Value Committee in March 2017), focussing on the Health and Social Care residential care homes for the elderly operated by the Council. This review was performed in conjunction with Corporate Health and Safety and Information Governance.

The Council currently operates ten residential care homes, providing 24-hour care for older people with trained staff and nursing support. Individual care home details are included at **Appendix 3**.

The Gylemuir care facility is unique as it provides an interim care service for patients recently discharged from hospital until more permanent care arrangements are made. The Gylemuir care home plays a vital role in supporting the NHS to reduce 'bed blocking' challenges, and is operated in partnership with the NHS.

Quality of care across all care homes is regulated and monitored by the Care Inspectorate to ensure that care provided meets the required standards detailed in the 'National Care Standards, Care Homes for Older People' requirements published in November 2007.

The Care Inspectorate is responsible for regulating and monitoring quality of care. In addition, the Health and Safety Executive (HSE) and Scottish Fire and Rescue Service (SFRS) are responsible for regulating health and safety (including some aspects of patient safety) and fire, respectively.

It is also essential that the Council ensures that health and safety (including patient safety, property and statutory inspection controls); records management; and other key operational risks (for example, workforce planning and budget management) are effectively managed across all care homes to support delivery of care.

This report summarises common themes arising from our visits, highlighting areas where implementation of effective controls that are consistently applied by both Health & Social Care senior management (Locality Managers) and Business Support is required, and where additional support and guidance from Property and Facilities Management; Human Resources; and Finance business partners would be beneficial in supporting service delivery.

Scope

All ten care homes were reviewed by Internal Audit, Corporate Health and Safety and Information Governance between January and July 2017.

Standard assurance checklists were developed and applied across all care homes by each of the three teams. The assurance checklists are included at **Appendix 5.**

2. Executive Summary

A significant number of systemic control weaknesses were identified across the entire Council care home portfolio by Internal Audit, Health and Safety and Information Governance.

Consequently, 44 Findings (7 High; 29 Medium and 8 low) have been raised. The nature of the Findings and their ratings are summarised in the table below. Further detail on each finding is included in the **Findings and Recommendations** section of the report (section 3 below).

Summary of Findings and Recommendations[1]	**High**	**Medium**	**Low**	**Total**
Internal Audit A1. Care Home Portfolio	3	1	-	4
A2. Financial Controls	1	4	2	7
A3. Workforce Controls	-	5	1	6
A4. Resilience	-	1	-	1
A5. Information Technology	-	1	1	2
Health and Safety B1. Health & Safety Controls	1	7	3	11
B2. Property and Statutory Inspection Controls	2	4	-	6
Information Governance C. Records Information and Compliance	-	6	1	7
Total	**7**	**29**	**8**	**44**

Care Home Action Plans

Each care home was given a status of either red, amber, or green (a RAG status) following completion of the standard checklist and consolidation of results. **Appendix 4 tab 1** details the overall RAG status for each care home for the 8 key areas reviewed. **Tabs 2 – 4** provide more detailed ratings.

Individual Internal Audit; Health and Safety; and Information Governance action plans were then prepared and provided to each Care Home to ensure that specific control weaknesses identified are addressed. Care home managers have been requested to prepare management responses for agreement with the relevant assurance teams.

Appendix 3 shows that action plans have been finalised for 9 care homes. The Action plan for Royston Mains is still to be finalised.

Recommendation for Implementation of a Care Homes Self Assurance Programme

Once the Findings noted above have been addressed, it is essential to ensure that the controls implemented continue to be operate effectively in future, and that Business Support arrangements

[1] All Internal Audit and Information Governance Findings have been classified in accordance with Internal Audit ratings methodology. Health and Safety have applied their own ratings methodology. See **appendix 1** for the basis of classifications applied to all Findings.

remain adequately structured and are supported by an effective control framework that is consistently applied to support effective delivery of care home services.

Internal Audit strongly recommends that the Health and Social Care partnership develops and implements a 'self-assurance' programme for care homes similar to that implemented by Communities and Families across schools in 2017/18 following completion of the Internal Audit schools' assurance programme.

This involved developing a standard testing programme that is completed by experienced business managers who visit other schools to assess their controls, make recommendations for improvement, and share best practice examples. This process supports completion of an annual 'self-assurance statement' by head teachers to confirm that the controls in place in their establishment are working effectively and highlight any risks that they feel are not being managed.

Implementation of a similar assurance programme across care homes covering the areas reviewed by Health and Safety, Internal Audit and Information Governance should enable early identification and resolution of control weaknesses, and could potentially prevent future exposure to significant risks.

Given the significant volume and nature of control weaknesses resulting from our review, we have raised a specific High rated Finding reflecting the need to establish a self assurance framework to support effective management of the Council's Care Homes portfolio by Health and Social Care in conjunction with Business Support (refer section 3, A.1.1 below).

A. Executive Summary - Internal Audit

A1. Care Homes Portfolio

Gylemuir Care Home – As noted in the Background section above, the Gylemuir care home is unique in terms of the interim care service it provides and is also vital in supporting the NHS with reduction of 'bed blocking' challenges.

Despite this, the strategic operating mode for Gylemuir has not been finalised and the home continues to operate under an interim registration certificate from the Care Inspectorate that is valid until June 2018. We have therefore included one 'High' Finding to ensure that this situation, together with the outcomes of the recent Care Inspectorate reviews of Gylemuir (June and August 2017) are effectively managed and addressed.

Changes in the Care Home Portfolio

Two new care homes have been added to the Council's care home portfolio since 2014 (Gylemuir and Royston Mains) and two care homes (Porthaven and Parkview) closed with their residents transferred across to the new Royston Mains facility.

Several control weaknesses were evident in both the Gylemuir and Royston Mains homes that were attributable to the processes applied when these care homes were established and residents transferred from care homes that were closed. For example, historic bank signatories remain on current bank accounts that related to the homes that were closed. We have therefore included one 'High' and one 'Medium' Findings to ensure that these weaknesses are addressed when making future changes to the care home portfolio.

A2. Financial Controls

Three care homes (Fords Road; Gylemuir; and Royston Mains) were rated as red for financial controls (immediate action required) with a further five rated as amber, and two as green.

Management of centrally allocated budgets was not effective, with 9 of the 10 care homes recording an overspend in 2016/17. This was mainly due to high sickness absence rates, unfilled vacancies & lack of budget for holiday cover for non-care roles necessitating increased expenditure on agency staff.

Additionally, no budgets had been set for any of the care homes by the end of the first quarter of the new financial year, and care home managers have not been receiving relevant financial management information on a regular basis to enable budget management.

Effective engagement between Health and Social Care Senior Management and Health and Social Care Finance is necessary to ensure that care home budgets are realistic and that there is appropriate ongoing oversight of performance of the care homes expenditure against budget.

Other areas of weaknesses identified included failure to review and update signatories for care home bank accounts; inappropriate access rights and approval limits for the Oracle purchasing system. We also confirmed that care home welfare funds were not consistently managed in line with applicable guidance, and lack of review of insurance limits for cash balances held in safes.

Consequently, 1 High; 4 Medium, and 2 Low recommendations are included at section 3.

A3. Workforce Controls

Four care homes (Fords Road; Drumbrae; Gylemuir; and Royston Mains) were rated 'red' for workforce controls, with immediate action required, with a further three assessed as amber. The remaining care homes generally managed training, recruitment and induction, and agency staffing well.

However, action is required to ensure that all care homes consistently maintain the resourcing levels required per Care Inspectorate Dependency Assessments, and to confirm that absence is effectively managed.

5 Medium and 1 Low Findings are therefore included at section 3 to ensure that these weaknesses are addressed.

A4. Resilience

Resilience was generally managed well with four care homes rated as amber and six as green. All care homes had a business continuity plan which had been tailored to their property, and seven had reviewed their business continuity plan within the past year.

Our 'Medium' rated Finding highlights the need for business continuity plans to be updated to reflect the current Health and Social Care management structure, and to ensure that care homes are provided with emergency contact numbers that reflect these and any planned future changes.

A5. Technology Equipment and User Access Rights

Seven care homes have been rated as 'amber' for Technology Equipment and User Access reflecting failure to deactivate active directory user accounts for leavers, leaving them with live e mail accounts and (potentially) access to other Council systems where this has not been revoked. Ferrylee was rated as 'red' overall as we identified issues with removal of leaver's access rights and there was no asset register. Consequently, one 'Medium' rated Finding has been raised.

One 'low' Finding has also been included at Section 3 reflecting the need for care homes to establish and maintain asset registers.

A6. Regulatory

All care homes had registration certificates on public display, and the latest Care Inspectorate reports were available on request. All homes have therefore been assessed as 'green' with no recommendations made.

B. Executive Summary – Health and Safety

All 10 care homes were assessed as partially compliant (amber) with respect to both health and safety and property and statutory controls, with a total of 17 health and safety issues identified that require to be addressed.

B1. Health and Safety Controls

A total of 11 health and safety controls findings were raised (1 High; 7 Medium; and 3 Low) that require to be addressed. The most common areas for improvement include: health and safety roles and responsibilities, risk assessment and control measures, first-aid, fire safety and emergency response. In addition, patient safety issues were identified that also require to be addressed at Ferrylee and Gylemuir Care Homes in relation to ligature and suffocation risks.

Areas of good practice were stress management, control of contractors and traffic management.

B2. Property and Statutory Controls

A total of 6 Property and Statutory Controls Findings were raised (2 High and 4 Medium) that require to be addressed. The most common areas requiring improvement were statutory inspections and the fixture of furniture, and window restrictors to a lesser extent.

Following our visits, immediate action was taken by Property and Facilities Management to resolve issues identified with fixed furniture and window restrictors, as these posed potentially significant safety risks to residents.

Action is required at both local level and Senior Management level to implement improvements for both health and safety and patient safety.

C. Executive Summary – Information Governance

All ten care homes have been rated overall as 'amber' reflecting lack of documented processes supporting the management of information, as well as a lack of awareness around some Council-wide information governance procedures.

All homes scored 'red' on questions regarding documented records management processes, information risk registers and privacy impact assessments.

It was noted that the lack of business support in some care homes was having a significant impact on their ability to address some of the issues that were raised during our reviews. Likewise, some of the care homes felt limited access to technology resources affected their ability to update electronic records in a timely manner.

There were eight questions where all the care homes scored 'green'. These included handling and storing data sensitive data; reviewing data; protecting information when it is taken off site; only using personal data for its intended purpose; and use of confidential waste.

Consequently, 6 Medium and 1 Low rated Findings have been raised to ensure that appropriate action is taken to address these issues.

The chart included at **Appendix 4 tab 4** provides a breakdown of each of the Information Governance themes by care home. The chart shows the information governance strengths of each of the homes, and the areas where further development is required.

3. Findings and Recommendations

A. Internal Audit

A1. Care Homes Portfolio

A1.1	Care Homes Self Assurance Framework	High

Action is required to address the significant and systemic operational control gaps emerging from the combined Internal Audit; Health and Safety and Information Governance review of the Council's Care Homes.

Recommendations

The Health and Social Care partnership should develop and implement a 'self-assurance' framework for care homes (similar to that implemented by Communities and Families across schools in 2017/18) to enable early identification and resolution of control weaknesses, and prevent future exposure to significant care quality; health and safety; clinical patient's safety; information governance; and other operational risks.

A1.2	Gylemuir	High

A temporary Care Inspectorate registration certificate was in place at Gylemuir Care Home during the audit visit in June 2017, which was due to expire at the end of that month.

The registration was then extended until the end of August 2017 with the condition that either the proposed date and the strategy for closure of the service or plans for refurbishment should be agreed with the Care Inspectorate.

Since then, the registration has been extended to June 2018 and a subsequent Inspectorate review performed. The interim Health and Social Care Chief Officer is prioritising the concerns raised by the Inspectorate to ensure that these are addressed and has suspended new admissions in the interim period.

The revised Inspectorate conditions of registration are that the Council *'must inform the Care Inspectorate by 30 March 2018 of the proposed date and the strategy for closure of the service or provide details of the future plans for the service. If the service is to be long term and a home for life a full programme of refurbishment must be agreed with the Care Inspectorate to ensure the premises comply with current standards and best practice'.*

Finally, our review confirmed that there were no clear operational guidelines in place for Gylemuir detailing management responsibilities for management and oversight of NHS team members providing care at the home. For example, the care home manager was unable to confirm that NHS team members had completed all necessary training for their role, or whether attendance management for NHS team managers was being recorded.

Recommendations

- Plans to address the most recent Care Inspectorate findings included in their June and August reports should be defined and implemented;
- The current admissions suspension decision should be regularly reviewed, and removed only when considered appropriate;
- A specific risk should be recorded in the Health and Social Care risk register reflecting the strategic risk associated with operation of the Gylemuir care home;
- Regular progress updates should be provided to the Inspectorate in relation to development of the Gylemuir strategy and progress with addressing inspectorate recommendations; and

- Clear guidance is required in relation to management and oversight of NHS team members employed at Gylemuir. This guidance should be developed and applied to all care homes where it is expected that NHS and CEC team members will work together in partnership.

A1.3	Additions to the Care Homes Portfolio	High

Our audit programme included visits to Gylemuir Care Facility, which was brought under Council management in December 2014, and Royston Mains Care Home, which opened in April 2017.

Both Gylemuir and Royston Mains were rated 'red' ('requires immediate attention') in multiple categories, and highlighted areas where the processes supporting opening care homes and closing care homes could be improved.

Whilst Gylemuir was an existing care facility transferred to the Council from another external provider and Royston Mains is a new purpose-built care home, both management teams have experienced similar difficulties since these care homes were established. These include:

- Service models - have not yet been finalised for Gylemuir or Royston Mains.
- Financial management – As with all care homes; the budget for Royston Mains was not finalised until July 2017 (more than three months' post year end) and the care home manager was not provided with detailed 2017/18 budget information to allow him to make informed choices over budget spend. The 2017/18 budget for Gylemuir has not yet been finalised.
- Telephony and technology – the homes have experienced unreliable connections to the Council's phone and computer networks since opening, resulting in inability to make or receive calls, send, or receive faxes (which are required to send prescriptions to the pharmacy), and access Council systems.
- Business support resources – high volumes of turnover in business support resource have impacted the homes ability to implement and maintain effective operational controls and ensure appropriate access to core Council systems.
- Systems access – neither management team had full (Royston Mains) or reliable (Gylemuir) access to core Council finance and people management systems at the time of opening, with Royston Mains only obtaining access to the iTrent people management system in July (3 months after opening). The homes have therefore been unable to perform essential administrative tasks (such as monitoring expenditure or recording sickness absence).
- Property condition - Royston Mains is a new purpose-built care home but staff have reported many problems with the building which have impacted their ability to provide a high standard of care. Gylemuir has also faced a number of repair and maintenance challenges as the building is currently leased from BUPA.

Recommendation

Health and Social Care plans to deliver at least two new care homes in the next few years. We recommend that 'lessons learned' review of the issues experienced at Gylemuir and Royston Mains is performed and the outcomes factored into the plans for opening new care homes in future to ensure that these issues do not recur.

This should include:

- Input from care professionals throughout the design and build process to identify design elements to avoid in future builds;
- Specification of key systems and tools which must be available on the day a new care home opens; and
- Recruitment and training of all care and business support teams prior to opening.

A1.4	Closure of Care Homes	Medium

Porthaven and Parkview Care Homes were closed in April 2017 and all residents were transferred to Royston Mains. We visited Royston Mains in July 2017, 3 months after the care home opened, and found:

- Bank Accounts - Porthaven and Parkview bank accounts were still open, but signatories had left the Council or transferred to another care home and Royston Mains staff, who were now responsible for managing those accounts, had no access to bank statements.
- Records Management – Financial records such as Cash Books relating to Porthaven and Parkview Welfare income were held in storage following the move to Royston Mains and were therefore, unavailable for review.
- Safes - the Porthaven safe had been moved to Royston Mains but was still registered with the Council's Insurance team as being located at Porthaven.
- Staff records - staff records had not been updated on the iTrent human resources system to reflect the care homes they had been transferred to, so the care home manager did not have access to personnel records. Review of the process applied when staff transfer between care homes confirmed that this is an ongoing issue.
- System access rights - Porthaven and Parkview purchasing approvers and requisitioners who had not transferred to Royston Mains were still active in the Oracle finance system.

Recommendation

We recommend that a checklist is created to guide managers through the process of closing a care home. This should include:

- Ensuring all staff and patient records (which may contain personal information) are cleared from the building and archived;
- Closing bank accounts and updating insurance records; and
- Removal of employee access rights to all core CEC systems and creating new access rights (where required).

This checklist should be suitable for use when closing any Council unit, not just care homes.

A2. Financial Controls

A2.1	Budget Monitoring	High

- At the time of our final visit in July 2017, four months into the new financial year, none of the care homes 2017/18 budgets had been finalised and no financial monitoring reports had been provided since March 2017.
- 9 out of 10 care homes significantly overspent staffing budgets in 2016/17 due to high sickness absence rates, unfilled vacancies & lack of budget for holiday cover for non-care roles necessitating increased expenditure on agency staff.
- Care home managers previously met with Finance (Service Accounting) monthly. These meetings no longer happen regularly resulting in a lack of oversight and challenge of care home expenditure. Consequently, care home managers no longer have a regular forum where they can seek advice on financial matters or raise operational issues (such as long-term sickness absence or new residents with high care needs) which may impact on their ability to meet their budget.
- Additionally, changes in the care home management structure implemented in January 2017 has resulted in limited contact between care centre managers and their line managers, and limited oversight of budgets within Health and Social Care.

Recommendation

Care home budgets should be reviewed to align them with current operational service models and expected operating costs.

- All Care home managers should be provided with monthly budget reports or given access to the Frontier system to enable review of performance against budget and communication of any issues; and
- Care home managers should be supported with budget management by re-establishing regular meetings with Finance and their line managers (cluster managers).

A2.2	Purchasing Controls	Medium

- Care home managers are currently authorised to approve expenditure up to £5,000 on the Oracle purchasing system. Weekly agency staffing invoices are frequently higher than this. Oracle authorisation limits were found to have been circumvented by 6 of the 10 care homes by processing part orders (for example a single invoice to the value of £6K is processed as two separate orders of £5K and £1K on Oracle).
- Oracle user access rights are not updated to reflect staff changes where team members leave, or are transferred to another care home. Additionally, current Oracle access rights do not reflect recent changes in senior management structures. We identified incorrect Oracle user access rights for approvers and requisitioners at 8 care homes.

Recommendation

- Oracle approval limits for care home managers should be reviewed to ensure that these are realistic and reflect operational requirements;
- Cluster managers with the appropriate approval limits should be asked to approve any purchase orders that exceed care home manager approval limits; and
- H&SC, Business Support and the Finance Systems Administration Team should review current Oracle access rights across all care home cost centres to identify and resolve any incorrect access rights.

A2.3	Welfare Fund and Outings Funds	Medium

- Welfare funds held across the care homes were generally less that £1K in value. The Welfare Fund Constitution (prepared by Finance) requires each care home to operate a Welfare Fund committee and to produce annual, audited, financial accounts.
- None of the care homes had a Welfare Fund Constitution in place, and only one produced an annual statement of accounts. A second care home was proactive about setting up a Welfare Fund Committee after our audit visit.
- There was evidence at some care homes that residents and their families were encouraged to participate in meetings about the Welfare Fund and submit suggestions for fundraising activities and how the Welfare Fund should be used.
- The Royston Mains care home operated a separate 'outings fund' in addition to the welfare fund. No guidance was available on how these funds should be used.
- No formal authorisation protocol was in place for welfare expenditure at any of the Care Homes visited. Seven of the care homes told us that the care home manager approves items of expenditure in excess of a specified amount, but this approval was not generally documented.
- Welfare Fund transactions are generally in cash, with some cheques used. Care homes do not have purchase cards or debit cards for the Welfare Fund, so in some cases a member of staff made online purchases on their personal credit card and reclaimed the expense back.
- All care home Welfare Fund income and expenditure records were maintained in paper format. None of the care homes kept electronic records.

Recommendation

- Guidelines for managing Welfare Funds that are aligned with the Welfare Fund constitution requirements should be developed and rolled out to all care homes;
- Each care home should establish a Welfare Fund committee to oversee administration of the Fund; decide how the funds should be spent and who can authorise expenditure;
- Each care home should produce a set of annual accounts to be reviewed by the Welfare Fund Committee. We do not consider an external audit of these accounts necessary given that Welfare Funds are typically low in value, but recommend that care homes establish peer review arrangement;
- Guidance should be prepared by Social Care Finance on how the outings fund should be used;
- Care homes should be provided with pre- paid purchase cards to reduce the amount of cash being handled in the care homes and avoid the need for staff to purchase items on personal cards; and
- Audit has provided Business Support with an Excel template which can be used to record cash and bank transactions and perform bank reconciliations. Business Support should consider rolling out this spreadsheet across all care homes with training and guidance provided on how this should be used.

A2.4	Bank Account & Cash Holding	Medium

- Standard RBS forms for changes to bank account signatories enables any existing signatory to set up a new signatory.
- Bank accounts signatories at all 10 care homes had not been reviewed or updated and (in some cases) care home managers were not aware of all signatories in place for their care home accounts.
- Current signatories included staff who had transferred to other care homes or other areas of the Council, and staff who had left Council employment. In one case, a signatory had transferred to another care home three years previously.
- Bank accounts remained open for two care homes that are now closed (Porthaven and Parkview), and included 10 signatories who are not employed at the new Royston Mains care home that residents were transferred to.

Recommendation

- Bank account signatory lists should be reviewed quarterly by Care Home managers and any necessary changes advised to the Council's Treasury team; and
- Treasury should perform an annual review of all care home bank account signatories to ensure that they are complete and accurate.

A2.5	Insurance	Medium

- Care home safe insurance details were not held by the Council's insurance team for 2 of the 10 care homes, and the location of a third safe was also not updated on the insurance list.
- One care home with a registered maximum insurance limit for holding cash in safes had exceeded the limit by £1,160 on the day of the audit.

Recommendation

- Details of make/model, size and position of safes should be provided by care homes to the Council's insurance team;
- Once received, the Insurance team should perform a review of limits to be held in safes and determine the grading of safes;
- Revised safe limits should be communicated to all Care Homes; and
- Care homes should perform periodic reviews to confirm that safe insurance limits are not breached.

A2.6	Residents' Savings	Low

- Cash and bank reconciliations were completed weekly at 7 of the 10 care homes, and signed as evidence of review by the business support officer at 5 of the care homes.
- Residents at 8 care homes had negative balances on their savings accounts at the time of audit. This was generally less than £20, but there were residents with significant 'negative balances' on their Residents' Savings Card at 2 care homes – Fords Road and Royston Mains.
- The BSA at Fords Road care home identified that there was unallocated Residents Savings of £1,379.64. Following an investigation; this was found to be attributable to a banking error and mismanagement of records.
- The reconciliation process had not been carried out at Royston Mains care home as the resident's savings records had not been amalgamated from Porthaven and Parkview Care homes into the new home and the BSO and BSA did not have full access to the necessary bank accounts.

Recommendation

- Clear guidance should be produced for care homes detailing the process to be applied when a resident does not have sufficient funds to cover necessary personal expenditure;
- Care home managers should be permitted discretion over small negative balances, but they must be recorded accurately and promptly, and the care home manager's authorisation of the position recorded;
- Recurring problems in relation to insufficient resident's savings funds should be discussed with the residents' social worker, and a process developed with Social Care Finance to enable access to interim financial support; and
- Business Support Team Leader should ensure that the reconciliation process is undertaken at all care homes on a regular basis. Any significant errors found within the reconciliation process should be reported to the Business Support Team Leader and rectified as soon as possible.

A2.7	Resident's Assets on death	Low

- Forms to record residents' cash and property held by the care home at death were routinely completed and forwarded to Health and Social Care Finance, however it was not clear what cash, valuables and other possessions should be recorded, or which sections of the form should be signed by the care home.
- There was one case where a family member had donated the amount left on the resident's savings card to the care home on his death: however, there was no confirmation of the family member's decision to make this donation, such as an email or letter.

Recommendation

- Forms to record residents' cash and property held by the care home at death should be reviewed by Health and Social Care Finance to ensure that the content of the form is clear and confirm that all assets owned by the resident should be recorded;
- The value of cash and details of physical possessions held should be certified by the care home manager prior to forwarding the form to Health and Social Care Finance or returning the assets to the family; and
- Care homes should be reminded to obtain written confirmation from the family where cash or valuables are donated to the care home. Signed receipts should also be obtained when returning assets or money to relatives.

A3. Workforce Controls

A3.1	Training	Medium

- All employees are required to complete bi-annual essential learning about the Council's key policies and procedures. The iTrent human resources system should be updated to confirm completion and enable HR to monitor completion across all council employees (a completion rate of 56% across all Council employees was recorded in 2016). Three of the ten care homes were unable to demonstrate that all employees had completed essential learning with completion recorded on iTrent.
- In addition to mandatory training, induction and regular refresher training should also be completed. Four of the ten care homes could not demonstrate that all social care workers had completed medications training in the last 2 years, and three of the ten care homes could not demonstrate that all relevant staff had competed manual handling training in the last 18 months.
- Three of the ten care homes were unable to provide evidence of training plans to confirm that employee training needs had been assessed and appropriate training attended or delivered.

Recommendation

- Care home managers should perform a six-monthly review to confirm that all employees have completed mandatory, induction, and refresher training and that completion has been recorded on the iTrent human resources system. Where training has not been completed, this should be discussed with employees and reflected (where appropriate) in their annual performance discussions; and
- Training planning should be implemented across all care homes to support assessment and identification of employee training needs and ensure that these are addressed by either attending at or delivering of training.

A3.2	Recruitment & Induction	Medium

- Nine of the care homes could not demonstrate that identification had been checked on the first day of employment. This is a new requirement and there was evidence that the care homes are starting to check ID.
- Checks of the Protection of Vulnerable Group (PVG) information recorded by human resources for new care home employees in the Council's iTrent human resources system identified inaccurate data input for 6 of the 10 care homes. PVG details for one employee were not recorded in iTrent at all (we were able to confirm that this employee had a satisfactory PVG certificate which was obtained before their start date), whilst other errors included incorrect dates and PVG classifications.

Recommendation

The on boarding process for Health & Social Care staff should be reviewed and checks included to ensure that accurate information regarding PVG checks for care homes is accurately recorded in the Council's iTrent human resources system.

Note: This recommendation is already covered by an existing Medium rated overdue audit recommendation for Health and Social Care (SW1601 ISS.5) - Social Work: Pre-Employment Verification. This finding will be linked with the existing overdue recommendation and no new finding will be raised.

A3.3	Performance and Attendance Management	Medium

- Line managers must complete annual performance reviews for all staff at grade 5 or above and record the outcomes in the iTrent human resources system. Performance reviews and scores had been recorded on iTrent for all ten care home management teams (care home managers; depute and business support officers) included in our sample. However, in discussion with care home managers,

it was established that whilst scores had been recorded in iTrent, performance review meetings had not taken across at least 5 of the 10 care homes.

- The Managing Attendance policy was not well embedded across the care homes. Eight care homes had not consistently recorded sickness absence dates in the iTrent system.
- Only three of the ten care homes could demonstrate that return to work interviews were carried out within 3 working days of the employee's return, and that employees with frequent or long-term absence were managed through the Managing Attendance stages.

Recommendation

- Care home managers should be trained in the new Performance Conversation framework;
- Six monthly and annual performance conversations should be completed for all employees and the outcomes recorded on the iTrent human resources system;
- Care home managers and business support officers should attend the 'managing attendance' workshops which are currently being delivered by Human Resources and ensure that managing attendance procedures are consistently applied; and
- The iTrent system should be reviewed on a quarterly basis by business support officers to confirm that absences and performance conversations are completely and accurately recorded.

A3.4	Agency Staffing	Medium

- Only 4 of the 10 care homes could demonstrate that induction checklists had been completed and copies of photo ID retained for agency staff on duty on the day of our visit.
- Care homes do not receive a breakdown of invoices from Adecco (the agency staffing supplier pre-April 2017) or Pertemps (the supplier post April 2017). Significant discrepancies between timesheets and hours billed were identified in four of the care homes, with minor differences identified in a further three care homes.

Recommendation

- Guidance should be produced for all care homes regarding the documentation that should be retained in the care homes to ensure agency staff have the necessary training and ID; and
- Care homes should receive analysis of the agency staff and hours worked charged to their cost centres to allow these to be reviewed and validated.

A3.5	Adequacy of Resources	Medium

- The Care Inspectorate Dependency Assessment was on display in all ten care homes and staffing levels were met on the day of the audit in nine of the ten care homes visited.
- The Care Inspectorate Dependency Assessment for the Royston Mains care home specifies that a dedicated mental health nurse must be on duty between 7am and 2pm. Royston Mains care home opened in April 2017 and is not yet operating at full capacity with only 45 of 60 places filled, as the specialist dementia unit is not yet open. There are no mental health nurses currently working at the home.
- The Gylemuir Care Inspectorate Dependency Assessment is based on a 30-bed centre, whilst the care home has capacity for 60 residents and regularly accommodates more than 30 residents. The care Inspectorate has been informed of this discrepancy, however Gylemuir are currently determining their own resourcing requirement for Gylemuir as opposed to applying Care Inspectorate requirements.

Recommendation

- Employee resources and budgets should be reviewed to ensure that Care Inspectorate Dependency Assessments requirements are consistently achieved; and

- Health and Social Care senior management should contact the Care Inspectorate to request formal clarification for Gylemuir resources requirements based on the volumes and needs of residents in the care home.

A3.6	Gifts	Low

- Whilst no concerns were identified at any of the care homes in relation to employees accepting gifts from residents or family members, no formal gifts and hospitality registers are maintained at individual care homes.
- Social Care finance maintain a central gifts and hospitality register for care homes, however there is no established guidance or procedures to ensure that details of gifts and hospitality received are provided by care homes to the Social Care finance team to support maintenance of the centralised register.

Recommendation

- Gifts and hospitality registers should be maintained in each care home to record all gifts and hospitality received by employees; and
- Gifts and hospitality details should be provided quarterly to the Health and Social Finance team (including provision of a nil return where applicable) to ensure that the central register is regularly updated and maintained.

A4. Resilience

A4.1	Business Continuity Plans	Medium

- There have been significant changes in the Health & Social Care senior management and business support structures in the past year. These changes have not been updated on resilience information provided to all care homes, so emergency contact lists are out of date.
- The standard business continuity plan template includes a flow chart outlining what procedures to follow in the event of an incident. Only two care homes displayed this chart in Duty Offices. However, as noted above, the flowchart was out of date as the emergency contacts listed no longer work for the Council;
- Two of the care homes visited did not have formal contingency boxes (boxes containing items for use in an emergency) in place.

Recommendation

- A list of emergency contact details for senior management and Council staff should be produced to reflect the revised Council structure;
- This list should be cascaded to all care homes with the instruction that local plans and contact lists be updated accordingly;
- All care homes should then be instructed to display updated incident flow charts at key points around the building; and
- Contingency boxes should be established in all care homes.

A5. Technology Equipment and User Access Rights

A5.1	Leavers	Medium

In seven of the ten care homes, employees who had left the Council were still listed on the Global Address List and had live active directory account enabling them to access Council systems, including e mail.

Recommendation

Care home managers should ensure that the Council's procedures for leavers are consistently applied, with requests to remove access directory accounts submitted in advance of the leaving date with a request for this to be actioned by ICT the day on or immediately after the agreed termination date.

A5.2	Asset Registers	Low

- Five care homes did not have an asset register in place at the time of our audit visit, with three of those indicating that they had no high value assets to record.
- The nature of items recorded on the 5 asset registers varied and usually only included Council issued desktops and mobile phones. Other assets including artwork, TVs, computers for service users and rented items were often excluded.

Recommendation

Clear guidance should be obtained from Finance and ICT regarding the value and nature of items that should be recorded in an asset register

B Health and Safety

B1. Health and Safety Controls

B1.1	Fire safety	High

- Whilst there were good arrangements and practices in place in some areas of fire safety at all care homes, none of the care homes were assessed as overall compliant (green) for fire safety.
- There were generally good controls in place for residents' smoking areas; fire signage; having nominated individuals for fire safety; unobstructed escape routes; fire alarms; fire extinguishers; sprinklers; and emergency lighting.
- The most common areas requiring improvement were in relation to number of fire wardens, fire training and the checking of evacuation equipment.

Recommendation

- Clear guidance on appointment of and role of fire wardens to be given to all care homes; and
- Incorporate checking of evacuation equipment into regular inspection checks at all care homes and ensure records of checks are kept.

B1.2	Health and safety training	Medium

- Health and safety training was assessed as compliant (green) at 3 care homes.

- Whilst induction training was generally carried out, refresher training was overdue or not recorded at 5 care homes. This included fire safety management, asbestos awareness, and *legionella* awareness.
- There was no evidence of training needs analysis having been carried out at Royston Mains Care Home.

Recommendation

A monitoring/ review process should be introduced to ensure that all training is up to date across all care homes.

B1.3	Health and safety workplace inspections / Housekeeping	Medium

- 5 care homes were assessed as compliant (green) for workplace inspections and housekeeping. Workplace inspections are required to be carried out quarterly.
- There were good standards of cleaning and housekeeping. However, there were gaps in emergency cleaning arrangements at 3 care homes.

Recommendation

- Standard emergency cleaning arrangements should be provided to all care homes e.g. for Norovirus; and
- A monitoring/ review process should be introduced to ensure that workplace inspections are being carried out, followed up and actions tracked to completion.

B1.4	First-aid arrangements	Medium

- Gaps were identified in first-aid provision, with all care homes assessed as partially compliant (amber).
- The gaps were in the appointment and training of first-aiders, and provision of information notices and adequately stocked first aid boxes.

Recommendation

Arrangements should be put in place for first aid needs to be assessed, implemented, and monitored at each care home.

B1.5	Emergency response	Medium

- This section includes nurse call alarms systems, lift breakdowns, bomb threats and emergency shut-offs. All care homes were assessed as partially compliant (amber) for emergency response.
- The main gaps identified were in relation to the lack of emergency procedures for lifts, and inadequate bomb threat procedures.

Recommendation

- Standard lift breakdown procedures information to be displayed at all care homes where there are passenger lifts; and
- Bomb threat procedures to be made available to all care home managers.

B1.6	Reporting and investigation of incidents	Medium

- Incidents, accidents, and work-related ill health cases are generally being reported at all care homes, however only 3 care homes were assessed as fully compliant.
- Gaps were identified at 3 care homes in relation to the reporting of adverse incidents involving medical devices to the Medicines and Healthcare Products Regulatory Agency (MHRA).

Recommendation

A procedure for reporting to the Medicines and Healthcare Products Regulatory Agency should be developed for all care homes and implemented.

B1.7	Control of contractors	Medium

- Control of contractors was assessed as compliant (green) at 8 care homes.
- The issue to be addressed at the other 2 care homes was the failure to provide health and safety information to all contractors, including emergency procedures.

Recommendation

Establish standard minimum information to be provided to contractors in liaison with Property and Facilities Management.

B1.8	Health and safety risk assessments and controls	Medium

- All care homes were assessed as partially compliant (amber) for health and safety risk assessments and control measures. Whilst some risk assessments were available at all care homes, a number of risk assessments were either missing, required more detail, or required to be signed off by management.
- 5 care homes were assessed as compliant (green) for health surveillance (health checks). Gaps in health surveillance identified included failure to carry out night workers' questionnaires and skin health surveillance.
- Issue of Personal Protective Equipment (PPE) was not recorded.

There were also questions asked in this section related to patient safety with the following finding:

- Not all ligature and suffocation risk controls had been implemented at Ferrylee Care Home and Gylemuir Care Home.

Recommendation

- A monitoring/ review process should be introduced to ensure that all risk assessments in all care homes are up to date;
- Review health surveillance and health assessment requirements at all care homes;
- Sharing of best practice in risk assessment between care homes should be facilitated and promoted; and
- Standard Personal Protective Equipment issue log form to be available for all care homes.

B1.9	Health and safety roles and responsibilities	Low

- All care homes were assessed as partially compliant (amber) for health and safety roles and responsibilities. Whilst roles, responsibilities and accountabilities set out in the Council Health and Safety Policy were understood, these were not included in personal objectives for key roles.
- Roles and responsibilities specific to each care home were not clearly set out in an organisational chart or other documents.

Recommendation

Personal objectives for key staff at all care homes should include health and safety responsibilities as part of the performance framework.

B1.10	Health and safety communications	Low

- 5 care homes were assessed as compliant (green) for health and safety communications.

- Health and safety was not included as a standing agenda item at staff meetings in all care homes.
- Health and safety information was not given to residents and visitors in all care homes.

Recommendation

Care home managers should be provided with a list of standard health and safety information to be included for residents and visitors.

B1.11	Stress/Employee assistance programme	Low

- 7 care homes were assessed as compliant (green) for managing stress, with 3 care homes assessed as partially compliant (amber) due to lack of information being provided to staff on the Employee Assistance Programme.
- Good arrangements were in place for stress risk assessment. Roles and responsibilities set out in the Stress Policy were understood.

Recommendation

Up to date Employee Assistance Programme information should be provided for all care homes in liaison with Human Resources.

B2. Property and Statutory Inspection Controls

B2.1	Beds/ furniture	High

- This section included bed rails, electric profiling beds and fixed furniture, e.g. wardrobes.
- 1 care home was assessed as compliant (green). A common area for improvement is to ensure that furniture is suitably fixed to prevent it from falling or being toppled. Property and Facilities Management were notified of this issue and have taken action to ensure that furniture such as wardrobes are secured.

Recommendation

Ensure that all furniture e.g. wardrobes, that is required to be in a fixed position for resident safety reasons, is secured, in liaison with Property and Facilities Management.

B2.2	Window restrictors	High

- Window restrictor suitability checks were in place at 4 care homes.
- One care home did not have any window restrictors in place and one care home had unsuitable window restrictors in place.

Recommendation

- Property and Facilities Management to ensure that all window restrictors fitted are suitable; and
- Inspection regime required to ensure that window restrictors are in place and in good working order.

B2.3	Statutory inspections	Medium

- 2 care homes were assessed as fully compliant (green) for statutory inspections. There was a lack of records available at Gylemuir and Royston Mains.
- Fixed electrical systems testing and gas safety checks were found to be in place at 9 care homes, with records available.
- The gaps in statutory inspections included pressure systems records at 6 care homes, ventilation at 3 care homes, hoists, and mobile lifting equipment at 2 care homes, carbon monoxide records at 2 care homes and passenger lifts records at 2 care homes.

- Clarification is needed as to whether pressure systems tests are required.

Recommendation

- Ensure that statutory tests and inspections are up to date and records available for all care homes, in liaison with Property and Facilities Management; and
- Clarification required from Property and Facilities Management as to whether pressure systems tests

B2.4	Water safety (including legionella)	Medium

- Only 4 care homes were assessed as fully compliant for water safety controls.
- *Legionella* risk assessments were in place at 7 care homes. There was no Legionella risk assessment available at Royston Mains and these were out of date at Jewel House and Marionville Court.
- *Legionella* control testing was being carried out in compliance with Health and Safety Executive guidance document 'L8', however, some documentation was incomplete at 3 care homes.

Recommendation

Ensure legionella risk assessments and associated records are available and up to date at all care homes in liaison with Property and Facilities Management and Scientific Services.

B2.5	Asbestos	Medium

- Asbestos registers were readily available at all 6 care homes that were required to have these.
- Asbestos management plan records including condition monitoring were available at 4 out of 6 care homes that are required to have these.

Recommendation

Ensure that asbestos management plan records are available and up to date at all relevant care homes, in liaison with Property and Facilities Management.

B2.6	Condition Surveys	Medium

- Records were available from Strategic Asset Management for 7 care homes. There is an ongoing programme of condition surveys being undertaken.

Recommendation

Property and Facilities Management to ensure that condition surveys are up to date for all care homes.

C. Information Governance

C1.1	Responsibilities	Medium

- There is a lack of awareness around Council information breach procedures.
- There is some knowledge around how to deal with statutory requests for information but there is a reliance on key staff for that knowledge. This presents a risk in terms of resilience.
- There is a lack of business support in some of the homes, vacancies are currently unfilled.

Recommendation

- Business Support to ensure care homes are provided with appropriate support; and
- Care homes to work with the Information Governance Unit to ensure that all employees are aware of Council procedures for reporting information breaches.

C1.2	Decision making	Medium

- There are no documented procedures for records creation, management, and disposal across all care homes.
- In most homes, disposals of records in situ are not documented at all. Where they are documented, it is done inconsistently. Where records are sent to and stored at the Council Records Management Centre, disposals are consistently and comprehensively documented in line with Council policy; however, the centre is not routinely used by all the care homes.
- The process for completion of Privacy Impact Assessments is unknown.
- No fair processing statements are provided by any of the care homes, although in some there are general discussions around consent.

Recommendation

- Care homes to work together with the Information Governance Unit (IGU) to establish a model records management manual to document record processes;
- Care homes to establish local disposal registers, as per Council guidance, to keep track of the disposal of records;
- IGU to provide relevant staff with an input around Privacy Impact Assessments; and
- The Leadership Team of Health and Social Care to work with IGU to prepare appropriate fair processing notices (this will likely come out of GDPR preparation).

C1.3	Compliance	Medium

- There is no awareness of information risk registers.
- There is little experience of dealing with ad-hoc requests for information.

Recommendation

- Care homes to work with the Information Governance Unit (IGU) to develop an appropriate information risk reporting framework; and
- IGU to provide guidance to care homes about information sharing.

C1.4	Availability	Medium

- Outlook is often used as a storage system, where emails are filed for years without any review.
- Local filing conventions are used but these are not generally documented and are not mapped to the Business Classification Scheme.
- Some managers use their personal (H) drives to store data relating to their staff or investigations they are undertaking at other care homes. This is in line with historical practices and advice, but should be reviewed in favour of appropriately secured areas of the G Drive.
- Only one care home utilises a USB stick for care home data, but this is due to serious ICT issues, which are currently being addressed. The USB stick is encrypted.

Recommendation

- Care homes to work together with the Information Governance Unit (IGU) to establish a model file plan to restructure their G drives; and
- As part of this work, the issues surrounding email storage and H drive use will be reviewed and appropriate processes implemented.

C1.5	Retention	Medium

- The closure of records is currently only applied to care plans where the resident is deceased.
- There is little awareness of records or files that might be required for long term retention.

Recommendation

Care homes to work together with the Information Governance Unit to link their client files and administrative records to Council retention rules and document these in their records management manuals.

C1.6	Disposal	Medium

- Most destruction appears to focus on care plans and not on other types of files held by the care homes.
- Disposal of information is also focused mainly on paper files, and not electronic information.

Recommendation

- The Leadership Team of Health and Social Care should agree who is responsible for removing/deleting service user data for deceased residents' data and communicate this to the care homes; and
- Care homes and the Information Governance Unit to cover the management and disposal of electronic records in their model records management manual template.

C1.7	Data Quality	Low

- Version control is not utilised fully in any of the care homes, however there have been some attempts made to differentiate between different versions standardised forms, guidance, and procedures.

Recommendation

- Care homes to work with IGU to ensure version control is implemented appropriately in conjunction with the model records management manual; and
- HSC to review all template forms on an annual basis and work with care homes to ensure correct versions are being used.

4. Health and Social Care – Care Home Action Plan

The management action plan detailed below will be completed by Health and Social Care with actions tracked by Internal Audit, Health and Safety and Information Governance as per the processes outlined in **Appendix 2**.

Finding	Recommendation	Management Response	Action Owner	Action Date
A. Internal Audit				
A1. Care Homes Portfolio				
A1.1 Care Homes Self Assurance Framework	The Health and Social Care partnership should develop and implement a 'self-assurance' framework for care homes (similar to that implemented by Communities and Families across schools in 2017/18) to enable early identification and resolution of control weaknesses, and prevent future exposure to significant care quality; health and safety; clinical patient's safety; information governance; and other operational risks.	A self assurance framework will be designed and implemented that will validate effective operation of controls in place to manage these risks. The Health and Social Care Partnership Operations Manager will be accountable for development; implementation and ongoing operation of the framework. Development and implementation support will be requested from Business Support and Quality Assurance and Compliance.	Interim Chief Officer, Health and Social Care	30th June 2019
A1.2 Gylemuir	Plans to address the most recent Care Inspectorate findings included in their June report should be defined and implemented.	Action plan developed in discussion with Care Inspectorate. Gylemuir action group set up with monthly meetings to monitor outputs and outcomes	Chief Nurse, Health and Social Care	28th February 2018
	The current admissions suspension decision should be regularly reviewed, and removed only when considered appropriate.	Following review of action plan, and ongoing improvement, admission suspension was lifted. Currently open to 30 residents, capacity will increase when staff recruited	Chief Nurse, Health and Social Care	28th February 2018
	A specific risk should be recorded in the Health and Social Care risk register reflecting the strategic risk associated with operation of the Gylemuir care home.	A new risk was added to the Edinburgh Integration Joint Board risk register in relation to Gylemuir. The H&SC risk register is in the process of being refreshed with specific locality risks being developed that will be recorded in Datex (NHS risk Management system). A specific risk for Gylemuir will be recorded in the	Chief Nurse, Health and Social Care	28th February 2018

		relevant locality risk register and in the consolidated Health and Social Care risk register.		
	Regular progress updates should be provided to the Inspectorate in relation to development of the Gylemuir strategy and progress with addressing inspectorate recommendations.	Ongoing communication with the Care Inspectorate continues at local and senior level. Care Inspectorate invited to join Gylemuir action group	Chief Nurse, Health and Social Care	30th June 2018
	Clear guidance is required in relation to management and oversight of NHS team members employed at Gylemuir. This guidance should be developed and applied to all care homes where it is expected that NHS and CEC team members will work together in partnership.	The staffing model at Gylemuir house has been reviewed, a Senior Charge Nurse has been seconded in to support direct management and professional support of NHS staff while the recruiting process continues to identify a substantive Senior Charge Nurse. NHS staff continue to operate under NHS governance and are professionally accountable through the nursing line. It is expected that this post will be permanently filled by April 2018 Nursing staff remain under NHS terms and conditions. The Senior Charge Nurse is directly managed by the Care Home manager and professionally accountable to the professional lead in North West locality	Chief Nurse, Health and Social Care	30th April 2018
A1.3 Additions to the Care Homes Portfolio	Health and Social Care plans to deliver at least two new care homes in the next few years. We recommend that 'lessons learned' review of the issues experienced at Gylemuir and Royston Mains is performed and the outcomes factored into the plans for opening new care homes in future to ensure that these issues do not recur. This should include: • Input from care professionals throughout the design and build process to identify design elements to avoid in future builds. • Specification of key systems and tools which must be available on the day a new care home opens, and	Business Support is in the process of developing a care homes open and closure plan to be applied to the opening and closure of all care homes in future. Once developed, this document can be used by the relevant Health and Social Care project managers responsible for opening and closure of Care Homes.	Business Services Manager, Health and Social Care	31st March 2018

	• Recruitment and training of all care and business support teams prior to opening.			
A1.4 Closure of Care Homes	We recommend that a checklist is created to guide managers through the process of closing a care home. This should include: • Ensuring all staff and patient records (which may contain personal information) are cleared from the building and archived • Closing bank accounts and updating insurance records • Removal of employee access rights to all core CEC systems and creating new access rights (where required). This checklist should be suitable for use when closing any Council unit, not just care homes.	Business Support is in the process of developing a care homes open and closure plan to be applied to the opening and closure of all care homes in future. Once developed, this document can be used by the relevant Health and Social Care project managers responsible for opening and closure of Care Homes.	Business Services Manager, Health and Social Care	31st March 2018
A2. Financial Controls				
A2.1 Budget Monitoring	Care home budgets should be reviewed and rebased to align them with current operational service models and expected operating costs.	This piece of work was completed as part of the restructure of budgets to reflect the locality operating model in September 2017. Budgets are regularly monitored through general ongoing monitoring performed by Finance and there is an established process for ensuring that overspends are communicated to budget owners. Business support will also be providing more support to Unit Managers in relation to ongoing budget management.	Senior Accountant, Finance, Health, and Social Care	28th February 2018
	All care home managers should be provided with monthly budget reports or given access to the Frontier system to enable review of performance against budget and communication of any issues.	Frontier reports sent out monthly	Senior Accountant, Finance, Health and Social Care	28th February 2018
	Care home managers should be supported with budget management by re-establishing regular meetings with Finance and their line managers (cluster managers).	All care home managers will have a budget meeting once a year with finance and on an ad hoc basis when required. Budget meetings started in Sept 2017.	Senior Accountant, Finance, Health and Social Care	28th February 2018

A2.2 Purchasing Controls	Oracle approval limits for care home managers should be reviewed to ensure that these are realistic and reflect operational requirements.	All requisitioners / authorisers listed and limits will be reviewed, agreed, and formally documented. Discussions will be held with Finance and revised limits have agreed and implemented. Revised limits will be based on the highest invoice value expected in any one unit and applied consistently across all Care Homes Unit Managers.	Locality Managers	28th March 2018.
	Cluster managers with the appropriate approval limits should be asked to approve any purchase orders that exceed care home manager approval limits.	Current approval guidelines and requisitioners / authorisers established to reflect new locality structure. Cluster Managers will approve any invoices that are outwith the authority limits for Unity Managers.	Treasury and Banking Officer, Corporate Finance Locality Managers	28th February 2018
	H&SC, Business Support and the Finance Systems Administration Team should review current Oracle access rights across all care home cost centres to identify and resolve any incorrect access rights.	Reviewed and cost centres removed from staff who have left.	Business Services Manager, Health and Social Care	28th February 2018
A2.3 Welfare Fund and outings Funds	Guidelines for managing Welfare Funds that are aligned with the Welfare Fund constitution requirements should be developed and rolled out to all care homes.	A working group has been established that will focus on welfare. The remit of the group will focus on welfare committees; constitutions; accounts; criteria and donations. 2 officers from the working group have been assigned responsibility to write and implement welfare guidelines	Business Services Manager, Health and Social Care	31st July 2018
	Each care home should establish a Welfare Fund committee to oversee administration of the Fund; decide how the funds should be spent and who can authorise expenditure.	A working group has been established that will focus on welfare. The remit of the group will focus on welfare committees; constitutions; accounts; criteria and donations. 2 officers from the working group have been assigned responsibility to write and implement welfare guidelines	Business Services Manager, Health and Social Care	31st July 2018
	Each care home should produce a set of annual accounts to be reviewed by the Welfare Fund Committee. We do not consider an external audit of these accounts necessary given that Welfare Funds are typically low in value, but	A working group has been established that will focus on welfare. The remit of the group will focus on welfare committees; constitutions; accounts; criteria and donations. 2 officers	Business Services Manager, Health and Social Care	31st July 2018

	recommend that care homes establish peer review arrangement.	from the working group have been assigned responsibility to write and implement welfare guidelines Task assigned to Business Officer for annual accounts and daily bookkeeping. Guidelines to be written for consistency		
	Guidance should be prepared by Social Care Finance on how the outings fund should be used;	A working group has been established that will focus on welfare. The remit of the group will focus on welfare committees; constitutions; accounts; criteria and donations. 2 officers from the working group have been assigned responsibility to write and implement welfare guidelines	Business Services Manager, Health and Social Care	31st July 2018
	Care homes should be provided with pre - paid purchase cards to reduce the amount of cash being handled in the care homes and avoid the need for staff to purchase items on personal cards.	Ensuring compliance with current procedures should reduce the amount of cash being handled in care homes, with no requirement for implementation of pre paid cards. Existing procedures will be reinforced.	Business Services Manager, Health and Social Care	28th February 2018
	Audit has provided Business Support with an Excel template which can be used to record cash and bank transactions and perform bank reconciliations. Business Support should consider rolling this across all care homes with training and guidance provided on how this should be used.	Spreadsheet introduced for all cash and running in all homes	Business Services Manager, Health and Social Care Business Support Team Managers	28th February 2018
A2.4 Bank Account & Cash Holding	Bank account signatory lists should be reviewed quarterly by Care Home managers and any necessary changes advised to the Council's Treasury team.	All homes are accurate as at October 2018 Signatory changes to be aligned to starters and leavers process	Business Services Manager, Health and Social Care Business Support Managers	28th February 2018 31st March 2018
	Treasury should perform an annual review of all care home bank account signatories to ensure that they are complete and accurate.	the recorded list of signatories will be issued annually by Treasury to the Care Homes with a request that they revert back within one month detailing any leavers who should be removed. Finance will then make the appropriate adjustments to existing bank account signatories.	Principal Treasury and Banking Manager, Finance	30th June 2018

A2.5 Insurance	Details of make/model, size and position of safes should be provided by care homes to the Council's insurance team.	All safes re-registered with Insurance Section	Business Services Manager, Health and Social Care Business Support Managers	28th February 2018
	Once received, the Insurance team should perform a review of limits to held in safes and determine the grading of safes.	Discussion between Insurance & Business support to determine that Corporate appointees included in CEC policy. Process for informing client/family of personal insurance requirements on admission for cash & valuables	Business Services Manager, Health and Social Care Business Support Managers	28th February 2018
	Revised safe limits should be communicated to all Care Homes.	List distributed to all homes	Business Support Team Managers	28th February 2018
	Care homes should perform periodic reviews to confirm that safe insurance limits are not breached.	Discussions to be held with family members as part of the admission process to ensure family is clear that insurance does not cover personal items for residents. CEC is covered for client money only where the Council is the resident's corporate appointee. Admission process will be included as part of a new monthly controls process to be implemented and monitored via completion of a monthly spreadsheet. A working group has been established to document the admissions process.	Business Services Manager, Health and Social Care Business Support Managers	30th June 2018
A2.6 Residents' Savings	Clear guidance should be produced for care homes detailing the process to be applied when a resident does not have sufficient funds to cover necessary personal expenditure.	Business Officer ongoing compliance with weekly reconciliations process. Officers assigned to write guidance	Business Services Manager, Health and Social Care	31st March 2018
	Care home managers should be permitted discretion over small negative balances, but they must be recorded accurately and promptly, and the care home manager's authorisation of the position recorded.	To be input to the guidance Business Officer compliance with current procedure. Space will be included in forms to record Unit Manager authorisation of the negative position.	Business Support Managers	28th February 2018

	Recurring problems in relation to insufficient resident's savings funds should be discussed with the residents' social worker, and a process developed with Social Care Finance to enable access to interim financial support.	Raise Awareness of S.12 financial assistance from Social Work Centres to all care staff and input to guidance. This will be achieved via an initial visit to all care homes by the Business Services Manager, Health and Social Care who will engage with Business Support Managers and Business Support Officers.	Business Services Manager, Health and Social Care	28th February 2018
	Business Support Team Leader should ensure that the reconciliation process is undertaken at all care homes on a regular basis. Any significant errors found within the reconciliation process should be reported to the Business Support Team Leader and rectified as soon as possible.	Reconciliations process will be included as part of a new monthly controls process to be implemented and monitored via completion of a monthly spreadsheet. A working group has been established to document all processes to be included. Business Officers will be responsible for ongoing compliance with procedure and evidenced in supervision notes.	Business Services Manager, Health and Social Care Business Support Managers Business Support Officers	30th June 2018
A2.7 Resident's Assets on death	Forms to record residents' cash and property held by the care home at death should be reviewed by Health and Social Care Finance to ensure that the content of the form is clear and confirm that all assets owned by the resident should be recorded.	Form 309 to be reviewed. Assigned to Business Support Officers to review and update in liaison with Unit Managers	Business Services Manager, Health and Social Care Business Support Managers Business Support Officers Unit Managers	28th February 2018
	The value of cash details of physical possessions held should be certified by the care home manager prior to forwarding the form to Health and Social Care Finance or returning the assets to the family	To be reviewed and included in Admissions and discharge procedure paperwork	BSM/UMs	28th February 2018
	Care homes should be reminded to obtain written confirmation from the family where cash or valuables are donated to the care home, receipts should also be obtained when returning assets or money to relatives.	Simple, standard donation form to be introduced which includes part for receipting signatures. This will be included in the revised admissions / discharge process that will be included as part of a new monthly controls process to be implemented and monitored via completion of	Business Services Manager, Health and Social Care Business Support Managers	30th June 2018

		a monthly spreadsheet. A working group has been established to document all processes to be included.		
A3. Workforce Controls				
A3.1 Training	Care home managers should perform a six-monthly review to confirm that all employees have completed mandatory, induction and refresher training and that completion has been recorded on the iTrent human resources system. Where training has not been completed, this should be discussed with employees and reflected (where appropriate) in their annual performance discussions.	This will be included as part of a new monthly controls process to be implemented and monitored via completion of a monthly spreadsheet. A working group has been established to document all processes to be included.	Cluster Managers/Unit manager	30th June 2019
	Training planning should be implemented across all care homes to support assessment and identification of employee training needs and ensure that these are addressed by either attending at or delivering of training.	A spreadsheet has been developed for all mandatory training and is being implemented in each home. The Business Support Officer will ensure the info is up to date and liaise with the Unit manager.	Business Services Manager, Health and Social Care Business Support Managers Business Support Officers	28th February 2018
A3.2 Recruitment & Induction	The on boarding process for Health & Social Care staff should be reviewed and checks included to ensure that accurate information regarding PVG checks for care homes is accurately recorded in the Council's iTrent human resources system.	Internal Audit Note: This recommendation is already covered by an existing Medium rated overdue audit recommendation for Health and Social Care (SW1601 ISS.5) - Social Work: Pre-Employment Verification. This finding will be linked with the existing overdue recommendation and no new finding will be raised.	N/A	N/A
A3.3 Performance and Attendance Management	Care home managers should be trained in the new Performance Conversation framework.	**Business Support Teams** All Business Support Officers have attended the training and will cover performance conversations for handymen and domestic care home staff. **Health and Social Care Teams** Will ensure that performance conversation training has been attended by all H&SC line managers in Care Homes.	Business Services Manager, Health and Social Care Business Support Managers Operations Manager, Health and Social Care	28th February 2018 for Business Support employees 30th June 2018

	Six monthly and annual performance conversations should be completed for all employees and the outcomes recorded on the iTrent human resources system.	**Business Support Teams** All Business Support Officers have attended the training and will cover performance conversations for handymen and domestic care home staff. MyPeople has been updated to reflect completion of annual performance conversations for these employees. **Health and Social Care Teams** Will ensure that annual performance conversations (once completed) are recorded on the iTrent system.	Business Services Manager, Health and Social Care Business Support Managers Business Support Officers Operations Manager, Health and Social Care	28th February 2018 for Business Support employees 30th June 2018
	Care home managers and business support officers should attend the 'managing attendance' workshops which are currently being delivered by Human Resources and ensure that managing attendance procedures are consistently applied.	**Business Support Teams** Business Support Officer planned program in place **Health and Social Care Teams** Will ensure that managing attendance workshops have been attended by all H&SC line managers in Care Homes.	Business Support Managers	30th June 2018 30th June 2018
	The iTrent system should be reviewed on a quarterly basis by business support managers to confirm that absences and performance conversations are completely and accurately recorded.	This is the responsibility of the Unit manager for their direct reports. The Business Support Officer will ensure that the Unit Manager is aware on a monthly basis for Domestics and Handymen reporting to them The Business Support Officer is required to monitor and report through the Customer process on a monthly basis. The staff nurse / charge nurse to be appointed at Gylemuir will ensure that this is performed for all NHS staff.	Business Support Managers Unit Managers Chief Nurse, Health and Social Care	30th June 2018 for Business Support employees 30th June 2018
A3.4 Agency Staffing	Guidance should be produced for all care homes regarding the documentation that should be retained in the care homes to ensure agency staff have the necessary training and ID.	To be integrated with Starters/Leavers process	Business Support Managers	28th February 2018
	Care homes should receive analysis of the agency staff and hours worked charged to their cost centres to allow these to be reviewed and validated.	The BSO will assist the UM (See A2.1) A paper is being presented to the Health and Social Care Senior Management Team wee	Chief Nurse, Health and Social Care	31st March2018

		commencing 15th January 2018 that proposes a solution where information will be provided to Locality Managers who will prepare reports for Care Homes. If this solution is agreed, it will be implemented immediately.		
A3.5 Adequacy of Resources	Employee resources and budgets should be reviewed to ensure that Care Inspectorate Dependency Assessments requirements are consistently achieved.	Unit managers submit monthly reports to Cluster manager and Locality management team. Locality management team responsible for ensuring resource meets the demand based on dependency scoring	Locality manager Operations Manager, Health and Social Care	31st January 2019
	Health and Social Care senior management should contact the Care Inspectorate to request formal clarification for Gylemuir resources requirements based on the volumes and needs of residents in the care home	The position has now changed as Gylemuir is building towards full capacity of 60 beds. There are still 15 vacancies, so capacity is currently being managed in line with the current staffing shortfall. Once the vacancies have been recruited, Gylemuir will operate at its licenced capacity of 60 beds. Consequently, this recommendation is no longer applicable	N/A	N/A
A3.6 Gifts	Gifts and hospitality registers should be maintained in each care home to record all gifts and hospitality received by employees.	This will be included as part of a new monthly controls process to be implemented and monitored via completion of a monthly spreadsheet. A working group has been established to document all processes to be included. The new process will specify that anything in excess of £10 in value should be included in the gifts and hospitality register.	Business Support Managers	28th February 2018
	Gifts and hospitality details should be provided quarterly to the Health and Social team (including provision of a nil return where applicable) to ensure that the central register is regularly updated and maintained.	This will be included as part of a new monthly controls process to be implemented and monitored via completion of a monthly spreadsheet. A working group has been established to document all processes to be included. The new process will specify that anything in excess of £10 in value should be included in the gifts and hospitality register and that the central hospitality register should be updated quarterly.	Business Support Managers	28th February 2018

A4. Resilience				
A4.1 Business Continuity Plans	A list of emergency contact details for senior management and Council staff should be produced to reflect the revised Council structure.	List pulled together by Business Support Officer and Business Support Managers and has been distributed.	Business Support Managers	28th February 2018
	This list should be cascaded to all care homes with the instruction that local plans and contact lists be updated accordingly.	List pulled together by Business Support Officer and Business Support Managers and has been distributed.	Business Support Managers	28th February 2018
	All care homes should then be instructed to display updated incident flow charts at key points around the building.	This will be included as part of a new monthly controls process to be implemented and monitored via completion of a monthly spreadsheet. A working group has been established to document all processes to be included. Unit Managers will be responsible for the content of the incident flow charts.	Business Support Managers	30th June 2018
	Contingency boxes should be established in all care homes.	All contingency boxes being revamped and sustained by Handyman. Evidenced in supervision notes	Business Support Managers	28th February 2018
A5. Technology Equipment and User Access Rights				
A5.1 Leavers	Care home managers should ensure that the Council's procedures for leavers are consistently applied, with requests to remove access directory accounts submitted in advance of the leaving date with a request for this to be actioned by ICT the day after the agreed termination date.	This will be part of the revamped Starters/Leavers process	Business Support Managers	28th February 2018
A5.2 Asset Registers	Clear guidance should be obtained from Finance and ICT regarding the value and nature of items that should be recorded in an asset register.	The asset registers currently used in Social Work centres has been copied and e mailed to all business support teams and unit managers in care homes for completion.	Business Support Managers Unit Managers	28th February 2018
B. Health and Safety				
B1. Health and Safety Controls				
B1.1 Fire safety	Clear guidance on appointment of and role of fire wardens to be given to all care homes.	Wardens guidance has been requested from Health and Safety colleagues and will be incorporated in a consolidated spreadsheet. The spreadsheet will list all tasks completed by the handymen that the Business Support	Business Support Managers	28th February 2018

		Officer is responsible for, together with the completion cycle and responsibilities (including fire wardens). Allocation of responsibilities will also ensure that those responsible have met all relevant fire warden training requirements.		
	Incorporate checking of evacuation equipment into regular inspection checks at all care homes and ensure records of checks are kept.	This will be incorporated in the spreadsheet being implemented that has a dual purpose of control mechanism and training needs assessment. Checking of evacuation equipment will be part of the handyman duties. The spreadsheet will list all tasks completed by the handymen that the Business Support Officer is responsible for, together with the completion cycle and responsibilities (including checking evacuation equipment). Allocation of responsibilities will also ensure that those responsible have met all relevant training requirements.	Business Support Managers	28th February 2018
B1.2 Health and safety training	A monitoring/ review process should be introduced to ensure that all training is up to date across all care homes.	This will be incorporated into the spreadsheet as indicated in both A3.1 and B1.1	Business Support Managers	28th February 2018
B1.3 Health and safety workplace inspections / Housekeeping	Standard emergency cleaning arrangements should be provided to all care homes e.g. for Norovirus.	This will be incorporated in the spreadsheet being implemented that has a dual purpose of control mechanism and training needs assessment. Checking of evacuation equipment will be part of the handyman duties. The spreadsheet will list all tasks completed by the domestic staff that the Business Support Officer is responsible for, together with the completion cycle and responsibilities. Allocation of responsibilities will also ensure that those responsible have met all relevant training requirements.	Business Support Team Managers	28th February 2018

	A monitoring/ review process should be introduced to ensure that workplace inspections are being carried out, followed up and actions tracked to completion.	Business Support Officer will check the controls spreadsheet on a monthly basis to confirm that workplace inspections have been recorded and evidence in supervision notes. Business Support Team Managers will also confirm that oversight has been performed as part of ongoing care home unit visits. Unit Managers will also have oversight and feed any issues into Locality Managers.	Business Support Team Managers Unit Managers	28th February 2018
B1.4 First-aid arrangements	Arrangements should be put in place for first aid needs to be assessed, implemented, and monitored at each care home.	Guidance from H&S colleagues Handyman role to check & stock first aid boxes and information notices. Add to spreadsheet. Monitored through supervision and monthly spreadsheet checks	Unit Manager Business Support Officer	28th February 2018 28th February 2018
B1.5 Emergency response	Standard lift breakdown procedures information to be displayed at all care homes where there are passenger lifts.	This will be incorporated in the spreadsheet being implemented that has a dual purpose of control mechanism and training needs assessment. Ensuring standard lift breakdown procedures information is displayed will be the responsibility of the handymen. The spreadsheet will list all tasks completed by the domestic staff that the Business Support Officer is responsible for, together with the completion cycle and responsibilities. Allocation of responsibilities will also ensure that those responsible have met all relevant training requirements. Completion will be monitored monthly.	Business Support Officer Operations Manager, Health and Social Care	28th February 2018
	Bomb threat procedures to be made available to all care home managers.	Care Home evacuation process is Unit Manager responsibility, and these will be updated to reflect the evacuation process in the event of a bomb threat. Resilience will be requested to provide support via a programme work across all 10 Council Care Homes to ensure they receive	Operations Manager, Health and Social Care	30th April 2018

		the training on counter terrorist awareness, including Bomb Threat procedures, suspicious package, and intruder threat.		
B1.6 Reporting and investigation of incidents	A procedure for reporting to the Medicines and Healthcare Products Regulatory Agency should be developed for all care homes and implemented.	The partnership currently has a 'medication matters' group – discussion regarding the process of reporting to be developed and agreed	Unit Managers Operations Manager, Health and Social Care	31st October 2018
B1.7 Control of contractors	Establish standard minimum information to be provided to contractors in liaison with Property and Facilities Management.	'Do' and 'Don't' A4 briefing sheet to be created for all care homes	Business Support Team Managers	28th February 2018
B1.8 Health and safety risk assessments and controls	A monitoring/ review process should be introduced to ensure that all risk assessments in all care homes are up to date.	This process will be incorporated within the new self assurance framework to be implemented across all Care Homes.	Interim Chief Officer, Health and Social Care Partnership	30th June 2019
	Review health surveillance and health assessment requirements at all care homes.	This process will be incorporated within the new self assurance framework to be implemented across all Care Homes.	Interim Chief Officer, Health and Social Care Partnership	30th June 2019
	Sharing of best practice in risk assessment between care homes should be facilitated and promoted.	The Hospital and Hosted Services Manager has been allocated as lead for Health and Safety in the Health and Social Care Partnership. Best practice in risk assessments will discussed at the newly established Health and Safety Group.	Hospital and Hosted Services Manager Operations Manager, Health and Social Care	30th June 2018
	Standard Personal Protective Equipment issue log form to be available for all care homes.	Set up and administered by Business Support Officers	Business Support Team Managers	28th February 2018
B1.9 Health and safety roles and responsibilities	Personal objectives for key staff at all care homes should include health and safety responsibilities as part of the performance framework.	Spotlight conversations for all staff and standing item in supervision. Business Support Officers attended 2017 Health and Safety conference and feed back to staff	Unit Managers/Business Support Officers Business Support Team Managers	28th February 2018

B1.10 Health and safety communications	Care home managers should be provided with a list of standard health and safety information to be included for residents and visitors.	BSO to devise A4 sheet for families in conjunction with UM. Add to admissions process and paperwork	Unit Managers/BSO	28th February 2018
B1.11 Stress/Employee assistance programme	Up to date Employee Assistance Programme information should be provided for all care homes in liaison with Human Resources.	**Business Support Teams** Employee Assistance Programme information has been provided to all Business Support team members. **Health and Social Care Teams** Information will also be provided by Locality and Unit Managers for all non business support team members.	Business Services Manager, Health and Social Care Operations Manager, Health and Social Care	28th February 2018 30th April 2018
B2. Property & Statutory Inspection Controls				
B2.1 Beds/ furniture	Ensure that all furniture e.g. wardrobes, that is required to be in a fixed position for resident safety reasons, is secured, in liaison with Property and Facilities Management.	Started by Unit Manager & Business Support Officer. This will be incorporated in the spreadsheet being implemented that has a dual purpose of control mechanism and training needs assessment. Ensuring that all furniture is secured will be the responsibility of the handymen. The spreadsheet will list all tasks completed by the domestic staff that the Business Support Officer is responsible for, together with the completion cycle and responsibilities. Allocation of responsibilities will also ensure that those responsible have met all relevant training requirements. Completion will be monitored monthly.	Business Support Team Managers	30th June 2018
B2.2 Window restrictors	Property and Facilities Management to ensure that all window restrictors fitted are suitable.	Property and Facilities Management has already confirmed suitability of all window restrictors.	Operations Manager, Health, and Social Care	28th February 2018
	Inspection regime required to ensure that window restrictors are in place and in good working order.	This will be incorporated in the spreadsheet being implemented that has a dual purpose of control mechanism and training needs assessment.	Business Support Team Managers	30th June 2018

		The spreadsheet will list all tasks completed by the domestic staff that the Business Support Officer is responsible for, together with the completion cycle and responsibilities. Allocation of responsibilities will also ensure that those responsible have met all relevant training requirements. Completion will be monitored monthly.		
B2.3 Statutory inspections	Ensure that statutory tests and inspections are up to date and records available for all care homes, in liaison with Property and Facilities Management.	This process will be incorporated within the new self assurance framework to be implemented across all Care Homes.	Interim Chief Officer, Health and Social Care Partnership	30th June 2019
	Clarification required from Property and Facilities Management as to whether pressure systems tests are required.	Confirmation will be obtained from Property and Facilities Management.	Interim Chief Officer, Health and Social Care Partnership	28th February 2018
B2.4 Water safety (including legionella)	Ensure legionella risk assessments are available and up to date at all care homes in liaison with Property and Facilities Management and Scientific Services.	This process will be incorporated within the new self assurance framework to be implemented across all Care Homes.	Interim Chief Officer, Health and Social Care Partnership	30th June 2019
B2.5 Asbestos	Ensure that asbestos management plan records are available and up to date at all relevant care homes, in liaison with Property and Facilities Management.	This process will be incorporated within the new self assurance framework to be implemented across all Care Homes.	Interim Chief Officer, Health and Social Care Partnership	30th June 2019
B2.6 Condition Surveys	Property and Facilities Management to ensure that condition surveys are up to date for all care homes.	Condition survey are now up to date for all Care Homes and a report confirming this will be presented to Finance and Resources Committee at the end of January 2018	Health and Social Care Operations Manager Senior Manager, Strategic Asset Management	28th February 2018
C1. Information Governance				
C1.1 Responsibilities	Business Support to ensure care homes are provided with appropriate support.	Business support vacancies have been filled	Business Support Team Managers	28th February 2018

	Care homes to work with the Information Governance Unit to ensure that all employees are aware of the Council procedures for reporting information breaches.	Information Governance Unit (IGU) will attend care home manager's meeting to deliver training	Unit Managers / IGU	30th April 2018
C1.2 Decision making	Care homes to work together with the Information Governance Unit (IGU) to establish a model records management manual to document record processes.	Look at how we can mirror and adapt the successful procedure operating in Social Work Centres Information Governance Unit (IGU) will review and comment on arrangements by target date.	Business Support Managers	21st December 2018
	Care homes to establish local disposal registers, as per Council guidance, to keep track of the disposal of records.	Mirror process in Social Work Centres. Information Governance Unit (IGU) will review and comment on arrangements by target date.	Business Support Managers	21st December 2018
	IGU to provide relevant staff with an input around Privacy Impact Assessments.	Information Governance Unit (IGU) will attend care home manager's meeting to deliver training	Unit Managers / IGU	30th April 2018
	The Leadership Team of Health and Social Care to work with IGU to prepare appropriate fair processing notices (this will likely come out of GDPR preparation).	Information Governance Unit (IGU) will progress this as part of the GDPR project plan	Health and Social Care Senior Management Team / Kevin Wilbraham, Information Governance Manager	30th June 2018
C1.3 Compliance	Care homes to work with the Information Governance Unit (IGU) to develop an appropriate information risk reporting framework.	Information Governance Unit (IGU) will attend care home manager's meeting to deliver training	Unit Managers / IGU	30th April 2018
	IGU to provide guidance to care homes about information sharing.	Information Governance Unit (IGU) have drafted guidance and will issue once complete	Unit Managers/IGU	30th April 2018
C1.4 Availability	Care homes to work together with the Information Governance Unit (IGU) to establish a model file plan to restructure their G drives.	Business Support Managers to put proposal to Unit Managers which includes criteria and naming conventions. Information Governance Unit (IGU) will offer advice/guidance where necessary.	BSM / IGU	28th September 2018

	As part of this work, the issues surrounding email storage and H drive use will be reviewed and appropriate processes implemented.	Information Governance Unit (IGU) will provide assistance / guidance where necessary	IGU / Unit Managers / BSM	28th September 2018
C1.5 Retention	Care homes to work together with the Information Governance Unit to link their client files and administrative records to Council retention rules and document these in their records management manuals.	Mirror and adapt current processes Information Governance Unit (IGU) will review and comment on arrangements by target date.	Unit Managers / Business Support Team Managers	21st December 2018
C1.6 Disposal	The Leadership Team of Health and Social Care should agree who is responsible for removing/deleting service user data for deceased residents' data and communicate this to the care homes.	Follow, adapt and update current retention process Information Governance Unit (IGU) will progress this as part of the General Data Protection Requirements (GDPR) project plan	Unit Managers / Business Support Team Managers / Kevin Wilbraham, Information Governance Manager	30th June 2018
	Care homes and the Information Governance Unit to cover the management and disposal of electronic records in their model records management manual template.	Swift data cannot be deleted. Admin rights for the Care Homes Access database to be reviewed.	Unit Managers Strategy and Insight / Business Support Managers	30th March 2018
C1.7 Data Quality	Care homes to work with IGU to ensure version control is implemented appropriately in conjunction with the model records management manual	Swift data cannot be deleted. Admin rights for the Care Homes Access database to be reviewed. IGU will review and comment on arrangements by target date.	Unit Managers Strategy and Insight / Business Support Managers	21st December 2018
	HSC to review all template forms on an annual basis and work with care homes to ensure correct versions are being used.	Information Governance Unit (IGU) will progress review of current forms as part of the General Data Protection Requirements (GDPR) project plan. Annual reviews thereafter carried out by Health and Social Care	Business Support Managers / Kevin Wilbraham, Information Governance Manager	30th June 2018

Appendix 1- Basis of our Ratings

Internal Audit and Information Governance Ratings

Finding rating	Assessment rationale
Critical	A finding that could have a: • ***Critical*** impact on operational performance; or • ***Critical*** monetary or financial statement impact; or • ***Critical*** breach in laws and regulations that could result in material fines or consequences***; or*** • ***Critical*** impact on the reputation or brand of the organisation which could threaten its future viability.
High	A finding that could have a: • ***Significant*** impact on operational performance; or • ***Significant*** monetary or financial statement impact; or • ***Significant*** breach in laws and regulations resulting in significant fines and consequences***; or*** • ***Significant*** impact on the reputation or brand of the organisation.
Medium	A finding that could have a: • ***Moderate*** impact on operational performance; or • ***Moderate*** monetary or financial statement impact; or • ***Moderate*** breach in laws and regulations resulting in fines and consequences; or • ***Moderate*** impact on the reputation or brand of the organisation.
Low	A finding that could have a: • ***Minor*** impact on the organisation's operational performance; or • ***Minor*** monetary or financial statement impact; or • ***Minor*** breach in laws and regulations with limited consequences; or • ***Minor*** impact on the reputation of the organisation.
Advisory	A finding that does not have a risk impact but has been raised to highlight areas of inefficiencies or good practice.

Health and Safety Ratings

Recommendation rating	Assessment rationale
High	A recommendation that if not carried out could have a: • ***Significant*** impact on health and safety • ***Significant*** breach in laws and regulations resulting in significant fines and consequences • ***Significant*** impact on the reputation or brand of the organisation
Medium	A recommendation that if not carried out could have a: • ***Moderate*** impact on health and safety • ***Moderate*** breach in laws and regulations resulting in fines and consequences • ***Moderate*** impact on the reputation or brand of the organisation
Low	A recommendation that if not carried out could have a: • ***Minor*** impact on health and safety • ***Minor*** breach in laws and regulations resulting in limited fines and consequences • ***Minor*** impact on the reputation or brand of the organisation

Appendix 2 – Recommendations Follow Up Process

Internal Audit will revisit the Fords Road, Gylemuir and Royston care homes in 6 months' time to confirm that their action plans have been completed and the control weaknesses identified addressed. We do not intend to revisit the other seven care homes as the control weaknesses identified there were less significant, and should be addressed by implementation of the Health and Social Care self-assurance framework recommended above.

Progress with implementation of the Internal Audit recommendations included in this report that cover all care homes will be monitored as part of our normal Internal Audit follow up process.

Health and Safety findings will be followed up through the quarterly Health and Social Care health and safety meetings to confirm that all agreed actions have been implemented.

Information Governance will work directly with the care home managers to implement the thematic recommendations. Time scales will be subject to further discussions with the care home managers and business support officers.

Appendix 3 - Current Status of Individual Care Home Reports

Care Home	Report to Care Home			Care Home Response			Final Consolidated Report Issued
	Internal Audit	Health & Safety	Information Governance	Internal Audit	Health & Safety	Information Governance	
Inch View	22 February 2017	27 March 2017	19 April 2017	16 March 2017	11 April 2017	12 May 2017	26 July 2017
Fords Road	13 May 2017	19 April 2017	19 April 2017	25 April 2017	27 April 2017	16 May 2017	25 July 2017
Clovenstone	04 May 2017	04 May 2017	07 June 2017	04 May 2017	09 May 2017	30 June 2017	25 July 2017
Drumbrae	26 May 2017	30 May 2017	19 June 2017	17 July 2017	04 July 2017	07 August 2017	11 August 2017
Ferrylee	01 June 2017	19 June 2017	16 June 2017	19 July 2017	05 July 2017	06 July 2017	24 July 2017
Gylemuir	15 June 2017	23 June 2017	04 July 2017	13 July 2017	14 July 2017	13 July 2017	17 November 2017
Jewel House	11 July 2017	29 June 2017	22 June 2017	27 July 2017	01 August 2017	03 August 2017	11 August 2017
Marionville	19 July 2017	06 July 2017	07 July 2017	02 August 2017	01 August 2017	07 August 2017	13 September 2017
Royston Mains	08 August 2017	10 August 2017	07 August 2017	Response Outstanding	14 September 2017	Response Outstanding	
Oaklands	10 August 2017	10 August 2017	19 July 2017	05 September 2017	04 September 2017	07 September 2017	10 October 2017

Appendix Four

Individual Care Home Report Ratings

This workbook highlights the RAG satus applied to each care home by Internal Audit; Health and Safety; and Information Governance.

Summary RAG tab - shows the Summary outcome for each care home across all 8 thematic areas covered by the 3 assurance teams.

Remaining tabs - show the detailed RAG outcomes for topics covered in each thematic area. These are aligned with the details of the checklists included at Appendix 5.

Areas Covered	Care Home										Total RAG ratings		
	Inch View	Fords Road	Clovenstone	Oaklands	Drumbrae	Ferrylee	Gylemuir	Jewel House	Marionville	Royston	No	Partial	Yes
Financial Controls											3	5	2
Workforce Controls											4	3	3
Resilience											0	4	6
IT											1	7	2
Regulatory											0	0	10
Health and Safety Controls											0	10	0
Property & Statutory Inspection Controls											0	10	0
Records Information & Compliance											0	10	0
											8	**49**	**23**

Validation Check	Ratings										Total RAG Ratings		
	Inch View	Fords Road	Clovenstone	Oaklands	Drumbrae	Ferrylee	Gylemuir	Jewel House	Marionville	Royston			
Financial Controls													
Care Home Funds (Centrally allocated budget, Welfare fund, Misc income)													
Budget Monitoring											1	5	3
Welfare Fund Governance											8	2	0
Income: Welfare Fund, Outings Fund, Food Budget											1	2	7
Expenditure: Welfare Fund, Outings Fund, Food Budget											1	9	0
Banking: Welfare Fund, Resident Savings											3	3	4
Bank Reconciliations											5	3	2
Cash: Imprest, Welfare Fund & Outings Fund Cash in Hand											1	6	3
Residents Savings													
Residents Savings Cards											2	1	7
Income											0	2	8
Expenditure											0	9	1
Resident Assets at Death											2	1	5
Bank Reconciliation											2	2	5
Cash											1	2	7
Workforce Controls													
Training											4	1	5
Recruitment & Induction											0	7	3
Performance and Attendance											4	4	2
Agency staffing											5	3	2
% Agency staff on duty on day of audit.	37%	31%	14%	30%	37%	33%	42%	25%	38%	27%			
% Agency staff on duty on night of audit.	25%	33%	25%	50%	33%	33%	20%	0%	25%	40%			
Day-to-day staffing											1	0	9
Gifts											1	0	9
Resilience													
Business Continuity Plans and Emergency Contacts											0	4	6
IT													
Equipment and High Value / Desirable Items											2	4	1
Leavers											3	4	2
Regulatory													
Registration Certificates & Inspection Reports											0	0	10

Validation Check	Ratings										Total RAG Ratings		
	Inch View	Fords Road	Clovenstone	Oaklands	Drumbrae	Ferrylee	Gylemuir	Jewel House	Marionville	Royston			
Health and Safety													
Health and Safety Roles and Responsibilities											0	10	0
Health and Safety Training											1	6	3
Health and Safety Communications											0	5	5
Health and Safety Risk Assessments											0	10	0
Health and Safety Control Measures											0	10	0
Health and Safety Workplace Inspections / Housekeeping											0	5	5
Stress/ Employee Assistance Programme											0	3	7
First-aid arrangements											0	10	0
Fire safety and emergency response arrangements (H&S)											0	10	0
Emergency response											0	10	0
Reporting and Investigation of Incidents											0	7	3
Escalation and monitoring of H&S risks and issues											0	7	3
Control of Contractors											0	2	8
Property & Statutory Inspection Controls													
Statutory Inspections											0	8	2
Asbestos											0	2	4
Water safety (including legionella)											0	6	4
Beds/Furniture											0	9	1
Window restrictors											2	4	4
Traffic Management											0	2	8
Condition Surveys											1	2	7
Walk round inspection											1	2	7

Validation Check	Ratings										Total RAG Ratings		
	Inch View	Fords Road	Clovenstone	Oaklands	Drumbrae	Ferrylee	Gylemuir	Jewel House	Marionville	Royston			
Information Governance													
Responsibilities (Accountability)											0	8	2
Decision Making (Transparency)											5	5	0
Data Quality											0	8	2
Protection											0	8	2
Compliance											0	10	0
Availability											0	10	0
Retention											0	9	1
Disposal											0	5	5

Appendix 5

Care Home Assurance Checklists

This workbook includes the checklists that were applied by Internal Audit; Health and Safety and Information Goverance at all 10 Council Care Homes.

Ref	Validation Check
Financial Controls	
Care Home Funds (Centrally allocated budget, Welfare fund, Misc income)	
	Budget Monitoring
1.1	Confirm that the Unit Manager reviews monthly budget monitoring and forecast statement before submission to Finance/Change & Development Managers. *Evidence: Signature/email*
1.2	If in potential overspend, confirm whether discussions are in place with Finance or Change & Dev Managers to mitigate issue.
1.3	If vacancies/likelihood of increased agency staff need, confirm reported to Finance and/or Change & Development Managers.
1.4	Establish Oracle access and authorisation levels. *Check current staff at Care Home agrees to SAG Team records*
	Welfare Fund Governance
2.1	There is a consititution for the Welfare Fund. *Confirm standard consititution is used.*
2.2	The Welfare Fund Committee has met at least once in the past year. *Minutes of AGM.*
2.3	A statement of accounts (receipts and payments, assets and liabilities, and a report on the activities of the Fund) was prepared for the year ending 31 March 2016. *Obtain copy.*
2.4	The statement of accounts for the year ending 31 March 2016 was audited by an independent examiner.
2.5	The statement of accounts for the year ending 31 March 2016 was reviewed by the Welfare Fund Committee.
	Income: Welfare Fund, Outings Fund, Food Budget
3.1	Ascertain whether prime records exist that ensure all income is known and recorded. *Cash book or basic accounting system.*
3.2	For an appropriate sample of each category verify that total income expected was banked intact. *Cash book to bank statement. No expenditure before cash is banked if Welfare Fund income.*
	Expenditure: Welfare Fund, Outings Fund, Food Budget
4.1	Scrutinise Welfare Fund expenditure to ascertain that expenditure appears reasonable and is compliant with the current guidance. *(Sample of 5: invoice, authorisation)*
4.2	Scrutinise Welfare Fund expenditure to ascertain that it is properly authorised. *(Sample of 5. Check whether there is an authorisation protocol (e.g. all expenditure over £20 must be approved by Unit Manager / incl expenditure from cash in hand.)*
4.3	Confirm that cheques are not presigned at any point. *Review all current cheque books in use to confirm*
4.4	Confirm all bank signatories are current members of staff.
	Banking: Welfare Fund, Resident Savings
5.1	Ascertain whether there is segregation of duties in relation to collection of cash & banking. *Describe process from receipt to banking.*
5.2	Confirm that income (cash) is banked at appropriate intervals. *Select from cash book and follow through to bank*
5.3	Confirm that cash is held securely and in compliance with insurance limits. *Verify insurance limit before visit.*
	Bank Reconciliations
6.1	For last month, all bank accounts managed by the Care Home (other than residents savings), bank accounts are reconciled within month of month end.
6.2	Reviewed and authorised by Business Support Officer (signed & dated). *Segregation of duties: if prepared by BSO, check reviewed & authorised by Unit Manager.*
6.3	Check addition, vouch totals to prime cash book, verify o/s cheques and lodgements to following bank statement.
6.4	Confirm errors / issues addressed and not simply accumulating.
	Cash: Imprest, Welfare Fund & Outings Fund Cash in Hand
7.1	Reconcile cash in hand to cash and vouchers. *Check Imprest, Welfare Fund and Outings Fund.*
7.2	Confirm that cash in hand is reconciled at least quarterly (signed & dated).
7.3	Cash in hand reconciliation reviewed and authorised by BSO (signed & dated).

Ref	Validation Check
Residents Savings	
	Residents Savings Cards
1.1	Care Home has a record of all monies held on behalf of each individual resident.
1.2	Residents savings cards are reviewed by the BSO periodically.
1.3	No residents savings cards have negative balances as at the date of the most recent weekly reconcilement.
	Income
2.1	Ascertain whether prime records exist that ensure all income is known and recorded. *Cash book or basic accounting system.*
2.2	Verify that residents records are updated accurately each week with personal allowances received from Social Care Finance Team. *Sample of 5 from Social Care Finance sheet to residents records.*
2.3	Verify that residents records are updated accurately with Family contributions. *Sample of 5 from receipt book to residents record to cash tin balance/ bank pay-in.*
	Expenditure
3.1	Scrutinise sample of expenditure on residents accounts to ascertain that expenditure on their behalf appears reasonable and there is evidence of segregation of duties. *Sample of 10.*
3.2	Confirm that cheques are not presigned at any point. *Review all current cheque books in use to confirm*
3.3	Confirm all bank signatories are current members of staff.
	Resident Assets at Death
4.1	Confirm that Property / cash form is completed. *Review 2 forms to confirm forms are countersigned, agree to closing balance on residents savings card, and either banked or cheque raised to next of kin.*
	Bank Reconciliation
5.1	Bank accounts are reconciled within month of month end. *Check 2 x weekly recs.*
5.2	Reviewed and authorised by Business Support Officer (signed & dated). *Segregation of duties: if prepared by BSO, check reviewed & authorised by Unit Manager.*
5.3	Check addition, vouch totals to prime cash book/residents accounts, verify o/s cheques and lodgements to following bank statement.
5.4	Confirm errors / issues addressed and not simply accumulating.
	Cash
6.1	Reconcile petty cash to cash and vouchers. Check r*esidents savings petty cash.*
6.2	Confirm that petty cash is reconciled at least quarterly (signed & dated).
6.3	Petty cash reconciliation reviewed and authorised by BSO (signed & dated).
Workforce Controls	
	Training
1.1	All staff have completed annual essential learning on key policies and procedures.
1.2	Training completed by staff is recorded on iTrent.
1.3	There is an annual training programme for all staff.
1.4	Have all staff completed manual handling training within the past 18 months?
1.5	Have all staff completed medications training within the past 2 years?
1.6	Have all staff completed adult protection training (one off)?
	Recruitment & Induction
2.1	The employee has completed the 9 day Health & Social Care induction course (care staff only).
2.2	Confirm that ID was checked on first day of employment.
2.3	Confirm that satisfactory PVG check was obtained before the first day of employment.
	Performance and Attendance

Ref	Validation Check
3.1	For employees grade 5 & above, PRD records are complete & up to date on iTrent. *Check for the Unit Manager, Business Support Officer & a Team Leader.*
3.2	Sickness has been recorded on system correctly
3.3	Managing attendance procedure has been followed properly and evidenced on iTrent if applicable.
	Agency staffing
-	% Agency staff on duty on day of audit.
-	% Agency staff on duty on night of audit.
4.1	Do agency staff on duty today/tonight have adequate experience and training? *Check agency staff training file.*
4.2	Have satisfactory ID checks been obtained for agency staff on duty today/tonight? *Check agency staff training file.*
4.3	Review last weekly invoice received from ASA for Care staff and check to Unit records.
4.4	Review last weekly invoice received from Adecco for non Care staff and check to Unit records.
	Day-to-day staffing
5.1	Do the total care staff hours per the duty rota meet the dependency assessment, and is this displayed?
5.2	Did the Unit Manager / Depute Manager on duty yesterday attend a handover meeting?
	Gifts
6.1	Are staff regularly reminded to declare gifts received from service users?
6.2	Are Social Care Finance regularly notified to update the service register?
Resilience	
1.1	Does the Care Home have a business continuity plan?
1.2	Has the business continuity plan been reviewed within the past year?
1.3	Is there a log of emergency contact details?
1.4	Is the log of emergency contact details easily accessible? *View contingency box*
1.5	Is the log updated regularly?
1.6	Are BCP flowcharts displayed around the building? (e.g. held in each duty office)
IT	
	Equipment and High Value / Desirable Items
1.1	Verify that records are held of equipment and other high value or desirable items, i.e iPads, mobile phones, electrical equipment
1.2	Select a sample of recent purchases and confirm listed on the asset register.
1.3	Physically check a sample of assets retained within the building
	Leavers
2.1	CGI user account (and Swift accounts if relevant) have been closed.
2.2	Laptops, iPads, mobile phones have been returned.
2.3	Data from personal devices has been cleansed.
Regulatory	
1.1	Is a current service registration certificate on public display?
1.2	Is the most recent Care Inspection report available to all service users if requested?

Ref	Validation Check
Health and Safety	
1	**Health and Safety Roles and Responsibilities**
1.1	Health and safety roles, responsibilities and accountabilities set out in the Council Health and Safety Policy are understood for key roles, e.g. Care Home Manager, Business Manager, Caretaker/ Handy Person.
1.2	Roles and responsibilities are clearly set out in the unit, and understood.
1.3	Health and Safety responsibilities are included in personal objectives for key roles.
1.4	Policy and Procedures in place to deal with violence and aggression and key staff aware of their responsibilities.
1.5	Suitable licence holders for SHE Assure have been identified.
2	**Health and Safety Training**
2.1	Induction H&S training is carried out for all staff.
2.2	All other H&S training needs have been identified, and implemented.
2.3	Training has been provided to all relevant staff on dealing with violence and aggression.
3	**Health and Safety Communications**
3.1	The Council Health and Safety Policy and guidance is readily accessible to all staff and third parties.
3.2	HSE Health and Safety Law Poster is displayed.
3.3	Employers' Liability Certificate is displayed.
3.4	Health and safety is discussed at Unit staff meetings.
3.5	Health and safety information is given to residents and visitors.
4	**Health and Safety Risk Assessments**
4.1	Adequate H&S risk assessments in place.
4.2	Risk assessments are in place for work-related driving of vehicles.
4.3	COSHH assessments in place for activities with significant exposure to hazardous substances.
4.4	Manual handling/ moving and handling assessments in place.
4.5	Working at height assessment(s) in place (risk of falling from height).
4.6	Workstation/DSE assessments in place, as appropriate.
4.7	Expectant / nursing mothers risk assessments in place, as appropriate.
4.8	Noise sources above 80dB(A) have been identified, and risk assessment(s) in place.
4.9	Risk assessments are in place for all tools, equipment and processes involving exposure to vibration.
4.10	Risk assessments take into account potential exposure to violence and aggression.
4.11	Risk assessments take into account risk from ligatures.
4.12	Risk assessments take into account suffocation risks.
5	**Health and Safety Control Measures**
5.1	Controls identified in risk assessments in place.

5.2	Controls identified for safe needle use are in place.
5.3	Controls identified for management of used sharps are in place.
5.4	Controls identified in risk assessments relating to driving at work are in place.
5.5	Suitable checks on vehicles (including minibuses) are carried out, routinely and prior to use.
5.6	Permit to work in place for high risk activities (e.g. access to roof).
5.7	Personal protective equipment is provided. Records available.
5.8	Controls identified in COSHH assessments are in place.
5.9	Health surveillance is carried out, as appropriate.
5.10	Suitable controls are in place for skin health management.
5.11	Controls identified in manual handling/ moving and handling assessments in place.
5.12	Controls identified in working at height risk assessments in place.
5.13	Ladders/ access equipment inspected on a regular basis. Records available.
5.14	Workstation/DSE adjustments implemented, as appropriate.
5.15	Controls identified in noise assessments in place.
5.16	Controls identified in vibration assessments in place.
5.17	Suitable controls identified to deal with violence and aggression are in place.
5.18	Suitable control measures have been implemented to identify and remove potential risks with regard to ligatures and ligature points.
5.19	Suitable control measures identified for suffocation risks are in place.
6	**Health and Safety Workplace Inspections / Housekeeping**
6.1	H&S Workplace Inspections are carried out every quarter.
6.2	Satisfactory standard of housekeeping.
6.3	Items stored at height are accessible, secure and safe.
6.4	Suitable cleaning programme in place.
6.5	Emergency cleaning arrangements in place e.g. to deal with Norovirus outbreak.
7	**Stress / Employee Assistance Programme**
7.1	Roles and responsibilities set out in the Council Stress Policy and Toolkit are understood for key roles.
7.2	Team stress risk assessments are carried out, as appropriate.
7.3	Individual stress risk assessments are carried out for individuals, as appropriate.
7.4	Information on the Employee Assistance Programme (EAP is readily available to staff, and staff are aware about the range of services (online, telephone and counselling services) plus EAP support for managers.
8	**First-aid arrangements**
8.1	Adequate number of first-aiders have been appointed.
8.2	First-aider training is up to date (*training records verified*).
8.3	Information on first-aid arrangements is displayed.
8.4	First-aid box(es) adequately stocked and checked on a regular basis (verify first aid-boxes contents).

8.5	First-aid / Treatment room is clean and tidy.
9	**Fire safety and emergency response arrangements (H&S)**
	Fire safety
9.1	Fire risk assessment in place.
9.2	Fire evacuation plan is in place.
9.3	Adequate fire prevention measures are in place for residents' smoking area.
9.4	Have Personal Emergency Evacuation Plans (PEEPs) been carried out where required.
9.5	Adequate fire signage appropriately displayed including fire action notices, fire exits, assembly point, fire equipment.
9.6	Planned fire evacuation drills are carried out and recorded.
9.7	Nominated individual and deputy to co-ordinate emergency response (fire / other emergencies).
9.8	Adequate number of fire wardens.
9.9	Fire safety training is up to date.
9.10	All emergency escape routes, fire doors and assembly routes are free from obstruction.
9.11	Fire alarm call point is tested weekly (different call point each week).
9.12	Fire extinguishers accessible, in good condition, inspected within last year.
9.13	Sprinkler system inspected and tested.
9.14	Emergency lighting tested at appropriate frequency.
9.15	Evacuation equipment checked e.g. Ski pads and evac chairs.
	Emergency response
9.16	Nurse call alarm system checks are carried out and recorded.
9.17	Emergency procedure in place for lift breakdowns.
9.18	Information on emergency procedure for lifts is displayed (near the lift).
9.19	Bomb threat procedures are in place with roles identified.
9.20	All emergency shut offs are clearly identified, accessible and functioning.
10	**Reporting and Investigation of Incidents**
10.1	All incidents, accidents and work-related ill health cases reported.
10.2	All incidents, accidents and work-related ill health cases investigated and followed up.
10.3	Information on incident reporting is communicated to all staff.
10.4	Arrangements are in place for reporting adverse incidents involving medical devices to the Medicines and Healthcare products Regulatory Agency (MHRA).
11	**Escalation and monitoring of H&S risks and issues**
11.1	There is a risk notification procedure that sets a protocol in case of any serious or imminent H&S risk.
11.2	The risk notification procedure has been communicated to staff and other relevant parties.
11.3	Implementation of H&S measures identified in H&S workplace inspections & audits is tracked to completion.
12	**Control of Contractors**

12.1	All contractors and visitors are required to sign in and out.
12.2	All contractors and visitors are provided with health and safety information, including emergency procedures.
12.3	All work undertaken by contractors is authorised by relevant service (e.g. Property).
12.4	Systems are in place to ensure contractors are adequately monitored.

Property & Statutory Inspection Controls

1	**Statutory Inspections**
	All statutory tests and inspections are up to date and records are available:-
1.1	Fixed electrical systems testing.
1.2	Portable appliance testing (electrical equipment).
1.3	Gas safety.
1.4	Carbon monoxide monitors.
1.5	Pressure Systems.
1.6	Ventilation systems e.g. LEV, general ventilation systems.
1.7	Hoists and mobile lifting equipment.
1.8	Passenger/ Goods Lifts: "Thorough Examination".
1.9	Access at height systems (e.g. anchor points, mansafe system).
1.10	Lightning conductors inspection and test (to assess adequacy of earthing, evidence of corrosion, alterations to structure), where applicable.
1.11	Floodlights.
1.12	Add any others
2	**Asbestos**
2.1	Asbestos register readily available identifying the presence and location of asbestos on the premises.
2.2	Asbestos management plan is in place and implemented (including Condition monitoring of buildings carried out on an annual basis).
3	**Water safety (including *legionella*)**
3.1	*Legionella* risk assessment in place.
3.2	Adequate maintenance and operation of water management system (L8). Records available.
3.3	Water temperature checks are carried out to prevent scalding. Records available.
3.4	Thermostatic controls are checked.
3.5	Temperature of radiators are monitored and maintained to avoid thermal injuries.
4	**Beds/Furniture**
4.1	Bed rails (side rails/ cot sides) are inspected and maintained. Records available.
4.2	Regular checks of bed rails are carried out to ensure that gaps that could cause entrapment of neck, head and chest are eliminated.
4.3	Electric profiling beds are maintained.
4.4	Fixed furniture e.g. wardrobes are secured.
5	**Window restrictors**

5.1	Window restrictors are checked on a regular basis.
5.2	Window restrictors suitability check has been carried out in last 12 month. Records available.
6	**Traffic Management**
6.1	There is clearly marked segregation between vehicles and pedestrians.
7	**Condition Surveys**
7.1	Condition survey carried out covering: integrity of internal building fabric; services (heating , lighting and ventilation) and external building fabric.
8	**Walk round inspection**
8.1	Regular walk round inspections carried out covering the internal fabric of the building and services.
8.2	Regular walk round inspections carried out covering the external fabric of the building,

Ref	Validation Check
Information Governance	
	General Knowledge
1.1	Do staff know how to report an information security incident and/or data protection breach?
1.2	Have staff completed the e-learning module?
1.3	Do staff know who to contact to answer IG questions corporately?
1.4	Do staff know how to recognise and support a statutory request for information (RFI)?
1.5	Are you able to easily find the information you need to answer the requests?
	Managing Records
2.1	Are there any standard processes or procedures for managing records?
2.2	Are standard templates used?
2.3	Is version control used to keep track of changes to records?
2.4	Is there an agreed G drive structure? Is it mapped to the Business Classification Scheme?
2.5	Are there file naming conventions?
2.6	Are emails taken out of Outlook at stored in relevant files (paper or electronic)?
2.7	Is information handover / transfer part of a local leaver's practice?
2.8	Who manages records?
	Retention
3.1	Are staff aware of the retention rules that apply to their area?
3.2	Is there a record management manual?
3.3	Are rules consistently applied to electronic and paper records?
3.4	Are records routinely marked as closed when they become inactive?
3.5	Are there separate rules for sensitive personal data?
	Disposal
4.1	What processes are in place to destroy records?
4.2	Is redundant, obsolete and trivial information routinely identified and cleared out?
4.3	Is confidential waste used?
4.4	Is there a disposal record which details a description of what has been destroyed?
4.5	Are records transferred to the City Archives?
	Protection
5.1	Do staff know how to handle information according to its sensitivity?
5.2	What controls are in place to protect information on and off site?
5.3	Are staff provided with sufficient secure Council devices to undertake their job?

5.4	Is removable media used to store information off the Council network? What controls are in place to manage its use?
5.5	Are any hosted services (apps or websites) used? How are they managed?
5.6	Are access controls attached to electronic folders?
5.7	Are access controls documented and regularly reviewed?
	Collecting Personal Data
6.1	What fair processing information is provided when personal data is collected?
6.2	Do you complete a privacy impact assessment?
6.3	What processes are in place to review personal data and ensure it is accurate/up to date?
6.4	Is personal data only used for the purpose for which it was collected?
6.5	Is consent from service users or their representatives recorded? Is this level of consent reviewed?
	Information Sharing
7.1	How is information shared with third parties?
7.2	Are there any procedures for dealing with ad hoc requests for information, e.g. from police?
7.3	Are staff aware of existing information sharing agreements?
7.4	Are there documented arrangements for general information sharing, e.g. dentists, opticians etc coming in?
	Information Risk
8.1	Are information risks identified, recorded and monitored within local risk registers?
8.2	What processes are in place to manage vital records in accordance with business continuity requirements?

The City of Edinburgh Council

Internal Audit

Social Work Centre Bank Account Reconciliations

Final Report

7 April 2018

HSC1714

EDINBVRGH
THE CITY OF EDINBURGH COUNCIL

Contents

This internal audit review is conducted for the City of Edinburgh Council under the auspices of the 2017/18 internal audit plan approved by the Governance, Risk and Best Value Committee in March 2017. The review is designed to help the City of Edinburgh Council assess and refine its internal control environment. It is not designed or intended to be suitable for any other purpose and should not be relied upon for any other purpose. The City of Edinburgh Council accepts no responsibility for any such reliance and disclaims all liability in relation thereto.

The internal audit work and reporting has been performed in line with the requirements of the Public Sector Internal Audit Standards (PSIAS) and as a result is not designed or intended to comply with any other auditing standards.

Although there is a number of specific recommendations included in this report to strengthen internal control, it is management's responsibility to design, implement and maintain an effective control framework, and for the prevention and detection of irregularities and fraud. This is an essential part of the efficient management of the City of Edinburgh Council. Communication of the issues and weaknesses arising from this audit does not absolve management of this responsibility. High and Critical risk findings will be raised with senior management and elected members as appropriate.

1. Background and Scope

Background

The City of Edinburgh Council (CEC) Health and Social Care Partnership currently operates a total of 38 centres across a range of different services. These include:

- Care Homes (CH)
- Resource and Day Centres (RDC)
- Hostels (H)
- Respite Centres (RC)
- Social Work Centres(SWC)
- Healthy Living Centres (HLC)
- Hospital teams (HT)

Each centre has an approved maximum level of imprest (petty cash) funds. Centres may also hold cash for emergency grant payments to their clients and may also administer monies on behalf of vulnerable citizens, under Corporate Appointee contracts.

Currently, electronic benefit payments are deposited by the Department of Works and Pensions (DWP), into a single central client fund bank account (using Social Security numbers as a reference) managed by centres on behalf of eligible, vulnerable clients. This account is administered by the Business support staff, who make electronic payments on behalf of clients for bills such as rent and utilities. The clients are also provided with regular cash allowances from their benefit funds to use for their personal living expenses.

Cash management and reconciliations are performed by the Business Support teams at each centre. Centres that hold imprest cash will make regular reimbursement claims to a centralised Health and Social Care (H&SC) administration team.

Secure cash transfer services between centres and banks are provided by Loomis Security Services to reduce the risks associate with Council employee's physically carrying cash.

Management information detailing imprest balances and emergency grant expenditure across the centres confirmed for the financial year 2016/17 that:

- Total imprest expenditure for the year across all centres was £76,821
- Total expenditure on vulnerable clients from emergency grant funding was £40,194
- Each centre made (on average) 12 reimbursement claims each year.

A Senior Business Support Manager was contacted in August 2017 by a member of staff who was concerned that bank reconciliations had not been performed for some time at West Pilton Gardens SWC. Following investigation, the centre received subsequent approval from the Health and Social Care Hub Manager to write off an outstanding discrepancy of £2,400 from their client fund account.

Further investigation by Business Support confirmed that this was also the case at the Bonnington Road centre and established that a significant sum (circa £35K) may require to be written off if the centre's imprest account could not be fully reconciled. The results of the subsequent investigation into the matter were inconclusive as to whether client funds had been impacted, however the account was reconciled and a final discrepancy of £2,166 is awaiting approval for write off by the budget owner.

In September 2017 a third centre, The Access Point contacted Internal Audit to advise that there had been a theft of £270 from the imprest fund held in a combination locked safe, with no sign of forced entry. This amount was also written off by the approved budget owner.

In response to the above incidents, Internal Audit was requested by the Head of Customer to perform a review of the adequacy and effectiveness of the reconciliation processes applied in the centres where concerns were raised, and across small sample of additional centres to confirm whether reconciliation procedures were consistently applied and identify any systemic control gaps.

Scope

The objective of the audit was to assess the design adequacy and operating effectiveness of reconciliation and cash management controls across a sample of seven centres (including the three centres where concerns over cash management were raised) and compliance with the following Council policies:

- Imprest accounts / petty cash Procedure and Guidelines (April 2013), and
- Bank Account Reconciliation and Administration Procedure (2014)

The centres chosen for review were:

- Firrhill Day Centre
- Wester Hailes Healthy Living Centre (Social Work and Criminal Justice funds)
- Castle Crags Day and Residential Centre
- Grindlay Court Criminal Justice Social Work Centre
- Bonnington Centre
- The Access Point, and
- West Pilton Gardens Social Work Centre

Our testing was performed in September 2017 and covered the period 1st April – 31st August 2017.

For the full terms of reference see appendix 2.

2. Executive summary

Total number of findings

Critical	-
High	2
Medium	-
Low	-
Advisory	-
Total	**2**

Summary of findings

Our review of cash management and reconciliation controls across seven social work centres identified a number of significant and systemic control weaknesses in relation to management of Corporate Appointee funds and cash management of imprest accounts.

The weaknesses identified could potentially result in breach of applicable Department of Works and Pensions benefit entitlement conditions for Corporate Appointee arrangements, and have resulted in instances of non-compliance with the Council's petty cash and bank reconciliation procedures, potentially exposing the Council to risk of fraud.

Whilst all unreconciled amounts written off were subject to approval by the relevant budget owners, we could not confirm whether this level of approval was within delegated authority levels as there is no established Finance policy or guidance supporting write off of unreconciled cash differences for client and petty cash accounts.

We also established that none of the seven centres were recording input VAT accurately through their imprest accounts, with the result that VAT paid was not fully reclaimed as part of the Council's quarterly VAT return process. As accounting for VAT was not included in our scope, this concern was raised with the Council's VAT officer who is now investigating the matter.

Consequently, two High rated findings have been raised.

Following our review of the Access Point centre, a cash related incident occurred in December 2017 with a cash difference of £900 was identified. We had confirmed at our visit to this centre confirmed that cash management and reconciliations controls were adequately designed and operating effectively. Management has confirmed that the cash difference was identified via the daily cash reconciliation process, and that an investigation is underway to establish why this incident occurred. Management has taken appropriate steps to deal with the incident and mitigate the potential risk of future cash losses.

The Details of the Findings raised and audit recommendations are laid out in Detailed Finding section of this report (section 3).

3. Detailed findings

1. Corporate Appointee Client Fund Management

Finding
Four of the 7 centres reviewed held Corporate Appointee Contracts (CA) for vulnerable citizens. The total value of funds CEC holds under Corporate Appointee contracts is high, with £1.1M being managed collectively on behalf of clients by the Wester Hailes Healthy Living Bonnington Centres. The process for managing Client Funds varied across the 4 centres and the following control gaps were identified: • No regular review process has been established to determine whether clients remain eligible with an ongoing need for a CA contract; • The client fund spreadsheets in the Bonnington Road and West Pilton Gardens centres highlighted that funds held on behalf of a client receiving Department of Work and Pension benefits exceeded the set upper benefit entitlement threshold of £16,000; • West Pilton social work, The Access Point and Bonnington centres were not handing personal cash allowances to recipients in a private, secure environment. They did not have a dedicated private room where cash envelopes could be securely stored during the allocated client cash collection days; • There was a lack of evidence across all four centres that Business Support Officers (BSOs) in all four centres performed independent monitoring of corporate appointee fund management processes; • There was no consistent approach to dealing with client funds following their death. BSO's found it difficult to locate the relevant guidance and advice; • Firrhill Centre did not hold client personal spending money in the safe. It was held in an unlocked cupboard accessible by all employees; • Castle Crags did not hold client spending money in the safe during daytime opening hours but held the funds in a box in the open office accessed by authorised CEC employees; • Firrhill and Castle Crags Business support staff did not have operational responsibility for the daily management of client' spending money. Senior social workers carried out this responsibility without having completed the necessary cash management training; • Firrhill Day centre had inconsistent procedures for the management of client spending money between the 'Blue' and 'Green' Centre teams; • Castle Crags day client team did not follow the good practice evidenced by the residential client team and had no controls in place for the management of day to day client spending money. Due to the high level of risk this presented they were requested by audit to implement the required process immediately.

Business Implication	Finding Rating
Control weaknesses in the management of client funds presents the following risks: • Potential reduction in or loss of benefit income due to excess funds held in client corporate Appointee accounts;	High

• Potential breach of DWP legislation through continued acceptance of benefit payments when account balances exceed specified maximum savings limits; • Risk of fraud in client funds held under Corporate Appointee contracts. • Misappropriation of client cash provided by relatives for their personal use; and • Inability to demonstrate that client funds are appropriately administered on their behalf.	

Action plans

Recommendation	Responsible Officer

To ensure effective control over funds held on behalf of CEC Clients the following actions should be implemented:
1. A full review of all Corporate Appointee contracts should be carried out to establish if:
  ○ Clients remain eligible with an ongoing need for a CA contract;
  ○ All corporate appointees have an allocated Social Worker administering and monitoring their contract,
  ○ Funds held on behalf of the client are within the maximum limits set by DWP
  ○ DWP should be contacted on behalf of the client to discuss funds held in excess of maximum cap set,
  ○ The client had needs which may be met by expenditure from their DWP funds.
2. Adults at Risk: Guardianship, Intervention Orders and Access to Funds procedures should be reviewed and updated to include a requirement for an annual review of existing Corporate Appointee contracts to confirm ongoing eligibility and need. The procedures should also be updated to include a requirement for ongoing review of client balances to ensure that applicable DWP limits are not breached.
3. Processes in Centres holding Corporate Appointee accounts should be aligned with the afore mentioned Procedure and consistently applied across all Centres.
4. Provision for additional secure cash holding facilities in relevant areas used to issue weekly allowance monies to clients should be introduced, to avoid transportation of large quantities of cash through main office areas.
5. Compliance with all Client fund and cash procedures should be independently monitored by the Business Support Officer, at least monthly, and evidence of this review documented and retained.
6. A more robust Day and Residential client cash administration process should be introduced, with documentary evidence of transactions retained, and cash balances appropriate secured.
7. Monthly, reconciliation of all funds held for clients should be carried out by a member of staff independent of the daily administration process.
8. All BSO's and Senior Social Workers should receive refresher training on the closing and reallocation of any deceased client fund
	1. Operations Manager, Health and Social Care and Business Support Manager
	2. to 8 – Senior Business Support Manager

accounts. Senior SW and BSO's should provide Senior H&SC management with an annual assurance that Client funds and cash have been managed in accordance with Council Policy and procedures, and regularly independently reviewed.	
Agreed Management Action	**Estimated Implementation Date**
1. **Health and Social Care** - Given the considerable business support and social worker resources implications, the above recommendations will take time to design, implement and maintain. Business Support is resolving problem appointee arrangements as we go along, however, the backlog of reviews will need a programme management approach to rectify errors and support the governance required. In the meantime, associated risks will be added to the Partnership's risk register to monitor controls and progress on a monthly basis, given its high finding rating. Following the Care Home Assurance Review, the Partnership is developing a self-assurance control framework. Locality Managers have agreed for corporate appointee arrangements to be included in the assurance framework – which if found to be successful and useful, can be mirrored by the other applicable services in this report. Business Support is working on new guidelines for the administration of Corporate Appointeeship (e.g. new procedures, monthly checklists, etc.), which will support the effective delivery of the framework.	28 June 2019
Business Support - Business Support will enable the review of current processes and guidelines in conjunction with Hub and Cluster Managers with sign off at the Locality Managers Forum. Business support will review all Corporate Appointee accounts and contact the relevant social worker, support worker or hub where the funds are over £16K for immediate review. Business support will advise social work when the funds exceed £16K where there is not a valid reason (for example, client deceased and social worker discussing estate with solicitor). Clarity on contact with DWP is being progressed and will be written into the new guidelines. Regular reporting will be introduced from the revised systems being implemented. This will be provided monthly at Senior Social Work level and annually for H&SC management	31 May 2018
2. New guidelines will be written to ensure clarity of responsibilities. Sections will be included detailing Social Work; Business Support; and Transactions team responsibilities. The objective is to create and implement an end to end process that includes eligibility criteria, DWP processes and a full administrative process that will be applied centrally and across Locality offices; clusters; and hubs.	30 April 2018
3. Disability residential and day clients cash administration is currently being reviewed and updated. Robust processes have already been implemented and further processes are scheduled for review. Deceased	30 April 2018

client process will be a section within the main guidelines and the update of these processes is in progress.	29 June 2018
4. Each individual property will be reviewed to minimise the risk of cash movement across main offices and protocols put in place for each.	31 May 2018
5. Monitoring of all client cash is held on a separate spreadsheet that the Business Support Officer will sign off weekly. The business support team manager will check against the new procedure and countersign monthly.	31 May 2018
6. Disability Day & Residential processes will be included in the new procedures under a specific section and will include the requirement to document and retain evidence of transactions, and ensure that cash balances are appropriately secured.	30 April 2018 (for IA Validation)
7. Monthly reconciliation by Business Support Officers in Disability Day & Residential has already been implemented	31 May 2018
8. Refresher training will be offered as part of the implementation of the new guidelines to all staff involved in the process, and recorded on staff training records. The training will also be incorporated into the new staff induction process.	

2. Cash Management Controls - Imprest and Emergency Grant Accounts

Finding

Cash management and reconciliation processes supporting imprest and emergency grant accounts were not consistently applied across all centres, and the following control gaps identified:

- Bank reconciliations were not consistently performed each month. Grindlay Court Criminal Justice centre had not completed bank reconciliations due to lack of access to the electronic Bankline system, despite repeated requests for access being submitted to the Council's Chief Cashier;
- None of the centres reviewed were applying input VAT accurately to imprest expenditure, with the result that VAT paid was not fully reclaimed as part of the Council's quarterly VAT return process. This concern was raised with the Council's VAT officer who is now investigating the matter further;
- Cash reconciliations in the Firrhill, Bonnington and Grindlay Court centres were affected by problems with the standard reconciliation spreadsheet provided by Finance, which prevented automated population and preparation of the general ledger journal entries from the completed reconciliation spreadsheet tab;
- Inconsistent use of the standard bank reconciliation proforma and failure to retain sufficient evidence of completion of bank reconciliations impacted the level of evidence available to confirm completion of independent review/oversight by the Business Support Officer (BSO);
- Bonnington Centre was in breach of Section 12.8 of the Council Finance rules, using imprest cash to 'top up' emergency grant cash as a method of cash flow. At the time of our review, the full value of the imprest fund had been used for payment of emergency grants, with no written evidence available supporting the rationale for this approach or confirming if or when the funds had been repaid;
- There was a lack of Business Support Officer awareness of imprest cash management procedures, and not all BSO's had received recent cash management training;

- The Firrhill and Grindlay Street centres do not use the cash collection and deposit service offered by Loomis;
- There have been significant changes in the administration staff within some of the centres and bank signatory lists have not been consistently updated to reflect these changes; and
- Evidence showed that Firrhill Day Centre, The Access Point, Castle Crags and Wester Hailes Healthy Living centres, were not aware of their safe insurance limits and were holding cash in excess of their approved rating. None of the centres were aware of the requirement to ensure safe keys are not stored in the building overnight; and
- There is no established guidance detailing the process to be applied and relevant authority levels when writing off unreconciled cash amounts.

Business Implication	Finding Rating
• Breach of CEC cash management policies and procedures, and Council standing orders; • Risk of fraud from unauthorised imprest or Emergency Grant payments; • Lack of awareness of Council policy for cash management and bank reconciliations leads to poor practice and errors in banking/cash accounting; • Staff at risk when carrying cash from the bank to the unit, especially as bank locations have reduced significantly in number; • Risk of fraud where staff, who are no longer employed by CEC remain as authorised signatories on accounts; and • Cash and property is not insured due to breach of agreed safe insurance limits and other insurance conditions.	**High**

Action plans

Recommendation	Responsible Officer
1. All staff responsible for cash handling/management should complete the Council's new Finance Reconciliation training and confirm awareness of Policy and Procedures prior to commencing cash handling activities. Completion of training should be formally documented; 2. Imprest and Emergency Grant fund administration should be performed in line with the Council's Imprest Procedures, Bank Reconciliation Procedures, and the Procedure for Adults at Risk (section 12 funds). Regular reconciliation of the funds should be completed only by staff employed and trained to handle cash; 3. Imprest and Emergency Grant funds should remain separate and effective cash flow management procedures should be established to prevent transfers between funds occurring; 4. Cash management and reconciliation administration activities performed across centres should be regularly reviewed in line with Council Policy and procedures, by an officer independent of the process and documented evidence of review retained; 5. Bank signatories should be reviewed annually and immediately updated following changes in personnel involved the cash management process; 6. There should be an annual review of the Insurance provision for cash and items of value held by the unit to confirm that insurance limits remain	Senior Business Support Manager (actions 1 – 6) Corporate Finance Senior Manager (action 7).

appropriate. The BSO should ensure that insurance conditions regarding cash limits and key storage are consistently applied; and 7. Guidance will be developed detailing the process and relevant authority levels to be applied when writing off unreconciled cash amounts, and communicated to all budget owners.	
Agreed Management Action	**Estimated Implementation Date**
1. All current Business Support staff responsible for cash handling/management will complete the Council's new Finance Reconciliation E-Learning course. Business Support Team Managers can request confirmation of their teams' E-Learning course completion from The Business Hub. A record will be kept locally for each member of staff as to when their annual refresher is due, this will be tracked on a team spreadsheet. Completion will be evidenced by a screen shot from the E-Leaning module. It is our intention to self-audit periodically that these actions are being adhered to.	31 May 2018
2. Business Support induction plans will ensure that all staff responsible for cash handling/management will complete the Council's new E-Learning Finance Reconciliation training and confirm awareness of Policy and Procedures prior to commencing cash handling activities. Induction plans are signed off by both staff member and line manager. Completion will be evidenced by a screen shot from the E-Leaning module. It is our intention to self-audit periodically that these actions are being adhered to. To ensure Clients Cash and Emergency Grant fund administration is performed in line with the Council's Imprest Procedures, Bank Reconciliation Procedures, and the Procedure for Adults at Risk (section 12 funds), a separate weekly reconciliation of the funds held in both Clients Cash and Emergency Grants will be completed by staff employed and trained to handle cash in every centre.	30 April 2018
3. A note to all staff will be sent reminding them that it is policy and procedure not to mix the two accounts cash and reiterate that if there are any issues in complying with this instruction, it should be escalated to both the relevant Business Support Manager and Business Support Team Manager.	31 May 2018
4. Copies of the signed reconciliations are to be stored within the relevant teams' G Drive folder with the spreadsheets. A spot check of these requirements will be carried out and recorded by Business Support Managers. Business Support Team Managers will complete a monthly review of financial processes within their team to ensure Clients Cash and Emergency Grant funds remain separate and effective cash flow management procedures are followed to prevent transfers between funds occurring. The Business Support Team Managers responsible for Residential Units have a large number of bank accounts so in these instances a spot check of different accounts every month will be completed.	30 April 2018 30 April 2018

Business Support Team Managers will complete peer reviews of financial processes within a colleague's team, a review to be conducted every two weeks, to ensure cash management and reconciliation administration activities performed across centres are in line with Council Policy and procedures, Findings will be documented and discussed with the appropriate Business Support Team Manager. If required an action plan will be agreed and signed by both managers and all documentation will be retained within the relevant team G Drive folder.	
5. Bank signatories will be reviewed annually at the start of every financial year in April and immediately updated following changes in personnel involved in the cash management process. Business Support Team Manager to add this to team diary and Business Support Officer should ensure that all signatories are up to date and appropriate. Business Support Manager will arrange reoccurring annual meeting to discuss requirements.	30 April 2018
6. An annual review of the Insurance provision for cash and items of value held by the unit will take place at the start of every financial year in April to confirm that insurance limits remain appropriate. To ensure that insurance limits are adhered to, Business Support Officers will contact CEC Insurance to enquire of any changes in safe limits. The Business Support Officer should ensure that insurance conditions regarding cash limits and key storage are consistently applied.	30 April 2018
7. As part of the 6-monthly update of the Council's key governance framework, delegated authority with regard to any necessary write-off of imprest related monies will be clarified and incorporated accordingly in the Council's Scheme of Delegation and Financial Regulations. Additional guidance in this area will also be included in refreshed imprest guidance which will be published on the Council's Orb and communicated to all relevant budget managers.	28th June 2018 (subject to Council approval)

Appendix 1 - Basis of our classifications

Finding rating	Assessment rationale
Critical	A finding that could have a: • ***Critical*** impact on operational performance; or • ***Critical*** monetary or financial statement impact; or • ***Critical*** breach in laws and regulations that could result in material fines or consequences***;*** *or* • ***Critical*** impact on the reputation or brand of the organisation which could threaten its future viability.
High	A finding that could have a: • ***Significant*** impact on operational performance; or • ***Significant*** monetary or financial statement impact; or • ***Significant*** breach in laws and regulations resulting in significant fines and consequences***;*** *or* • ***Significant*** impact on the reputation or brand of the organisation.
Medium	A finding that could have a: • ***Moderate*** impact on operational performance; or • ***Moderate*** monetary or financial statement impact; or • ***Moderate*** breach in laws and regulations resulting in fines and consequences; or • ***Moderate*** impact on the reputation or brand of the organisation.
Low	A finding that could have a: • ***Minor*** impact on the organisation's operational performance; or • ***Minor*** monetary or financial statement impact; or • ***Minor*** breach in laws and regulations with limited consequences; or • ***Minor*** impact on the reputation of the organisation.
Advisory	A finding that does not have a risk impact but has been raised to highlight areas of inefficiencies or good practice.

Appendix 2 – Terms of Reference

Terms of Reference – Health and Social Care Centres – Bank Reconciliations and Cash Management

To: Michelle Miller, Interim Chief Officer, Health and Social Care
Stephen Moir, Executive Director, Resources

From: Lesley Newdall, Chief Internal Auditor Date: 21th September 2017

Cc: Nicola Harvey, Head of Customer
Hugh Dunn, Head of Finance
John Arthur, Council Customer Engagement Manager
Karen Dallas, Principal Accountant – Health and Social Care
Kenny Raeburn, Senior Accountant – Health and Social Care
Louise McRae, Business Support Manager

This review has been added to the 2017/18 Internal Audit plan at the request of the Head of Customer following concerns raised over errors in the administration and reconciliation of imprest and client money bank accounts in two Social Work Centres.

Background

The City of Edinburgh Council (CEC) Health and Social Care currently operates a total of 35 Centres across a range of different services;

- 10 Care Homes (CH)
- 10 Resource and Day Centres (RDC)
- 1 Hostel (H)
- 2 Respite Centres (RC)
- 7 Social Work Centres(SWC)
- 1 Healthy Living Centre (HLC)
- 4 Hospital teams (HT)

Each centre has an imprest account and some also have a client's cash accounts, where applicable, administers monies on behalf of some of its more vulnerable clients, by way of Corporate Appointee contracts. Cash management and reconciliations are performed by the Business Support teams at each centre.

A Senior Business Support Manager was recently contacted by a member of staff who was concerned that bank reconciliations had not been performed for some time at one SWC. Further investigation by Business Support confirmed that this was also the case at another SWC, and established that a significant sum (circa £35K) may require to be written off if the accounts at these centres cannot be fully reconciled. Work is ongoing to establish whether the unreconciled amounts relate to client monies.

The key policies and procedures that apply to cash management and reconciliations are:

- Imprest accounts / petty cash Procedure and Guidelines (April 2013), and
- Bank Account Reconciliation and Administration Procedure (2014)

Scope

The scope of this review will assess the design and operating effectiveness of reconciliations and cash management controls in place across a sample of seven centres, including the original two centres where concerns were raised, to mitigate the following key risk:

- Statutory Requirements - Failure to manage and monitor performance, embed assurance and comply with statutory and legal requirements (e.g. Equalities and Human Rights Acts) and corporate policies (e.g. Anti-Fraud and Bribery) results in financial and reputational damage

We will also confirm whether the reconciliations issues identified at the two centres are systemic, and establish the control weaknesses that have resulted in failure to perform reconciliations, and failure to identify the issue.

Our testing will be performed across the period 1st April – 31st August 2017.

Limitations of Scope

The review will focus on Health and Social Care centres only, but will exclude the ten Council operated Care Homes, which have recently been subject to an Internal Audit review. Our sample of seven centres will provide assurance across 28% of the remaining 25 centres.

Approach

Our audit approach is as follows:

- Visit each unit and assess current compliance with existing policies and procedures
- Reperform the most recent bank reconciliations (August 2017), and
- Review a sample of bank reconciliations performed and cash management processes between 1st April and 31st August 2017.

The sub-processes and related control objectives included in the review are:

Sub-process	Control Objectives
Administration of Income	• Confirm all income streams are administered in accordance with Council Policies. • Prime records are maintained to ensure all income is completely and accurately recorded. • All income is evidenced as being banked intact, and • There is appropriate segregation of duties in the cash management, banking and reconciliation processes.
Administration of Expenditure	• Confirm all expenditure is administered in accordance with council policies. • Expenditure is authorised and independently reviewed. • Cheques are not pre-signed. • Bank account signatories are current members of staff.
Bank Account Reconciliation	• All bank accounts are reconciled monthly and in accordance with Council Policy. • Bank reconciliations are reviewed and authorised by a manager independent of the process. • Errors or issued are addressed promptly and Senior Manager notified when significant reconciling items occur.
Administration of Imprest	• Imprest funds (especially cash) are administered in accordance with Council Policies.

	• Cash in hand is reconciled regularly and independently verified. • Expenditure on imprest fund is in accordance with Council Policy. • Imprest reimbursement claims are independently authorised and submitted at least quarterly. • Imprest cash is held separately from Client monies
Client Fund Administration.	• Individual account held for each client. • Client cash is minimised and held in accordance with Council Policy • Client cash is reconciled monthly and independently reviewed. • Evidence is retained for expenditure on behalf of clients. • Client fund administration is independently reviewed regularly
Security of Cash in Hand	• Cash held is kept at or below the maximum limit specified in Council Policy. • All cash is held within an approved, insured safe. • Access to cash safe is limited to relevant individuals. • All monies placed in and removed from the safe is evidenced for reconciliation.

Internal Audit Team

Name	Role	Contact Details
Lesley Newdall	Chief Internal Auditor	0131 469 3216
Hugh Thomson	Principal Audit Manager	0131 469 3147
Lorraine Twyford	Internal Auditor	0131 469 3145

Key Contacts

Name	Title	Role	Contact Details
Nicola Harvey	Head of Customer	Head of Customer	0131 469 5006
John Arthur	Senior Manager – Business Support	Senior Manager, Business Support	0131 529 7260
Louise McRae	Business Support Manager (North West and Communities and Familites)	Key Audit Contact Sponsor	0131 529 2109

Timetable

Fieldwork Start	20/09/17
Fieldwork Completed	29/09/17
Draft report to Auditee	06/10/17
Response from Auditee	20/10/17
Final Report to Auditee	27/10/17

Follow Up Process

Where reportable audit findings are identified, the extent to which each recommendation has been implemented will be reviewed in accordance with estimated implementation dates outlined in the final report.

Evidence should be prepared and submitted to Audit in support of action taken to implement recommendations. Actions remain outstanding until suitable evidence is provided to close them down.

Monitoring of outstanding management actions is undertaken via monthly updates to the Director and their elected audit departmental contact. The audit departmental contact liaises with service areas to ensure that updates and appropriate evidence are provided when required.

Details of outstanding actions are reported to the Governance, Risk & Best Value (GRBV) Committee on a quarterly basis.

Appendix 1: Information Request

It would be helpful to have the following available prior to our audit or at the latest our first day of field work:

- Budget statements for each Social Work Centre
- Latest Imprest Claim for each SWC
- Procedures for managing Client Funds

This list is not intended to be exhaustive; we may require additional information during the audit which we will bring to your attention at the earliest opportunity.

The City of Edinburgh Council

Internal Audit

Edinburgh Alcohol and Drug Partnership (EADP) – Contract Management

Edinburgh Health and Social Care Partnership

Final Report

14th November 2017

HSC1715

EDINBVRGH
THE CITY OF EDINBURGH COUNCIL

Contents

This internal audit review is conducted for the City of Edinburgh Council under the auspices of the 2017/18 internal audit plan approved by the Governance, Risk and Best Value Committee in March 2017. The review is designed to help the City of Edinburgh Council assess and refine its internal control environment. It is not designed or intended to be suitable for any other purpose and should not be relied upon for any other purpose. The City of Edinburgh Council accepts no responsibility for any such reliance and disclaims all liability in relation thereto.

The internal audit work and reporting has been performed in line with the requirements of the Public Sector Internal Audit Standards (PSIAS) and as a result is not designed or intended to comply with any other auditing standards.

Although there is a number of specific recommendations included in this report to strengthen internal control, it is management's responsibility to design, implement and maintain an effective control framework, and for the prevention and detection of irregularities and fraud. This is an essential part of the efficient management of the City of Edinburgh Council. Communication of the issues and weaknesses arising from this audit does not absolve management of this responsibility. High and Critical risk findings will be raised with senior management and elected members as appropriate.

1. Background and Scope

Background

There is a statutory obligation for the City of Edinburgh Council (CEC) to care for adults who have mental health and substance misuse issues as per the requirements of the Scottish Government's framework for alcohol and drug services.

This obligation is delegated to the Edinburgh Health and Social Care Partnership and delivered through Edinburgh Alcohol and Drug Partnership (EADP) which oversees the development and implementation of an alcohol and drug strategy for the city.

EADP is a partnership between CEC, Edinburgh Health and Social Care Partnership; NHS Lothian; Police Scotland; the Scottish Prison Service; the third sector; and those with experience of addiction and recovery. Whilst EADP is not a statutory function, it has a lead role in developing and implementing a local alcohol and drug strategy to reduce the number of people with substance misuse problems. The work of this partnership has a high profile for the Government; the Council and the Edinburgh Health and Social Care Partnership.

Governance

The EADP Executive Board is responsible for the strategic direction of the partnership, but does not have any specific contract management responsibilities – this is delegated to the EADP Commissioning Collaborative Core Group.

The Treatment Recovery Collaborative is responsible for implementation of the strategy agreed by the EADP, via delivery of treatment and recovery services across the City. This is achieved by four alliances of statutory and voluntary sector service providers who work together to plan and deliver services with the objective of enhancing the Recovery-Oriented System of Care (ROSC) in Edinburgh and making recommendations to the EADP Commissioning Collaborative Core Group.

Contract Details

There are currently two contracts supporting delivery of ROSC across the City. Both contracts are for a term of three years, with an option to extend for a further 24 months and were approved by the Council's Finance and Resources (F&R) Committee in December 2015.

1. Adult Community Treatment Services ("Hubs") – £7,251,395 (over 5 years)

This contract was awarded to two providers (A) and (B), with (A) covering three localities and (B) one locality. Provider (A) went into Administration in June 2017 and the Council is currently in the process of agreeing a new contract with an alternative provider identified by the existing supplier.

2. Adult Counselling (Psychological Therapies) Service - £3,149,250 (over 5 years)

This contract was awarded to a consortium of three providers (C, D, & E) with provider (C) being the main provider responsible for providing direction to providers (D) and (E).

The F&R Committee reports note that the EADP "will be responsible for contract management and will monitor management and performance information".

The Health and Social Care Partnership EADP team had two dedicated team members (the Joint Programme Manager and the Commissioning Manager) who had specialised budget and contract management knowledge. However, the Joint Programme Manager has left the Council in October 2017.

The Joint Programme Manager has advised that the contracts specify that third party suppliers are measured on the basis of service 'outcomes' as opposed to an ongoing assessment of performance via service levels and key performance indicators.

Scope

The scope of this review was to assess the design and operating effectiveness of the Council's controls relating to the management of support services provided under contract by third parties for EADP, and covered the following key Corporate Leadership Team (CLT) and Safer and Stronger Community (SSC) risks:

- **CLT6 Budget Management:** Material overspends on service budgets may impact upon the funding of other services.
- **CLT7 Customer Expectations:** Customer dissatisfaction around delivery of customer facing services may lead to increased complaints with consequential increased financial strain and reputational damage.
- **SS2 Financial Delivery:** The need to deliver significant savings and reduced income result in cuts to services and a failure to deliver the strategic outcomes agreed by the Council; including keeping people safe and reducing poverty and inequality.

Our review focussed on the following key themes:

- People
- Administration
- Managing Performance
- Ongoing Supplier Risk Management

For the full terms of reference see appendix 2.

2. Executive summary

Total number of findings

Critical	0
High	1
Medium	2
Low	1
Advisory	0
Total	**4**

Summary of findings

Our review confirmed that whilst the two main third party contracts supporting delivery of drug and alcohol treatment and recovery services across Edinburgh are being managed, improvements are required to address a number of control weaknesses. These weaknesses could result in failure to address supplier performance issues, with a subsequent impact on service delivery and customer expectations. Consequently, one, High, two Medium and one Low rated Findings have been raised reflecting:

- Lack of contract management process documentation, non-compliance with the Council's Records Management policy, and key person dependency,
- Gaps in risk and supplier performance management,
- Lack of formal supplier sustainability monitoring, and
- The need to sign and formalise one third party contract.

Our detailed findings and recommendations are laid out within Section 3: Detailed findings.

During our review, we identified the following areas of good practice:

- There was evidence to support that the contract manager was sufficiently skilled and experienced to manage the contract.
- The EADP team had been given delegated authority by the Finance and Resources Committee to manage the contract.

3. Detailed findings

1. Risk and Supplier Performance Management

Finding
Risk Management Risks associated with contract management and supplier performance have not been recorded and there is no evidence to confirm that risks are being managed or reported to relevant governance forums. Two risks have already crystallised: • Supplier Sustainability - in June 2017, one third party provider went into administration and the Council were unaware of this until the provider advised the Joint Programme Manager a few days before. Whilst no issues occurred in this instance as services were transferred to a new provider via a TUPE agreement by the existing supplier, this risk was not documented and was not identified via ongoing contract management. • Key Person Dependency - The Joint Programme Manager has left the Council in October 2017 and no contingent resource has been established to fulfil this role. **Supplier Performance Management** Whilst we have been advised that third party supplier performance is mostly outcomes based, there are a number of expectations and success measures included in the contract specification documentation supporting the contracts. We identified one service specification included within the Adult Treatment Services contract that was not delivered in a timely manner or appropriately escalated when not delivered. This related to the requirement for provision of an NHS nurse to support training for staff on 'dried blood spot testing'. This training was not provided until almost the end of the first year of the contract due to lack of NHS funding, and could have significantly impacted on service delivery and customer experience. This service issue occurred due to lack of a clear escalation process to ensure that supplier performance issues are identified and resolved in a timely manner. We also established that: • Success measures included in the contract specification documentation are not prioritised or ranked in terms of service delivery importance, • The contract specification includes the requirement for receipt of quarterly supplier returns, however, submission dates have not been specified, and • There is no independent validation of management information supporting success measures provided by 3rd parties.

Business Implication	Finding Rating
Suboptimal 3rd party performance is not identified and escalated with adverse impact on service provision and customer experience.	High

Action plans	
Recommendation	**Responsible Officer**
1. Risk management and reporting should be established with quarterly reviews of risk registers performed to identify and prioritise all new and	EADP Joint Commissioning Officer/

emerging risks, determine actions required and allocate ownership. Risk registers should also be reviewed and approved by relevant committees / governance forums. 2. An escalation process should be established and agreed with third party suppliers and appropriate committees / governance forums (such as the Core Group) to ensure that all significant supplier performance management issues are identified and resolved. This will include specification of thresholds to raise an issue, and a process to ensure that all issues are communicated to suppliers and resolution monitored. 3. Supplier performance expectations should be prioritised and communicated and agreed with third party suppliers. 4. Timeframes for receipt of quarterly supplier returns should be established and agreed with third party suppliers. 5. Management should consider whether independent validation of 3rd party management information should be performed (perhaps on a sample basis). If validation is implemented, the process applied and the outcomes should be documented. If validation is not implemented, risk of receipt of inaccurate supplier information should be recorded in the relevant risk register.	Strategy and Quality Manager Mental Health and Substance Misuse
Agreed Management Action	**Estimated Implementation Date**
1. **Recommendation 1 -** A contracts management risk register will be developed describing, prioritising, and addressing risks to delivery. The risk register will be shared with and approved by the Core group by January 2018. The risk register will be refreshed quarterly and reviewed by the Core Group.	30th March 2018
2. **Recommendations 2, 3 & 4 -** The existing contract management procedures will be summarised in a single document. It will include the dates information needs to come in, the key contacts, the escalation process in the event of non-performance and the priority metrics that would trigger those processes (waiting times, numbers taken onto caseloads, planned discharges). There will still be subject knowledge and judgement involved in monitoring the contracts; the escalation process cannot be reduced to an algorithm. To be agreed with the providers to confirm our shared understanding and shared with the EADP core group by January 2018.	31st January 2018
3. **Recommendation 5 -** The Health and Social Care quality assurance team will be approached to discuss the potential for an annual audit review that may reduce our dependence on provider generated data. They will provide an options paper to the Core group by January 2018 confirming whether this is possible.	31st January 2018
4. **Recommendation 5** - If the QA team can support completion of an annual review, the first annual review will be performed by June 2018. If this is not possible, management will accept this risk on the basis that there is insufficient resource capacity within the contract management team.	29th June 2018

2. Key Person Dependency and Process Documentation

Finding
Management of the two Treatment Services and Counselling contracts is performed by two key EADP partnership team members – the Joint Programme Manager and the Commissioning Manager; who have specialised contract and budget management knowledge specific to these contracts. The Joint Programme Manager has left the Council in October 2017. It is understood that the Commissioning Manager will assume some of the Joint Programme Manager's responsibilities. with a more senior manager providing overview. Our review of the existing contract management process established that the current contract management process has not been documented and that existing contract management documentation is not maintained in line with the requirements of the Council's Records Management Policy. Specifically: • There are no documented operational procedures supporting the current contract management process. • There is no established escalation process for reporting supplier performance issues. • There is no list of key supplier contacts. • Evidence supporting the current contract monitoring process (including emails) is retained on a server, however, documents are not stored in a format consistent with the Council's Records Management policy, including retention and disposal of records as per prescribed policy requirements. It is understood that an Administrator previously dealt with the administration of contract monitoring documents including adherence to timescales for receipt and review of third party quarterly returns This resource has now been removed from the team as part of the Council's transformation programme.

Business Implication	Finding Rating
• Key person dependency risk - due to the departure of the Joint Programme Manager, resulting in loss of knowledge and experience. • Inability to effectively manage the contracts due to lack of process documentation and supplier contact information. • Risk that supplier performance issues are not identified and escalated in a timely manner. • Non-compliance with the Council's Records Management Policy.	**Medium**

Action plans	
Recommendation	**Responsible Officer**
1. Contingent resources / support should be identified and suitably trained to support ongoing contract management. 2. Contract management processes should be documented. 3. The escalation process referred to within the "Risk and Supplier Performance Management issue (recommendation 2)" should be documented within the new contract management processes. 4. A list of key supplier contacts for each of the individual contracts should be prepared and maintained. 5. To ensure ongoing compliance with the Council's Records Management policy, a process should be established specifying the contract	EADP Joint Commissioning Officer / Strategy and Quality Manager Mental Health and Substance Misuse

management records and information to be retained; detailing, where the information should be stored and specifying dates for archiving and disposal. 6. The Contract Manager should ensure that third party supplier monitoring information received is transferred from his electronic email box to the secured drive in a timely manner.	
Agreed Management Action	**Estimated Implementation Date**
1. **Recommendation 1 -** Involvement from Health and Social Care contracts team will be requested to support contract monitoring to ensure that there is a second person with knowledge of the process. An options paper confirming whether this possible will be provided to the Core group by January 2018.	31st January 2018
2. **Recommendation 1 -** If the contracts team cannot provide additional support, key person dependency risk will be recorded as a risk on the risk register.	31st January 2018
3. **Recommendations 2, 3 and 4 -** The existing contract management procedures will be summarised in a single document. It will include the dates information needs to come in, the key contacts, the escalation process in the event of non-performance and the priority metrics that would trigger those processes (waiting times, numbers taken onto caseloads, planned discharges). There will still be subject knowledge and judgement involved in monitoring the contracts; the escalation process cannot be reduced to an algorithm. To be agreed with the providers to confirm our shared understanding and shared with the EADP core group by January 2018.	31st January 2018
4. **Recommendation 5 and 6 -** Records retention policy: Direction will be requested from the Information Governance team in relation to Records Management Policy requirements and how they should be applied to retention, archiving and destruction of contract management information. Any lessons learned will be shared with the Health and Social Care contracts management team.	30th March 2018

3. Supplier Sustainability

Finding
No reviews are currently performed to confirm ongoing sustainability of 3rd party service providers. In June 2017, one third party provider went into administration and the EADP team were unaware of this until the provider advised the Joint Programme Manager a few days before. It is noted that no issues occurred in this instance as services were transferred to a new provider via a TUPE agreement by the existing supplier. The risk of Supplier Sustainability was not recorded on any risk register to manage the risk of loss of service provision due to loss of provider.

Business Implication	Finding Rating
Lack of sustainability of service provision.	Medium

Action plans	
Recommendation	**Responsible Officer**
1. A Supplier Sustainability risk should be recorded on the appropriate risk register. 2. Contingency plans for ongoing emergency Service Provision should be prepared to ensure ongoing Service Provision in the event of supplier failure. Any involvement required form existing suppliers should be discussed and agreed with them, and the plans documented and approved by the Core Group.	EADP Joint Commissioning Officer
Agreed Management Action	**Estimated Implementation Date**
1. A supplier sustainability risk will be recorded in the risk register to be developed by March and implemented by March 2018. 2. Contingency plans will be developed, discussed with existing suppliers, and approved by the Core Group.	30th March 2018 31st January 2018

4. Unsigned Contract Agreement

Finding
On 2nd June 2017, the main provider contracted under the Adult Community Treatment Services Contract went into 'Administration'. The Joint Programme Manager advised that the provider contacted the EADP team towards the end of May to inform them of this and to advise that the contract terms and conditions were being transferred to another provider with immediate effect. It is understood at that point that the original providers' staff had already been 'TUPEd' over to the new contract provider. The Joint Programme Manager noted that the Council was in the process of signing a Novation Agreement to transfer the terms and conditions over to the new contract provider. However, it is understood that the Novation Agreement is still unsigned (as at our audit closing meeting of 3rd October) although the provider has been providing service delivery under contract since the transfer of staff in June.

Business Implication	Finding Rating
Risk of breach of contract which cannot be addressed as there is no signed contract between both parties.	Low

Action plans	
Recommendation	**Responsible Officer**
The EADP Novation Contract Agreement should be signed by both parties immediately.	EADP Joint Commissioning Officer
Agreed Management Action	**Estimated Implementation Date**
EADP Joint Commissioning Officer will follow up the novation agreement for the new contract and resolve by the end of November 2017.	22nd December 2017

Appendix 1 - Basis of our classifications

Finding rating	Assessment rationale
Critical	A finding that could have a: • ***Critical*** impact on operational performance; or • ***Critical*** monetary or financial statement impact; or • ***Critical*** breach in laws and regulations that could result in material fines or consequences***; or*** • ***Critical*** impact on the reputation or brand of the organisation which could threaten its future viability.
High	A finding that could have a: • ***Significant*** impact on operational performance; or • ***Significant*** monetary or financial statement impact; or • ***Significant*** breach in laws and regulations resulting in significant fines and consequences***; or*** • ***Significant*** impact on the reputation or brand of the organisation.
Medium	A finding that could have a: • ***Moderate*** impact on operational performance; or • ***Moderate*** monetary or financial statement impact; or • ***Moderate*** breach in laws and regulations resulting in fines and consequences; or • ***Moderate*** impact on the reputation or brand of the organisation.
Low	A finding that could have a: • ***Minor*** impact on the organisation's operational performance; or • ***Minor*** monetary or financial statement impact; or • ***Minor*** breach in laws and regulations with limited consequences; or • ***Minor*** impact on the reputation of the organisation.
Advisory	A finding that does not have a risk impact but has been raised to highlight areas of inefficiencies or good practice.

Appendix 2 – Terms of Reference

Health and Social Care

Terms of Reference:
Edinburgh Alcohol and Drug Partnership (EADP) – Contract Management

To: Rob McCulloch-Graham, Chief Officer, Edinburgh Health & Social Care Partnership

From: Lesley Newdall, Chief Internal Auditor Date: 17 May 2017

Cc: Colin Beck, Senior Manager Mental Health, Criminal Justice and Substance Misuse,
Nicholas Smith, Joint Programme Manager.

This review is being undertaken as part of the 2017/18 internal audit plan approved by the Governance, Risk and Best Value Committee in March 2017.

Background

Edinburgh Alcohol and Drug Partnership (EADP) oversees the development and implementation of an alcohol and drug strategy for the city.

It is a partnership between the **City of Edinburgh Council**, NHS Lothian, Police Scotland, the third sector and those with experience of addiction and recovery. It is a forum where these organisations work together to make Edinburgh a city which has a healthy attitude towards drinking and where recovery from problem alcohol or drug use is a reality.

Within the strategy, responsibility for developing and delivering treatment and recovery services sits with the **Treatment and Recovery Collaborative** (a body composed of the commissioners and providers of services, who come together to plan services based on the views and needs of users and carers).

There are currently two individual third party contracts in respect of the EADP, these are: -

- Adult Counselling (Psychological Therapies) Service
  (*Contract CT0465 – maximum potential value of contract, including extension is £3,149,250),*
- Adult Community Treatment Services ("Hubs")
  (Contract CT0476 – maximum potential value of contract, including extension is £7,251,395).

Both contracts are for a term of three years, with an option to extend for a further 24 months and have been approved by the Finance and Resources Committee in December 2015.

The overall aim of the contracts is to ensure that the providers deliver a high quality, recovery orientated system of care, in conjunction with integrated health and social care services.

The Edinburgh Alcohol and Drug Partnership (EADP) will be responsible for contract management and will monitor management and performance information.

This review was included on the plan as risks over budget management and customer expectation were highlighted in the Chief Executive's Risk Register and financial delivery in the Service Area's Risk Register

Scope

The scope of this review will be to assess the design and operating effectiveness of the Council's controls relating to the contract management of support services provided under contract by third sector parties for EADP.

The sub-processes and related control objectives included in the review are:

Sub-process	Control Objectives
People	• The contract manager has appropriate skills and access to training and development; • The contract manager has appropriate delegated authority to manage the contract appropriately; and • The contract manager has sufficient resources to perform the required duties.
Administration	• Key documents, including the contract are retained and accessible; • Relevant ongoing contract management information is retained and managed; and • There is regular reporting of contract management information.
Managing Performance	• Service Management is well structured and understood by both parties; • Supplier performance is assessed using clear, objective and meaningful metrics; • Independent checking mechanisms form part of the reporting process; • Payments made to the supplier are in line with the contract and well managed; • There is a clear process in place to resolve issues quickly; and • There are clear points of contact in each organisation.
Ongoing Supplier Risk Management	• The contract manager monitors the supplier's financial health and business performance; and • The contract Manager monitors the supplier's compliance with contractual 'non-performance' issues.

Limitations of Scope

The scope of our review is outlined above. Testing will be undertaken on a sample basis for the period 01 April 2016 to 31 March 2017.

Approach

Our audit approach is as follows:

- Obtain an understanding of the Early Intervention and Prevention area through discussions with key personnel, review of systems documentation and walkthrough tests;
- Identify the key risks around Early Intervention and Prevention;
- Evaluate the design of the controls in place to address the key risks; and
- Test the operating effectiveness of the key controls.

Internal Audit Team

Name	Role	Contact Details
Lesley Newdall	Chief Internal Auditor	0131 429 3216
Hugh Thomson	Principal Audit Manager	0131 469 3147
Karen Sutherland	Internal Auditor	0131 469 3451

Key Contacts

Name	Title	Role	Contact Details
Rob McCulloch-Graham	Chief Officer Edinburgh Health & Social Care Partnership	Review Sponsor	0131 553 8201
Colin Beck	Senior Manager Mental Health, Criminal Justice & Substance Misuse	Key Contact	0131 553 8200
Michelle Miller	Head of Service, Safer & Stronger Communities & Chief Social Work Officer & Chair of the Alcohol and Drug Partnership	Departmental Contact	0131 553 8520
Maria McILgorm	Chief Strategy & Performance Officer	Departmental Contact	0131 469 3916
Nicholas Smith	Joint Programme Manager	Departmental Contact	0131 529 2117
David Williams	EADP Joint Commissioning Officer	Departmental Contact	0131 553 8217

Timetable

Fieldwork Start	17 May 2017
Fieldwork Completed	26 May 2017
Draft report to Auditee	09 June 2017
Response from Auditee	23 June 2017
Final Report to Auditee	30 June 2017

Follow Up Process

Where reportable audit findings are identified, the extent to which each recommendation has been implemented will be reviewed in accordance with estimated implementation dates outlined in the final report.

Evidence should be prepared and submitted to Audit in support of action taken to implement recommendations. Actions remain outstanding until suitable evidence is provided to close them down.

Monitoring of outstanding management actions is undertaken via monthly updates to the Chief Officer Edinburgh Health & Social Care Partnership and his Business Manager. The Business Manager liaises with service areas to ensure that updates and appropriate evidence are provided when required.

Details of outstanding actions are reported to the Governance, Risk & Best Value (GRBV) Committee on a quarterly basis.

Appendix 1: Information Request

It would be helpful to have the following available prior to our audit or at the latest our first day of field work:

- Contract Management procedures.
- Performance templates / checklists.

This list is not intended to be exhaustive; we may require additional information during the audit which we will bring to your attention at the earliest opportunity.

The City of Edinburgh Council

Internal Audit

Asset Management Strategy

Final Report

9th November 2017

Contents

This internal audit review is conducted for the City of Edinburgh Council under the auspices of the 2017/8 internal audit plan approved by the Governance, Risk and Best Value Committee in March 2017. The review is designed to help the City of Edinburgh Council assess and refine its internal control environment. It is not designed or intended to be suitable for any other purpose and should not be relied upon for any other purpose. The City of Edinburgh Council accepts no responsibility for any such reliance and disclaims all liability in relation thereto.

The internal audit work and reporting has been performed in line with the requirements of the Public Sector Internal Audit Standards (PSIAS) and as a result is not designed or intended to comply with any other auditing standards.

Although there is a number of specific recommendations included in this report to strengthen internal control, it is management's responsibility to design, implement and maintain an effective control framework, and for the prevention and detection of irregularities and fraud. This is an essential part of the efficient management of the City of Edinburgh Council. Communication of the issues and weaknesses arising from this audit does not absolve management of this responsibility. High and Critical risk findings will be raised with senior management and elected members as appropriate

1. Background and Scope

Background

In September 2015, the business case for a new Property and Asset Management strategy was approved by the Finance and Resources Committee. The proposals estimated delivery of circa £18M savings in the first four years with savings of circa £80M over a ten-year period, and aimed to:

- Create a credible, focused and sustainable delivery model for properties and facilities management.
- Provide a fit for purpose, right-sized, and safe estate.
- Provide an appropriate level of service at an acceptable and efficient cost, and
- Act in a commercial manner in pursuit of maximising value for the Council.

New property and asset management processes have been designed and are currently being implemented across the Council's Operational Estate and Investment property portfolios. An ongoing asset condition assessment process has also been implemented, with the first full set of property condition surveys scheduled to be completed by October 2017.

The Council property portfolio is split into Investments (properties that generate either sales or rental income) and Operational Estate (properties that are currently used to support provision of Council services).

Details of the properties, their condition and any sale or leasing arrangements are currently maintained on the Asset Information System (AIS), but will shortly be transferred across to the new Computer Aided Facility Management (CAFM) system which is in the process of being implemented. The CAFM system is being implemented in stages, with the first phase, Asset Condition, complete. The financial value of the Council's property portfolio is recorded in the Logotech system, held in the Finance division, which is fed by the information maintained in AIS.

Scope

The scope of this review was to assess the design and operating effectiveness of the new property and asset management processes and controls, confirming that they support delivery of the strategy and mitigate the following key risks:

- Capital Asset Management (CLT)
- Health and Safety (CLT)
- Safety of Physical Estate (Resources)

For the full terms of reference see Appendix 2*.*

2. Executive summary

Total number of findings

Critical	-
High	-
Medium	3
Low	2
Advisory	1
Total	**6**

Summary of findings

Our review has confirmed that progress is evident with implementation of the recommendations included in the September 2015 Property and Asset Management strategy.

Whilst some of the controls supporting implementation of the new asset management processes across the Investment and Estates portfolios are well designed and are operating effectively, there are some areas where controls could be enhanced, and documentation and record keeping improved.

Our main concerns relate to the potential security risks associated with sharing Council properties with third parties, and the health and safety risks associated with the potential delay in completion of repairs for properties in the Investment portfolio. We were also unable to obtain information requested on two properties in the Investment portfolio to support our testing, which highlights potential weaknesses with records management and archiving processes in addition to the lack of completeness of Investment property information maintained in the AIS system.

Consequently, three Medium; two Low; and one Advisory Findings have been raised. Our detailed findings are included at *Section 2: Detailed findings.*

From the review, the following areas of good practice were identified:

- The decisions to sell assets are within delegated authority limits or approved by the Finance and Resources Committee.
- The remit and responsibilities of the Property Board was submitted to the Corporate Leadership Team and approved by the Property Board at the first meeting on the 8th of March 2017.
- A Detailed plan and engagement programme has been produced to support the Waverley Court restack.

2. Detailed findings

1. Visibility and Security of Shared Council Property

Findings
There are historic arrangements in place with external partner agencies such as the Police, or third sector organisations to share space in Council owned properties. However, most of these are not supported by formal lease agreements and rent is not consistently charged. These agreements were created by individual service areas and there is a lack of visibility of informal property sharing arrangements. As there is no visibility of external property sharing arrangements with external partner agencies, it is unclear whether appropriate security arrangements have been established to ensure Council assets and records are protected. Waverley Court is one of the key projects where the Council estate is currently shared with an external third party (CGI) with plans to generate additional rental income. Security arrangements for Waverley Court were developed by the Capital Projects Team and the design report, with costs and recommendations, was submitted to the Corporate Leadership Team in August 2017. It is essential to ensure that the new security arrangements are implemented prior to finalisation of the revised CGI lease.

Business Implication	Finding Rating
Lack of visibility of the Council's shared estate arrangements and lack of formal security supporting them could result in the Council's assets and records being compromised. Additionally, there may be opportunity to derive additional rental income from these arrangements.	**Medium**

Action plans	
Recommendation	**Responsible Officer**
• A review of existing shared property arrangements should be completed to identify Council properties shared with external organisations. • For shared properties identified, it should be established which buildings non-Council employees can access. Appropriate physical security arrangements should then be implemented to prevent Council assets and records from being compromised. • Where formal rental agreements do not exist for shared properties they should be formalised and implemented (where appropriate) to maximise income generated from these arrangements.	Lindsay Glasgow, Strategic Asset Management Senior Manager
Agreed Management Action	**Estimated Implementation Date**
A review of the office estate is underway by the Operational Estates team to identify third party users and approach them to seek appropriate leases or licences to allow them to occupy the premises and ensure the Council is appropriately reimbursed. The Operational Estates team are also reviewing third sector tenancies across the Operational Estate. This will require the collation of information directly from establishments (who have traditionally made direct arrangements with third parties), to capture all instances and formalise these	31st October 2018 31st October 2019

arrangements. Given the size and complexity of this task, it is envisaged that this will take around two years to complete. In addition, as part of our preparations for the forthcoming General Data Protection Regulation, the Information Governance Unit will be undertaking a series of physical reviews to identify any risks to Council information. The reviews will assess a number of controls and practices, including control of access to Council buildings, visitor supervision, confidential waste disposal, and how information is stored and displayed. Buildings from across the Council's estate have been identified with Facilities Management, with planned visits due to commence later this month. The review programme will run for an initial 12-month period. The Strategic Asset team will then implement any necessary adaptations to the buildings to introduce secure access.	31st October 2018

2. Investment Property Portfolio

Findings

Our review of the controls established to support management of the investment property portfolio identified the following operational control gaps:

- Signed leases requested for 2 investment properties could not be located. Additionally, records held on AIS are not fully up to date for all properties in the investment portfolio.
- There is no centralised recording of inspections and repairs for investment property portfolio. Manual records of property inspections and repairs are held by surveyors. The Head of Service has advised that this due to resource constraints.
- No monitoring is performed to confirm that necessary repairs have been performed, with reliance placed on receiving invoices to ensure that repairs have been completed. The Head of Service has advised that this is due to resource constraints.
- The main key performance indicator (KPI) reported and monitored by the Investments team is the value of rental income received. No KPIs have been established to illustrate the percentage of the investment portfolio properties that are leased and those that are currently vacant. It is therefore not possible to determine whether rental or sales income generated across the portfolio has been optimised.
- One Royal Institute of Chartered Surveyors (RICS) Registered Valuer currently completes rent renewals and negotiations with tenants. Negotiations can be verbal and are not always documented. Resources do not permit two officers to be involved in all negotiations, however all rent revaluations and new leases are approved by an independent Investments Manager in line with applicable Council standing orders.

Business Implication	Finding Rating
• Records management procedures should be reviewed and refreshed to ensure that all files can either be located or retrieved from storage upon request. • The Investments team should ensure that the AIS system is updated to include all current property details. • Current and accurate property details cannot be extracted from the AIS system for the Investment property portfolio. • Information on investment property condition may not be easily accessible, especially where surveyors have left the Council or are on long term sickness absence.	**Medium**

• Risk that delayed completion of repairs is not identified where invoices are not received. • Failure to record the need for essential repairs and ensure they are completed will increase the risk of occurrence of health and safety related incidents • Risk that a property could remain vacant for a significant period and that potential rental income is not optimised.	

Action plans	
Recommendation	**Responsible Officer**
• Property inspections and repairs for investment properties should be recorded centrally to allow this information to be accessed when required. • Records in the AIS system should be reviewed to ensure the information recorded for each property is up to date, complete and accurate. • Monitoring of repairs across the Investment property portfolio should be implemented to confirm that essential repairs are completed in a timely manner. • Guidance should be produced on the acceptable timelines for agreeing new leases on rental properties. • The KPIs reported by the Investment Team should be reviewed to include a specific KPI in relation to the percentage of the portfolio that has been leased. • Investment properties which have been vacant for more than six months should be reviewed to ascertain if other options would maximise returns.	Graeme McGartland, Investments Senior Manager
Agreed Management Action	**Estimated Implementation Date**
• All property inspections will now be recorded and placed on file with immediate effect. Notes of repairs and inspection notes for properties will be added to AIS system	22nd December 2017
• A full review of the AIS data will be undertaken by all staff in the Investment team to ensure records are up to date.	22nd December 2017
• Monitoring of repairs will now be routine and an inspection carried out when the invoice is received prior to payment. Tenants are generally on full repairing and insuring leases and therefore repairs etc will be identified during either interim or final dilapidation investigations. Structural survey exercise is also looking at investment portfolio.	22nd December 2017
• Void rates on commercial property has been introduced as one of eleven KPI by Strategy and Insight and reported to RMT monthly	22nd December 2017
• A guidance good practice note will be prepared on timeline for dealing with the reletting and negotiation of new leases, this will include process for an options appraisal of properties that have been vacant for more than 6 months.	22nd December 2017

3. Estates Property Portfolio

Findings
The Property and Asset Management strategy presented to the Finance and Resources Committee in September 2015 introduced the concept of the corporate landlord. The actions required to develop the concept are still in progress. These include development, finalisation and implementation of: • Terms of reference for the recently established Asset Investment Groups. • The content of management information packs to be provided to Localities Leadership teams. • Finalisation of locality property requirements. • The process supporting, and responsibilities for, preparation of business cases for all new property development requests for submission to Asset Investment Groups and the Property Board. • Fully indexed property lifecycle costs across the portfolio. • A process for receipt, assessment, and prioritisation of requests for property space from Service Areas. Whilst there is clear evidence of progress in each of these areas, there is no defined project plan or roadmap to support delivery and oversight of the remaining Operational Estate aspects of the wider property and asset management strategy.

Business Implication	Finding Rating
Progress with implementation of the Operational Estate aspects of the property and asset management strategy cannot be formally monitored or tracked.	Medium

Action plans	
Recommendation	**Responsible Officer**
• A project plan or roadmap detailing the remaining Operational Estate actions and timeframes for completion should be prepared. • The plan will also record those areas where implementation is dependent on completion of actions by other Service Areas. • Regular progress updates against plan will be provided at appropriate governance forums. This could include Senior Management meetings; Asset Management Strategy project meetings; or the Property Board	Lindsay Glasgow, Strategic Asset Management Senior Manager
Agreed Management Action	**Estimated Implementation Date**
• A project plan for the development of this information, bringing together the various on-going strands of work will be produced. This will set out dependencies (including other service areas) and risks, and will be incorporated within the Property Board governance with regular updates. It is also proposed to present this monthly to the Asset Management Strategy Board. This plan will reflect completion dates for the following:	22nd December 2017
• The remit for the Asset Investment Groups has been drafted and is in the process of being approved at each departmental AIG meeting.	22nd December 2017
• Base data and analysis for life cycle costing for the pipeline estate is nearing completion and the next step is to apply inflation. This information will be stored in a FAST model, developed with Finance, to allow scenario planning.	22nd December 2017

• The identification of locality office accommodation requirements is mid-way through a two-month assessment, with requirements identify by the end of October and detailed models to be completed in November. • A change request process for property changes has been developed and will be implemented in tandem with the 'go-live' date of the FM review. • The first business cases for new property investment for the 2018/19 budget are currently being developed and are expected to be completed in December 2017.	22nd December 2017 29th December 2017 29th December 2017

4. Property Condition surveys

Findings
The contractual agreement between the Council and Faithful and Gould specifies that a target of 10% of the condition surveys completed by Faithful and Gould's external surveyors are to be reviewed by the Council to confirm that the quality of surveys meets Council expectations. To date circa 5% of condition surveys completed by the external contractor have been reviewed. Although the surveys sampled and reviewed by the Council have found the surveys to be thorough and the reported costs realistic, issues have been noted regarding the categorisation of property condition findings. Condition surveys completed by the Council use a team of three fabric surveyors and two Mechanical and Electrical surveyors. The lead officer inputs the results into the Computer Aided Facility Management (CAFM) system. The quality of the survey details recorded and captured in the system is then independently verified by another surveyor. However, due to resource constraints, the officer performing the verification may be part of the original survey team.

Business Implication	Finding Rating
Insufficient independent oversight of surveys performed by third parties and Council employees could result in failure to identify issues with quality or the estimated cost of repairs.	Low

Action plans	
Recommendation	**Responsible Officer**
• The volume of independent review of third party surveyors performed by the Council should be increased to meet the 10% target to ensure that any system issues with the quality of the surveys is identified and resolved. • The review performed should ensure that survey grade applied (on a scale of A to D) accurately reflects the condition of the property and the costs associated with the repair.	Lindsay Glasgow, Strategic Asset Management Senior Manager
Agreed Management Action	**Estimated Implementation Date**
Surveys were completed in mid-September 2017, with the quality assurance process well underway. Any surveys identified as inconsistent between identified costs and condition grade are being returned to the third party for further assessment. This has resulted in instances where the condition grade has been adjusted to reflect the level of spend required. A full 10%	22nd December 2017

sample will be completed, along with scrutiny of any other obvious anomalies.	

5. Accuracy of Data in Core Systems

Findings	
The Asset Information System (AIS) maintains records of the Council's full property portfolio, but does not have the functionality to record the allocation of the properties between the investment or estate portfolios. The Logotech system used by finance is populated from the AIS system maintained by corporate property. The AIS system is currently being replaced on a staged basis by the Computer Aided Facility Management (CAFM) system. The expectation is that the data source for Logotech will transfer from AIS to CAFM when the relevant CAFM module is available.	
Business Implication	**Finding Rating**
• Risk that the full property portfolio has not been accurately allocated to either the Investments or Operational Estate portfolio, and that unallocated properties are not effectively managed. • Risk that the AIS, CAFM and Logotech systems are not fully and accurately populated with details of the Council's property portfolio, with a potential impact on the value of fixed assets included in the financial statements.	**Low**

Action plans	
Recommendation	**Responsible Officer**
• A review of the properties recorded on AIS should be performed to confirm that the full estate has been allocated to either the Investments of Operational Estate property portfolio. • Prior to the transfer of the source data feed from AIS to CAFM, it should be confirmed that the CAFM system includes the full population of property data, with the correct allocation of properties between the estates or investment portfolios. • A reconciliation between the property data recorded in the AIS and CAFM systems should be performed to confirm completeness of the property data held in CAFM and ensure that Logotech accurately reflects the value of the entire Council estate	Lindsay Glasgow, Strategic Asset Management Senior Manager / Andrew Field, Senior Manager, Properties and Facilities Management
Agreed Management Action	**Estimated Implementation Date**
The majority of assets have been ascribed to either Investments or Operational Estates. There remain a number that are more difficult to categorise and it proposed that the two teams will meet to apportion these to the correct team by Christmas 2017. This extra information will be added to the AIS system, which will subsequently feed CAFM when the data is migrated from AIS to CAFM. The implementation plan for CAFM will include a quality assurance process to ensure that all data is correctly aligned between systems, in order to feed the Logotech system with complete details of the entire Council property	29th December 2017 28th December 2018

base. The timing of this relates to the go-live date of this module of CAFM. In the meantime, the full Council database continues to be held on AIS.	

6. Out of hours property hire and leasing arrangements.

Findings	
It has been identified that there may be a lack of oversight regarding security arrangements supporting the let of Council property for out of hours' leases (for example, hire of school halls for evening community lets). It is understood that a draft Facilities Management Service Level Agreement is currently being prepared that will include provision of security and janitorial services.	
Business Implication	**Finding Rating**
If Council properties do not have appropriate internal security arrangements in place, the Council's assets and records could be compromised due to out of hours letting arrangements.	**Advisory**

Action plans	
Recommendation	**Responsible Officer**
The Facilities Management SLA should specify the minimum security arrangements required to support out of hours lets of Council properties and protect Council assets and records.	Andrew Field, Senior Manager, Properties and Facilities Management
Agreed Management Action	**Estimated Implementation Date**
The SLA – and accompanying Services Portfolio Matrix (SPM) – will detail the requirement for security staff to have a thorough understanding of the layout, working and management knowledge of each building and its functionality. These will be managed and monitored through the static patrols or through the key holding alarm response mobile unit. Where applicable CCTV will also relay back to the control room.	The SLA will be approved with Children & Families in early November 2017 with an implementation date of February 2018

Appendix 1 - Basis of our classifications

Finding rating	Assessment rationale
Critical	A finding that could have a: • ***Critical*** impact on operational performance; or • ***Critical*** monetary or financial statement impact; or • ***Critical*** breach in laws and regulations that could result in material fines or consequences***; or*** • ***Critical*** impact on the reputation or brand of the organisation which could threaten its future viability.
High	A finding that could have a: • ***Significant*** impact on operational performance; or • ***Significant*** monetary or financial statement impact; or • ***Significant*** breach in laws and regulations resulting in significant fines and consequences***; or*** • ***Significant*** impact on the reputation or brand of the organisation.
Medium	A finding that could have a: • ***Moderate*** impact on operational performance; or • ***Moderate*** monetary or financial statement impact; or • ***Moderate*** breach in laws and regulations resulting in fines and consequences; or • ***Moderate*** impact on the reputation or brand of the organisation.
Low	A finding that could have a: • ***Minor*** impact on the organisation's operational performance; or • ***Minor*** monetary or financial statement impact; or • ***Minor*** breach in laws and regulations with limited consequences; or • ***Minor*** impact on the reputation of the organisation.
Advisory	A finding that does not have a risk impact but has been raised to highlight areas of inefficiencies or good practice.

Appendix 2 – Terms of Reference

Terms of Reference – Property and Asset Management Strategy

To: Stephen Moir, Executive Director of Resources

From: Lesley Newdall, Chief Internal Auditor Date: 19th July 2017

Cc: Peter Watton, Head of Property and Facilities Management

This review is being undertaken as part of the 2017/18 internal audit plan approved by the Governance, Risk and Best Value Committee in March 2017.

Background

In September 2015, the business case for a new Property and Asset Management strategy was approved by the Finance and Resources Committee. The proposals estimated delivery of circa £18M savings in the first four years with savings of circa £80M over a ten-year period, and aimed to:

- Create a credible, focused and sustainable delivery model for properties and facilities management.
- Provide a fit for purpose, right-sized, and safe estate.
- Provide an appropriate level of service at an acceptable and efficient cost, and
- Act in a commercial manner in pursuit of maximising value for the Council.

New property and asset management processes have been designed and are currently being implemented for the Council's Estates and Investment portfolios. An ongoing he asset condition assessment process is has also been implemented, with the first full set of property condition surveys scheduled to complete by October 2017.

Scope

The scope of this review will be to assess the design and operating effectiveness of the new property and asset management processes and controls, confirming that they support delivery of the strategy and mitigate the following key risks:

- Capital Asset Management (CLT)
- Safety of Physical Estate (Resources)

Approach

Our audit approach is as follows:

- Obtain an understanding of progress towards implementation of the new processes and controls through discussions with key personnel, review of systems documentation and walkthrough tests.
- Identify the key risks and controls.
- Evaluate the design of the controls in place to address the key risks, and
- Test the operating effectiveness of the key controls where these have been implemented.

Specific Objectives

Sub-process	Control Objectives
Investments	For the investment property portfolio, confirm that: • A full list of all properties is maintained • All vacant properties are either in the process of being leased, sold, or transferred across to housing stock. • An assessment of the condition of all vacant properties has been performed. • An appropriate repairs and maintenance programme has been established to maintain all vacant buildings. • Progress against financial plan is regularly monitored. For leased properties in the investment portfolio, confirm that: • Decision to lease is fully documented and approved. • All leases recently renewed have been subject to appropriate rent increases that are aligned with market rates • A plan has been prepared to ensure that all future lease renewals will be subject to a rent review prior to finalisation of lease. • All rental and lease agreements have been approved in line with applicable standing orders / delegated authorities (note: any leases in excess of 5 years and £50K income must be approved by the Finance and Resources Committee). • Leases have been prepared by Legal and signed copies are retained. • A plan has been prepared to perform annual checks of the condition of all leased units, with appropriate action taken to ensure where significant maintenance requirements are addressed by the lessee. For properties currently marketed for sale or recently disposed confirm that: • The decision to sell has been formally documented • There is sufficient evidence to confirm that the properties are advertised at market rate • Any decreases in selling price are appropriately documented • The highest bid is consistently accepted and evidence of all offers retained. Where the highest bid is not accepted, rationale has been documented and approved.
Estates	Assess progress with the implementation of • Maintenance of a full list of all Council estates maintained. • A formal term of reference detailing the role, and responsibilities of, and attendees at the Asset Investment Groups and the Council's Property Board. • A plan to agree estate requirements with locality committees by December 2017, with progress monitored and reported to the Asset Investment Groups. • A process to receive and address all requests for space from Service Areas and localities (including linkage with ICT in relation to Technology requirements) and prepare demand strategies for agreement with Asset Investment Groups. • Creation of Estate demand strategies that consider the requirements of the Local Development Plan.

	• Formal approval of all Estates decisions by the Asset Investment Group prior to preparation of business cases for submission to the Property Board. All decisions are formally minuted. • Accurate calculation of property lifecycle costs and inclusion in business cases for all new developments approved by the Property Board. All Property Board decisions are minuted. • Accurate calculation of Property lifecycle costs for all existing properties included in the Estates portfolio, and clear definition of ongoing maintenance responsibilities. • Lease agreements with rents agreed at market rate for leased properties and based on 'cost of desks' for shared properties. • Approval of rental and lease agreements in line with applicable standing orders / delegated authorities (note: any leases in excess of 5 years and £50K income must be approved by the Finance and Resources Committee). • Preparation of Leases have been prepared by Legal with signed copies are retained. • Establishing appropriate physical security arrangements have been for shared properties. • Preparing a detailed plan to support the Waverley Court restack, with progress updates reported to Senior Management.
Asset Condition	Confirm that: • Sufficient progress is evident to ensure completion of all asset condition surveys by October 2017. • Asset condition and associated repair costs are completely and accurately recorded for all properties. • Cumulative repair costs are being monitored and with funding gaps identified and reported to Senior Management and Finance and Resources Committee.
Follow-up	• Confirm that sufficient progress is evident with the Internal Audit findings raised in the Facilities Management (Transformation Programme) and Property Maintenance audits.

Limitations of Scope

The scope of our review is outlined above. There will be limited focus on Facilities Management given the two audits (Facilities Management Transformation Programme and Property Maintenance) completed in January and February 2017.

Internal Audit Team

Name	Role	Contact Details
Lesley Newdall	Chief Internal Auditor	0131 429 3216
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Key Contacts

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Rob Leech	Programme Manager, Property and Asset Management	'robleech@anturasconsulting.com'
Crawford McGhie	Acting Head of Operational Support (School Estates Planning)	0131 469 3149
Lindsay Glasgow	Asset Strategy Manager	0131 469 3312
John Clarke	Estates Group Leader	0131 469 3338
Lisa Goldie	Estate Optimisation Manager	0131 529 7834
Graeme McGartland	Investments Senior Manager	0131 529 5956
Murdo MacLeod	Technical Operations Manager, Facilities Management	0131 529 5436

Timetable

Fieldwork Start	17 July 2017
Fieldwork Completed	28 July 2017
Draft report to Management	8 August 2017
Receipt of Management Responses	22 August 2017
Final Report Issued	31 August 2017

Follow Up Process

Where reportable audit findings are identified, the extent to which each recommendation has been implemented will be reviewed in accordance with estimated implementation dates outlined in the final report.

Evidence should be prepared and submitted to Audit in support of action taken to implement recommendations. Actions remain outstanding until suitable evidence is provided to close them down.

Monitoring of outstanding management actions is undertaken via monthly updates to the Director and his executive assistant. The executive assistant liaises with service areas to ensure that updates and appropriate evidence are provided when required.

Details of outstanding actions are reported to the Governance, Risk & Best Value (GRBV)