

Notice of meeting and agenda

Governance, Risk and Best Value Committee

10:00am, Tuesday, 31 July 2018

Dean of Guild Court Room, City Chambers, High Street, Edinburgh

This is a public meeting and members of the public are welcome to attend

Contact –

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1. Order of Business

- 1.1 Including any notices of motion and any other items of business submitted as urgent for consideration at the meeting.

2. Declarations of Interest

- 2.1 Members should declare any financial and non-financial interests they have in the items of business for consideration, identifying the relevant agenda item and the nature of their interest.

3. Deputations

- 3.1 If any

4. Minutes

- 4.1 Minute of the Governance, Risk and Best Value Committee of 5 June 2018 – submitted for approval as a correct record (circulated)

5. Outstanding Actions

- 5.1 Outstanding Actions – 31 July 2018 (circulated)

6. Work Programme

- 6.1 Governance, Risk and Best Value Work Programme – 31 July 2018 (circulated)

7. Reports

- 7.1 Internal Audit Opinion and Annual Report for the Year Ended 31 March 2018 – report by the Executive Director of Resources (circulated)
- 7.2 Internal Audit Update Report: 1 January – 31 July 2018 – report by the Executive Director of Resources (circulated)
- 7.3 Improving the Implementation of Council Decision Making – report by the Chief Executive (circulated)
- 7.4 Licensing Forum: Update on Review of Constitution and Membership – report by the Executive Director of Place (circulated)
- 7.5 Quarterly Status Update - ICT Programme – report by the Executive Director of Resources (circulated)
- 7.6 Expansion of Early Learning and Childcare from 600-1140 Hours by 2020. Audit Scotland Report and Risks- report by the Executive Director for Communities and Families (circulated)

- 7.7 Annual Workforce Controls Report – referral from the Finance and Resources Committee (circulated)

8. Motions

- 8.1 None.

Laurence Rockey

Head of Strategy and Insight

Committee Members

Councillors Mowat (Convener), Main (Vice-Convener), Bird, Bridgman, Jim Campbell, Doggart, Howie, Lang, Munro, Rae and Watt.

Information about the Governance, Risk and Best Value Committee

The Governance, Risk and Best Value Committee consists of 11 Councillors appointed by the City of Edinburgh Council. The Governance, Risk and Best Value Committee usually meet every four weeks in the City Chambers, High Street in Edinburgh. There is a seated public gallery and the meeting is open to all members of the public.

Further information

If you have any questions about the agenda or meeting arrangements, please contact Gavin King, Strategy and Insight, City of Edinburgh Council, Waverley Court, Business Centre 2.1, Edinburgh EH8 8BG, Tel 0131 529 4239, e-mail gavin.king@edinburgh.gov.uk

A copy of the agenda and papers for this meeting will be available for inspection prior to the meeting at the main reception office, City Chambers, High Street, Edinburgh.

The agenda, minutes and public reports for this meeting and all the main Council committees can be viewed online by going to www.edinburgh.gov.uk/cpol.

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Governance, Risk and Best Value Committee

10.00am, Tuesday, 5 June 2018

Present

Councillors Mowat (Convener), Main (Vice-Convener), Bird, Jim Campbell, Doggart, Howie, Lang, McVey (substituting for Councillor Bridgman), Munro, Rae and Watt.

1. Minute

Decision

To approve the minute of 8 May 2018 as a correct record.

2. Outstanding Actions

Details were provided on the outstanding actions arising from decisions taken by the Committee.

Decision

- 1) To agree to close the following Actions:
 - Action 2** - Internal Audit – Audit and Risk Service: Delivery Model Update
 - Action 5** - Outstanding Actions (Governance of the Edinburgh Partnership)
 - Action 11** - City of Edinburgh Council – 2016/17 Annual Audit Report to the Council and the Controller of Audit
 - Action 12** - Complaints Management
 - Action 17** - Internal Audit Report – Historic Internal Audit Findings
 - Action 18(4)** – Status of the ICT Programme
- 2) **Action 14(2) – Licensing Forum – Review of Constitution and Membership**
– to note that a report would be submitted to the Committee in July on the revised constitution and recruitment process for the Licensing Forum.
- 3) To note the remaining outstanding actions.
(Reference – Outstanding Actions – 5 June 2018, submitted.)

3. Work Programme

Decision

- 1) To ask for expected dates for those reports marked TBC.

- 2) To otherwise note the work programme.

(Reference – Governance, Risk and Best Value Committee Work Programme – 5 June 2018, submitted.)

4. Internal Audit Overdue Findings – Late Management Responses – and 2017-18 Plan Completion

Details were provided on overdue Internal Audit findings and audit reports issued in draft where management responses had not been received within the agreed service standard timeframes as at 23 March 2018 together with the progress of the delivery of the 2017/18 Internal Audit plan as at 11 May 2018.

Decision

- 1) To note the status of the overdue Internal Audit findings as at 23 March 2018.
- 2) To note Internal Audit progress towards implementation of an automated open and overdue findings monitoring and reporting process.
- 3) To note that a further 30 historic Internal Audit findings dating back to 1 April 2015 that had not been implemented, or implemented but not sustained, would be reopened as overdue (based on the original implementation date) with effect from 15 May, as reported to Committee on 8 May 2018.
- 4) To note that there was one report issued in draft where management responses had not been received within the agreed two-week service standard (Lothian Pension Fund Pensions Tax). This report had now been finalised.
- 5) To note that the proposals in relation to shadow IT set out in the report by the Executive Director of Resources had been approved by the Corporate Leadership Team (CLT) with an 18-month timeframe agreed to address shadow IT risk.
- 6) To note the progress with the 18 audits to be completed to support the 2017/18 Internal Audit annual opinion.

(References – Governance, Risk and Best Value Committee, 8 May 2018 (item 6); report by the Executive Director of Resources, submitted.)

5. Response to Historic Internal Audit Findings

Details were provided on statements which had been obtained from each Directorate confirming their ability and capacity to address all the full population of current, historic and emerging Internal Audit findings and their capacity to support delivery of the 2018/19 Internal Audit annual plan.

Decision

- 1) To note the Council's response to the decision on historic Internal Audit findings.
- 2) To note that updates would be provided on a quarterly basis as part of the Internal Audit Quarterly Activity Report.

(References – Governance, Risk and Best Value Committee, 8 May 2018 (item 6); report by the Executive Director of Resources, submitted.)

6. Internal Audit Report – Housing Property Follow Up – May 2018

The outcomes of the Internal Audit follow-up review of Edinburgh Building Services were presented.

Decision

- 1) To note the outcomes of the May 2018 Housing Property follow-up review.
- 2) To note the progress made by both HPS and Repairs Direct with implementation of agreed management actions to address the findings raised in the original August 2016 report.
- 3) To note that the High and Medium rated findings to be re-opened were included in the total population of 30 historic Internal Audit findings to be re-opened as approved by the Committee on 8 May 2018.
- 4) To note that implementation of the agreed management actions to address the High and Medium findings that had been re-opened and the new findings raised would be tracked as part of the monthly Internal Audit follow-up process.
- 5) To ask the Executive Director of Place to provide updated information on gas inspection records.
- 6) To refer the report to the Housing and Economy Committee for scrutiny.

(Reference – report by the Chief Internal Auditor, submitted.)

7. Internal Audit and Risk – Update on Service Delivery Model

The Committee had agreed a new model of working for the Internal Audit and Risk functions of the Council. An update on delivery through the new model of working was presented.

Decision

To note the report by the Executive Director of Resources.

(References –Governance, Risk and Best Value Committee, 21 April 2016 (item 8); report by the Executive Director of Resources, submitted.)

8. Accounts Commission – Local Government in Scotland – Challenges and Performance 2018

Details were provided on the Accounts Commission's complementary, forward-looking report assessing councils' readiness to confront the growing challenges that lay ahead following its earlier Scotland-wide review of 2016/17 local government financial performance. It had re-emphasised a number of previous messages of relevance to all councils in Scotland, including the need for robust financial and service planning, appropriately resourced transformational change programmes and close working with

elected members and communities in prioritising services to deliver key outcomes and secure financial sustainability.

Decision

- 1) To note the joint report by the Chief Executive and Executive Director of Resources.
- 2) To refer the report to all Executive Committees for consideration, with particular emphasis on the issues raised in Paragraphs 3.4 and 3.6.3 of the report.

(Reference – joint report by the Chief Executive and the Executive Director of Resources, submitted.)

9. National and Local Scrutiny Plans 2018-19

Details were provided on the Audit Scotland National and Local Scrutiny Plans which summarised the planned scrutiny activity for the City of Edinburgh Council from April 2018 to March 2019.

Decision

- 1) To note the report by the Chief Executive.
- 2) To refer the report to the Housing and Economy Committee highlighting Paragraph 24 of the Local Scrutiny Plan.

(Reference - report by the Chief Executive, submitted.)

10. Edinburgh Partnership – Review and Consultation of Governance and Partnership Working Arrangements

Details were provided on the proposed review and consultation on the potential for enhancing community planning arrangements at neighbourhood level together with the scope and timescale for this.

Decision

To note the report by the Chief Executive.

(Reference – report by the Chief Executive, submitted.)

11. Complaints Management - Update

Details were provided on a Council-wide review of complaints management across Council services and the development of a Corporate Complaint Improvement Plan to strengthen arrangements in this area. Progress against the Improvement Plan was set out and improved figures for 2017-18 were highlighted.

Decision

- 1) To note the implementation of the Improvement Plan.
- 2) To note improved complaints performance across the organisation.

- 3) To ask the Chief Executive for a briefing note on the reasons for the increase in the timescales for handling complaints.
- 4) To ask the Executive Director of Place for a briefing note on how the improvement to waste service complaints had been achieved and what had still to be done.

(References – Governance, Risk and Best Value Committee 31 October 2017 (item 4); report by the Chief Executive, submitted.)

12. Change Portfolio

Details were provided on the Council's new approach to delivery of major capital projects together with an update on the status of the portfolio in May.

Decision

- 1) To note the new format for the Council's change portfolio.
- 2) To note the dashboard containing the status of projects within the portfolio as at the end of April in Appendix 1 to the report by the Chief Executive.
- 3) To note those projects which had been assessed as RED for two months of more.
- 4) To ask for a report on the Asset Management Strategy Dashboard following a report on the matter being considered by the Finance and Resources Committee on 12 June 2018.

(References – Governance, Risk and Best Value Committee, 20 February 2018 (item 9); report by the Chief Executive, submitted.)

13. Immediate Pressures and Longer Term Sustainability – Health and Social Care

Details were provided on short-term actions that were underway, together with longer-term intentions, for the alleviation of pressures on services and budgets and the service design changes necessary to support sustainability of health and social care in Edinburgh.

Decision

To note the short term actions underway, and the medium and longer-term actions set out in the plan at Appendix 1 to the report by the Chief Officer, Edinburgh Health and Social Care Partnership.

(Reference – report by the Chief Officer, Edinburgh Health and Social Care Partnership, submitted.)

14. Whistleblowing Update

The Committee considered a high level overview of the operation of the Council's whistleblowing hotline for the period 1 January to 31 March 2018.

Decision

To note the report.

(Reference – report by the Chief Executive, submitted.)

15. Reports Presented to Council and Committees – Motion by Councillor Daggart - Referral from the City of Edinburgh Council

The Convener ruled that the following item, notice of which had been given at the start of the meeting, be considered as a matter of urgency to allow the Committee to give early consideration to this matter.

The City of Edinburgh Council had referred the following adjusted motion by Councillor Daggart for consideration:

“Council:

Instructs the Chief Executive to report to Governance, Risk and Best Value Committee by 28 August 2018 on the number of reports presented to Council and all Council committees since the inception of the current Council. The report should contain:

- a) Number of reports due for committee
- b) Number of reports presented to committee/Council on time
- c) Number of reports presented late, or not at all, to committee/Council
- d) The reasons for the late presenting of reports
- e) Steps the Chief Executive will take to ensure no further report deadlines are missed during the current Council: and

Any other information the Chief Executive believes will inform Council.”

Decision

To agree that a report be submitted to the Committee on 28 August 2018 on the terms of the motion referred by the Council.

(References – Act of Council No 17 of 31 May 2018; referral report from the City of Edinburgh Council, submitted.)

17. Whistleblowing Monitoring Report

The Committee, in terms of Section 50(A)(4) of the Local Government (Scotland) Act 1973, excluded the public from the meeting during consideration of the following item of business for the reason that it involved the likely disclosure of exempt information as defined in Paragraphs 1, 12 and 15 of Part 1 of Schedule 7(A) of the Act.

An overview of the disclosures received and investigation outcome reports completed during the period 1 January to 31 March 2018 was provided.

Decision

To note the report.

(Reference – report by the Chief Executive, submitted)

Governance, Risk and Best Value Committee

July 2018

No	Date	Report Title	Action	Action Owner	Expected completion date	Actual completion date	Comments
1	19/10/2015	Committee Report Process	To investigate technology offered by the new IT provider with a view to improving report format and reducing officer workload. To request a progress report back to Committee in one year.	Chief Executive	August 2018		Work has been undertaken looking at different options. An option has been identified and funding options are being explored.
2	26/09/16	Corporate Leadership Team Risk Update	To request that progress reports on the additional precautionary surveys currently being undertaken in buildings sharing similar design features to those of the PPP1 schools, would be referred to the Governance, Risk and	Executive Director of Resources	December 2018		A report was submitted to the Corporate Policy and Strategy Committee in December 2017 who have called for a further update in 12 months.

No	Date	Report Title	Action	Action Owner	Expected completion date	Actual completion date	Comments
			Best Value Committee for scrutiny.				The update report will then be referred to this Committee.
3	24/10/16	Home Care and Re-ablement Service Contact Time	To request an update report 6 months after the implementation of the new ICT system for shift allocation.	Chief Officer, Edinburgh Health and Social Care Partnership			A project is currently underway to look at short term interventions to increase efficiency and contact time within the internal Home Care and Reablement service. This will consider issues such as sickness absence management, mobile working technology, improved management information and efficiency of travel.
	29/09/17		To ask the Chief Officer, Edinburgh Health and Social Care Partnership to provide an update on why the new ICT system for shift allocation was not implemented earlier in the year	Chief Officer, Edinburgh Health and Social Care Partnership			The replacement of

No	Date	Report Title	Action	Action Owner	Expected completion date	Actual completion date	Comments
							<p>the existing shift/resource allocation system has been placed on hold pending a wider consideration of the ICT strategy for the Partnership and the wide variety of systems currently utilised within the Partnership. An outline business case is in development for the replacement of the existing Swift system. Any replacement for our shift allocation system would need to interface effectively with the replacement for Swift.</p>

No	Date	Report Title	Action	Action Owner	Expected completion date	Actual completion date	Comments
4	20.04.2017	Governance of Major Projects: progress report	<p>1) To note the review underway for how change was reported and managed across the Council which will also include strengthening of governance arrangements around project and programme delivery. This would be reported to the Governance, Risk and Best Value Committee with developed proposals in the next reporting period.</p> <p>2) To request that members of Governance, Risk and Best Value Committee have input into the scope of the lessons learned report to be drafted on the New</p>	Chief Executive	February 2018	20 February 2018	<p>1) CLOSED</p> <p>2) The lessons learned exercise will be carried out as part of the normal project activity at the end of the project. The scope will be</p>

No	Date	Report Title	Action	Action Owner	Expected completion date	Actual completion date	Comments
			Boroughmuir High School and that this report was referred to the Governance, Risk and Best Value Committee following consideration at the Education, Children and Families Committee.		August 2018		shared with elected members for comment. 8 May 2018 To ask the Executive Director for Communities and Families to set up a workshop for members to enable them to contribute to the scoping of the lessons learned report
			3) To request communication with teachers, parents and parent councils on the progress with WIFI provision in schools.		June 2017	June 2017	3) CLOSED

No	Date	Report Title	Action	Action Owner	Expected completion date	Actual completion date	Comments
5.	01/08/2017	Governance, Risk and Best Value Work Programme – 1 August 2017	To note an investigation report on retention of case records would be reported to the appropriate committee and a timescale for this would be provided as soon as possible.	Executive Director for Communities and Families	September 2018		<p>The internal auditor's investigation is still ongoing therefore it may take a few months before an update is provided.</p> <p>The Executive Director for Communities and Families will provide an update once the Chief Internal Auditor's investigation is concluded.</p> <p>The final audit report would be referred from the Corporate Policy and Strategy Committee to GRBV.</p>

No	Date	Report Title	Action	Action Owner	Expected completion date	Actual completion date	Comments
6	01/08/2017	Employee Engagement Update 2017	To request the action plan drafted following the 2017 employee survey was reported to GRBV for scrutiny and approval prior to implementation	Executive Director of Resources	September 2018		<p>The report will be provided following completion of the employee survey which is due to commence in March 2018 and following an analysis and reporting of the results an action plan will be developed and reported to committee to address the results.</p> <p><u>UPDATE</u></p> <p>The employee survey closed at the end of June 2018 and the results are currently being analysed.</p>

No	Date	Report Title	Action	Action Owner	Expected completion date	Actual completion date	Comments
7	26/09/2017	Internal Audit: Overdue Recommendations and Late Management Responses	<p>1) To request an update on:</p> <p>a) the progress of actions due to close in September.</p> <p>b) Mortuary Services</p> <p>2) To request a scoping report with proposals to address the outstanding actions for Health and Social Care back to GRBV with an appendix highlighting who is responsible for each area.</p>	Chief Internal Auditor	<p>October 2017</p> <p>August 2018</p>	<p>October 2017</p>	<p>1) CLOSED</p> <p>2) Following discussion with the Chief Officer, Edinburgh Health and Social Care Partnership, it has been agreed that overdue H&SC recommendations will be reviewed in conjunction with the findings of the</p>

No	Date	Report Title	Action	Action Owner	Expected completion date	Actual completion date	Comments
							IJB H&SC purchasing budget audit that is due to complete by 31 March 2018. It is expected that the emerging findings from this review will replace a number of the historic overdue findings.
8	26/09/2017	Principles to Govern the Working Relationships between the City of Edinburgh Council Governance, Risk and Best Value Committee and the Edinburgh	To accept the high-level principles subject to further information on how elected members could best engage with the process.	Chief Internal Auditor	August 2018		An update will be provided to Committee in August 2018 on how elected members can best engage with the process.

No	Date	Report Title	Action	Action Owner	Expected completion date	Actual completion date	Comments
		Integrated Joint Board Audit and Risk Committee					
9	31/10/2017	Spot-checking on the Dissemination of Council Policies	To note that a report which explored with directorates more effective ways to monitor the dissemination and understanding of Council policies by employees would be submitted by Spring 2018.	Chief Executive	July 2018		
10	20/02/18	Licensing Forum - Review of Constitution and Membership	1) To call for a report to the next meeting of the Committee on the current appointment process to the Licensing Forum together with the timelines for reviewing the current process.	Executive Director of Place	March 2018	20 March 2018	1) CLOSED

No	Date	Report Title	Action	Action Owner	Expected completion date	Actual completion date	Comments
			2) To request a review of the appointment process to the Licensing Forum.	Executive Director of Place	July 2018		2) Recommended for Closure Report on agenda for this meeting
11	20/03/18	Internal Audit Quarterly Update Report Quarter 3 – (1 October – 31 December 2017)	<p>1) To circulate performance information in regard to third party suppliers for Adult Drug and Alcohol services to members for information.</p> <p>2) To ask that Internal Audit provide a future update on GDPR readiness.</p> <p>3) To ask for a report on the Edinburgh Alcohol and Drug Partnership governance and reporting arrangements and</p>	<p>Chief Officer, Edinburgh Health and Social Care Partnership</p> <p>Chief Internal Auditor</p> <p>Chief Social Work Officer/Head of Safer and Stronger communities</p>	<p>August 2018</p> <p>28 August 2018</p> <p>May 2018</p>	<p>8 May 2018</p>	CLOSED

No	Date	Report Title	Action	Action Owner	Expected completion date	Actual completion date	Comments
			that that report be referred on to the Edinburgh Alcohol and Drug Partnership.				
12	08/05/18	Internal Audit Report - Building Standards March 2018	To note that a further update would be provided in August 2018.	Executive Director of Place	August 2018		
13	08/05/18	Status of the ICT Programme	<p>1) To call for a programme to measure milestones over time going forward with an end date of June 2019</p> <p>2) To request that the Governance, Risk and Best Value Committee be provided with a programme for the End User Compute</p>	Executive Director of Resources		<p>July 2018</p> <p>July 2018</p>	<p>1) Recommended for Closure</p> <p>Briefing note circulated to Committee members on 13 July 2018.</p> <p>2) Recommended for Closure</p> <p>Briefing note circulated to members on 13 July 2018</p>

No	Date	Report Title	Action	Action Owner	Expected completion date	Actual completion date	Comments
			<p>Project to enable milestones to be measured by the Committee.</p> <p>3) To ask the Executive Director to provide a quarterly report which includes a programme with timescales of “stable service”, detailing the 28 transformation projects including those that have been completed and those awaiting commencement and when they can be expected.</p> <p>4) To ask the Executive Director to provide information to members on the on-line fault reporting system</p>		July 2018	July 2018	<p>3) Recommended for closure</p> <p>Report on agenda for this meeting</p> <p>4) CLOSED.</p>

No	Date	Report Title	Action	Action Owner	Expected completion date	Actual completion date	Comments
14	05/06/18	Internal Audit Report - Housing Property Follow Up - May 2018	To ask the Executive Director of Place to provide updated information on gas inspection records.	Executive Director of Place			
15	05/06/18	Complaints Management - Update	<p>1) To ask the Chief Executive for a briefing note on the reasons for the increase in the timescales for handling complaints.</p> <p>2) To ask the Executive Director of Place for a briefing note on how the improvement to waste service complaints had been achieved and what had still to be done.</p>	<p>Chief Executive</p> <p>Executive Director of Place</p>	August 2018		A briefing note is in being prepared

No	Date	Report Title	Action	Action Owner	Expected completion date	Actual completion date	Comments
16	05/06/18	Change Portfolio	To ask for a report on the Asset Management Strategy Programme Dashboard following a report on the matter being considered by the Finance and Resources Committee	Executive Director of Resources	October 2018		The Asset Management Strategy is proposed to re-set following discussion at the Finance and Resources Committee in June 2018 and will then be reported back to Finance and Resources in September 2018, following which it will be referred to GRBV Committee in October 2018
17	05/06/18	Reports Presented to Council and Committees - referral from the City of Edinburgh Council	To agree that a report be submitted to the Committee on 28 August 2018 on the terms of the motion referred by the Council	Chief Executive	28 August 2018		

Governance, Risk and Best Value Committee

	Title / description	Sub section	Purpose/Reason	Category or type	Lead officer	Stakeholders	Progress updates	Expected date
Section A – Regular Audit Items								
1	Internal Audit: Overdue Recommendations and Late Management Responses		Paper outlines previous issues with follow up of internal audit recommendations, and an overview of the revised process within internal audit to follow up recommendations, including the role of CLG and the Committee	Internal Audit	Chief Internal Auditor	Council Wide	Quarterly	25 September 2018 15 January 2019 7 May 2019
2	Internal Audit Quarterly Activity Report		Review of quarterly IA activity with focus on high and medium risk findings to allow committee to challenge and request to see further detail on findings or to question relevant officers about findings	Internal Audit	Chief Internal Auditor	Council Wide	Quarterly	31 July 2018 25 September 2018 15 January 2019

3	IA Annual Report for the Year		Review of annual IA activity with overall IA opinion on governance framework of the Council for consideration and challenge by Committee	Internal Audit	Chief Internal Auditor	Council Wide	Annually	31 July 2018
4	IA Audit Plan for the year		Presentation of Risk Based Internal Audit Plan for approval by Committee	Internal Audit	Chief Internal Auditor	Council Wide	Annually	20 March 2019
5	Accounts Commission	Annual report	Local Government in Scotland: Financial Overview	External Audit	Executive Director of Resources	Council Wide	Annually	January 2019
6	Accounts Commission	Annual report	Local Government in Scotland: Performance and Challenges	External Audit	Executive Director of Resources	Council Wide	Annually	August 2018
7	Annual Audit Plan	Scott Moncrieff	Annual audit plan	External Audit	Executive Director of Resources	Council Wide	Annually	March 2019
8	Annual ISA 260 Audit Report	Scott Moncrieff	Annual Audit Report	External Audit	Executive Director of Resources	Council Wide	Annually	September 2018
9	Interim Audit Report	Scott Moncrieff	Interim audit report on Council wide internal financial control framework	External Audit	Executive Director of Resources	Council Wide	Annually	August 2018
10	IT Audit Report	Scott Moncrieff	Scope agreed during annual external audit planning cycle	External Audit	Executive Director of Resources	Council Wide	Annually	October 2018

11	Audit Charter			External Audit	Executive Director of Resources	Council Wide		March 2019
Section B – Scrutiny Items								
12	Governance of Major Projects	TBC	To ensure major projects undertaken by the Council were being adequately project managed	Major Project	Chief Executive	All		November 2018
13	Welfare Reform	Review	Regular update reports	Scrutiny	Executive Director of Resources	Council Wide	Annual	March 2019
14	Review of CLT Risk Scrutiny	Risk	Quarterly review of CLT's scrutiny of risk	Risk Management	Chief Executive	Council Wide	Quarterly	28 Aug 2018 27 November 2018 February 2019
15	Whistleblowing Quarterly Report		Quarterly Report	Scrutiny	Chief Executive	Internal	Quarterly	28 Aug 2018 27 November 2018 February 2019
16	Workforce Control	Staff	Annual report	Scrutiny	Executive Director of Resources	Council Wide	Annual	September 2018
17	Committee Decisions	Democracy	Annual report	Scrutiny	Chief Executive	Governance, Risk and Best Value Committee	Annual	Date TBC Re-examine after improved information tracking.
18	Monitoring of Council Policies	Democracy	Annual report	Scrutiny	Chief Executive	Council Wide	Annual	Spring 2018

19	Edinburgh Shared Repairs Service and Legacy Closure Programme	Review	Progress reports	Scrutiny	Executive Director of Resources	All	Six-monthly	August 2018
20	Revenue Monitoring	Review	Progress reports	Scrutiny	Executive Director of Resources	Council Wide	Quarterly	August 2018 October 2018 February 2019
21	Capital Monitoring	Review	Progress reports	Scrutiny	Executive Director of Resources	Council Wide	Quarterly	August 2018 October 2018 February 2019
22	Revenue Outturn	Review	Progress reports	Scrutiny	Executive Director of Resources	Council Wide	Annual	September 2018
23	Capital Outturn and Receipts	Review	Progress reports	Scrutiny	Executive Director of Resources	Council Wide	Annual	September 2018
24	Treasury – Strategy report	Review	Progress reports	Scrutiny	Executive Director of Resources	Council Wide	Annual	March 2019
25	Treasury – Annual report	Review	Progress reports	Scrutiny	Executive Director of Resources	Council Wide	Annual	August 2018
26	Treasury – Mid-term report	Review	Progress reports	Scrutiny	Executive Director of Resources	Council Wide	Annual	January 2019

27	Status of the ICT Programme	Review	Progress Reports	Scrutiny	Executive Director of Resources	Council Wide	Quarterly	July 2018 October 2018
Section C – Council Companies								
28	Edinburgh Leisure	Review	Progress Report	Scrutiny	Executive Director for Communities and Families	Council Wide	Annual	November 2018
29	Festival City Theatres Trust	Review	Progress Report	Scrutiny	Executive Director of Place	Council Wide	Annual	November 2018
30	Other ALEOs to be confirmed	Review	Progress Report	Scrutiny	Relevant Director	Council Wide	Annual	TBC

GRBV Upcoming Reports

Appendix 1

Report Title	Type	Flexible/Not Flexible
28 August 2018		
Interim Audit Report	Scrutiny	Flexible
Review of CLT Risk Scrutiny	Scrutiny	Flexible
Revenue Monitoring	Scrutiny	Flexible
Revenue Outturn	Scrutiny	Flexible
Capital Monitoring – Outturn and Receipts	Scrutiny	Flexible
Capital Monitoring – Month 3 Position	Scrutiny	Flexible
Principals to Govern the Working Relationships between the City of Edinburgh Council Governance, Risk and Best Value Committee and the Edinburgh Integration Joint Board Audit and Risk Committee	Scrutiny	Flexible
Building Standards Update	Scrutiny	Flexible
Scoping Report with Proposals to Address the Outstanding Actions for Health and Social Care	Scrutiny	Flexible

GDPR Readiness Audit	Scrutiny	Flexible
Governance of Major Projects – Boroughmuir High School	Scrutiny	Flexible
Whistleblowing Quarterly Report	Scrutiny	Flexible
Committee Report Process	Scrutiny	Flexible
Reports Presented to Council and Committees	Scrutiny	Flexible
September 2018		
Employee Engagement Update 2016	Scrutiny	Flexible
Internal Audit: Overdue Recommendations and Late Management Responses	Scrutiny	Flexible
Internal Audit Quarterly Activity Report	Scrutiny	Flexible
Annual ISA 260 Audit Report	Scrutiny	Flexible
Revenue Outturn	Scrutiny	Flexible
October 2018		
Status of the ICT Programme Quarterly Report	Scrutiny	Flexible

IT Audit Report	Scrutiny	Flexible
Revenue Monitoring - Review	Scrutiny	Flexible
Capital Monitoring - Review	Scrutiny	Flexible

Governance, Risk and Best Value Committee

10.00am, Tuesday 31 July 2018

Internal Audit Opinion and Annual Report for the Year Ended 31 March 2018

Item number 7.1
Report number
Executive/routine
Wards
Council Commitments

Executive Summary

This report details Internal Audit's annual opinion for the City of Edinburgh Council (the Council) for the year ended 31 March 2018. Our opinion is based on the outcomes of the audits included in the Council's 2017/18 Internal Audit annual plan, and the status of open Internal Audit findings as at 31 March 2018.

Internal Audit considers that significant enhancements are required to the established control environment and governance and risk management frameworks to ensure that the Council's most significant risks are effectively mitigated and managed, and is therefore reporting a 'red' rated opinion, with our assessment towards the middle of this category.

Whilst no 'Critical' Internal Audit findings have been raised, a number of significant weaknesses in the control environment have been identified. Consequently, we believe that the Council's established control environment; governance; and risk management frameworks have not adapted sufficiently to support effective management of the changing risk environment and the Council's most significant risks, putting achievement of the Council's objectives at risk.

This report is a component part of the overall annual assurance provided to the Council, 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 within the Council.

This report has been prepared in line with Public Sector Internal Audit Standards (PSIAS) requirements.

Internal Audit Opinion and Annual Report for the Year Ended 31 March 2018

1. Recommendations

- 1.1 It is recommended that the Committee notes the Internal Audit opinion for the year ended 31 March 2018.

2. Background

- 2.1 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.
- 2.2 It is the responsibility of the Council's Chief Internal Auditor to provide an independent and objective annual opinion on the adequacy and effectiveness of the Council's control environment and governance and risk management frameworks in line with PSIAS requirements. The opinion is provided to the Governance, Risk, and Best Value Committee and should be used to inform the Council's Annual Governance Statement.
- 2.3 The objective of Internal Audit is to provide a high quality independent audit service to the Council, in accordance with PSIAS requirements, which provides assurance over the control environment established to manage the Council's key risks and their overall governance and risk management arrangements.
- 2.4 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 the weaknesses identified via timely implementation of these agreed management actions.
- 2.5 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.

3. Main report

Internal Audit Opinion

- 3.1 Internal Audit considers that significant enhancements are required to the control environment and governance and risk management frameworks to ensure that the

Council's most significant risks are effectively mitigated and managed, and is raising a 'red' rated opinion (see category 3 at Appendix 1), with our assessment towards the middle of this category.

- 3.2 Whilst no "Critical" Internal Audit findings have been raised, a number of significant weaknesses in the control environment have been identified. Consequently, we believe that the Council's established control environment; governance; and risk management frameworks have not adapted sufficiently to support effective management of the changing risk environment and the Council's most significant risks, putting achievement of the Council's objectives at risk.
- 3.3 This opinion is reflective of the increased number of findings raised in comparison to prior years; the increasing trend in the percentage of open findings that are overdue; and the 30 historic findings reopened as agreed management actions were either not implemented, or had been implemented but not sustained (further detail is included at paragraphs 3.10 – 3.13 below).
- 3.4 Consequently, the Council should endeavour to improve its control environment and governance and risk management frameworks to ensure that all significant risks are effectively managed and mitigated.
- 3.5 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 2.
- 3.6 Internal Audit is not the only source of assurance provided to the Council as 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 Council's control environment and governance and risk management frameworks.

Basis of opinion

- 3.7 Our opinion is based on the outcome of 27 audits completed across the Council in the year to 31 March 2018, and the status of open internal audit findings as at 31 March 2018 (see Appendix 5).
- 3.8 The audits included in the plan were designed to test the adequacy of the design and operating effectiveness of the Council's control environment, and governance and risk management frameworks, established to mitigate the Council's most significant risks.
- 3.9 The outcomes of two audits referred to the Governance, Risk and Best Value Committee by the Edinburgh Integration Joint Board are also reflected in our opinion, as these specifically relate to Health and Social Care Partnership services delivered by the Council.
- 3.10 As the Council is the administering authority for Lothian Pension Fund (LPF), our opinion also includes the outcome of the four audit reviews performed for LPF and the status of their open audit findings as at 31 March 2018.

- 3.11 A separate Internal Audit opinion for LPF was prepared and presented at the Pensions Audit Committee on 27 June 2018. This was also a 'red' rated opinion, with our assessment towards the middle of this category.
- 3.12 This opinion does not include audit reviews performed for the Lothian Valuation Joint Board (LVJB) and the other arms-length external organisations that currently receive audit assurance from the Council's Internal Audit team.

Audit outcomes

- 3.13 A total of 126 findings were raised (47 High; 55 Medium; and 24 Low) have been raised across a total of 31 completed audits,
- 3.13.1 **Council** - 25 audits were completed, with a total of 109 findings (38 High; 51 Medium; and 20 Low) raised. This includes the outcomes of 4 reviews carried forward from 2016/17;
- 3.13.2 **EIJB** – 2 audits were completed on behalf of the EIJB that relate to Partnership services delivered by the Council, with a total of 6 findings (5 High and 1 Medium) raised;
- 3.13.3 **LPF** - 4 audits were completed with a total of 11 findings (4 High; 3 Medium; 4 Low) raised; and

Note that this does not include any 'Advisory' findings raised.

- 3.14 40% of the High rated findings raised resulted from the Care Homes Assurance; Health and Social Care Purchasing Budget; Building Standards; Drivers Health and Safety; and GIRFEC - Named Person audits, with management actions owned by the Health and Social Care Partnership; Place; Resources (Customer and Human Resources); and Communities and Families directorates.
- 3.15 All 6 of the High rated findings referred to the GRBV by the EIJB Audit and Risk Committee relate directly to Health and Social Care Partnership services delivered by the Council.
- 3.16 Appendix 3 includes details of all 2017/18 completed and 2016/17 carried forward audits for Council and LPF; and referrals from the EIJB Audit and Risk Committee.
- 3.17 Appendix 4 details the 5 2017/18 audits approaching completion.

Status of Internal Audit Findings

- 3.18 There were 86 open Internal Audit findings across Service Areas as at 31 March 2018 Of these, 41 (47%) were overdue (4 High; 27 Medium; and 10 Low).

Comparison to Prior Year

- 3.19 An amber rated opinion was reported in 2017/18 reflecting that the Council's control environment and governance and risk management frameworks were 'generally adequate but with some enhancements required'. This opinion highlighted weaknesses in the control environment and governance and risk management

frameworks with instances of non-compliance with existing controls that (if not addressed), could put achievement of the Council's objectives at risk.

- 3.18 The change in the Council's control environment and governance and risk management frameworks in comparison to 2017/18 is confirmed by:
- 3.18.1 the increased number of total findings raised, with 126 raised in 2017/18 in comparison to 113 and 115 in 2016/17 and 2015/16 respectively;
 - 3.18.2 the increased number of high rated findings raised with 47 raised in 2017/18 in comparison to 26 and 15 in 2016/17 and 2015/16;
 - 3.18.3 the increasing trend in the percentage of open IA findings that are overdue as at 31 March (42% in 2017/18; 40% in 2016/17; 19% in 2015/16); and
 - 3.18.4 the 30 (11 High and 19 Medium) historic Internal Audit findings that have been reopened (dating back to 1 April 2016) where agreed management actions had not been implemented, or were implemented but not sustained.

Internal Audit Independence

- 3.19 PSIAS require that Internal Audit must be independent and internal auditors' objective in performing their work. To ensure conformance with these requirements, Internal Audit has established processes to ensure that both team and personal independence is consistently maintained and that any potential conflicts of interest are effectively managed.
- 3.20 We do not consider 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 (for example headcount restrictions) when completing our work.

Conformance with Public Sector Internal Audit Standards

- 3.21 Internal Audit has not conformed with PSIAS requirements during 2017/18 for the following reasons:
- 3.21.1 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
 - 3.22.1 Long term sickness absence and recruitment 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.
- 3.22 We consider that these resourcing challenges have been managed to ensure sufficient and appropriate audit coverage.

Action taken to address instances of non PSIAS conformance

- 3.23 A manual follow-up process was implemented immediately following identification of the historic issue, and a new software based automated process was implemented in July 2018.

- 3.24 Resources were drawn down from the existing co-source arrangement with PwC to address resourcing gaps and ensure completion of the annual audit plan.
- 3.25 Internal quality assurance reviews will be reinstated taking effect from 1 April 2018, with two quality assurance reviews have been scheduled for completion in the 2018/19 plan year.

4. Measures of success

- 4.1 Effective governance, risk management and internal control within the City of Edinburgh Council.

5. Financial impact

- 5.1 No direct financial impact.

6. Risk, policy, compliance, and governance impact

- 6.1 This report highlights that the Council is currently exposed to increased volumes of risk that puts achievement of its objectives at risk.

7. Equalities impact

- 7.1 Not applicable.

8. Sustainability impact

- 8.1 Not applicable.

9. Consultation and engagement

- 9.1 Not applicable.

10. Background reading/external references

- 10.1 [Public Sector Internal Audit Standards](#)
- 10.2 [Lothian Pension Fund Internal Audit Opinion and Annual Report for the Year Ended 31 March 2018 - Item 5.2 Appendix 2](#)
- 10.3 [Internal Audit Report - Historic Internal Audit Findings](#)
- 10.4 [Internal Audit Opinion and Annual Report for the Year Ended 31 March 2017](#)
- 10.5 [Internal Audit Opinion and Annual Report for the Year Ended 31 March 2016](#)

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11. Appendices

- Appendix 1 Internal Audit Annual Opinion Definitions
- Appendix 2 Limitations and responsibilities of internal audit and management responsibilities
- Appendix 3 Audits completed between 1 April 2017 and 31 March 2018
- Appendix 4 Reviews nearing completion
- Appendix 5 Status of Internal Audit Findings as at 31 March 2018

Appendix 1 – Internal Audit Annual Opinion Definitions

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. We have adopted the approach set out below to form an opinion for Lothian Pension Fund.

We consider that there are 4 possible opinion types that could apply to the Council. These are detailed below:

<p>1 Adequate</p> <p><i>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</i></p>	<p>2 Generally adequate but with enhancements required</p> <p><i>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</i></p>
<p>3 Significant enhancements required</p> <p><i>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</i></p>	<p>4. Inadequate</p> <p><i>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.</i></p>

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.

Appendix 2 - Limitations and responsibilities of internal audit and management responsibilities

Limitations and responsibilities of internal audit

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 Council's control environment and governance and risk management frameworks that were not identified as they were not included in the Council's 2017/18 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 3 - Audits completed between 1 April 2017 and 31 March 2018

	No. of findings raised			
Note that no 'Critical' rated audit findings have been raised in 2017/18				
Review Title	High	Medium	Low	Totals
Council Wide				
Drivers	3	6	0	9
Phishing Resilience	2	1	0	3
*Cyber – External Vulnerability	3	2	0	5
Totals	8	9	0	17
Safer and Stronger				
Short Term Homelessness Provision	2	3	1	6
CCTV Infrastructure	2	0	0	2
Totals	4	3	1	8
Resources				
Asset Management Strategy	0	3	2	5
Edinburgh Shared Repairs	0	0	2	2
Treasury Controls Design	0	2	0	2
Starters	2	1	0	3
CGI Contract management	0	2	0	2
*IT Disaster Recovery	1	0	0	1
*ICT Monitoring of Contract Payments	0	1	3	4
Totals	3	9	7	19
Communities and Families				
Foster Care Review	1	2	1	4
*'GIRFEC' – Named Person	3	1	0	4
Totals	4	3	1	8
Strategy and Insight				
Project Benefits Realisation	2	0	0	2
Resilience	2	2	1	5
Totals	4	2	1	7
Health and Social Care				
Care Homes	4	12	4	20
Social Work Centre Bank Account Reconciliations	2	0	0	2
EADP Contract Management	1	2	1	4
Totals	7	14	5	26

Appendix 3 (cont) - Audits completed between 1 April 2017 and 31 March 2018

Review Title	No. of findings raised			
	High	Medium	Low	Totals
Place				
Port Facility Security Plan	1	4	1	6
Transfer of management dev funding	0	0	0	0
Planning Control - Building Standards	5	0	0	5
Housing Property Services Follow Up	0	1	1	2
Local Development Plan	2	1	1	4
H&S Waste and Recycling	0	4	2	6
Totals	8	10	5	23
Projects				
Ross Bandstand	0	1	0	1
Lothian Pension Fund				
Information Governance	0	2	3	5
IT Resilience and Disaster Recovery	2	0	0	2
Payroll Outsourcing	1	0	1	2
Pensions Tax	1	1	0	2
Totals	4	3	4	11
Reviews referred by the EIJB Audit and Risk Committee				
Heath and Social Care Purchasing Budget Management	4	0	0	4
Review of Social Care Commissioning	1	1	0	2
Totals	5	1	0	6
2017/18 Total – 32 Audits	47	55	24	126
2016/17 Total – 38 Audits	26	65	22	113
2015/16 Total – 35 Audits	15	66	34	115

* Audits carried forward from 2016/17

Appendix 4 – 2017/18 Reviews nearing completion

The following table shows the Internal Audit reviews from the 2017/18 Internal Audit plan that are nearing completion at the time of preparing this report.

Service Area	Title
Resources	Customer Transformation
Resources / Place	St James Project
Place	Zero Waste Project
Place	Structures and Flood Prevention
Place	Fleet Project

Appendix 5 – Status of Internal Audit Findings at 31 March 2018

Directorate / Service Area	Open Findings	Overdue Findings			
		High	Medium	Low	Total
Communities and Families	4	0	2	1	3
Health and Social Care	35	4	8	2	14
Resources (including ICT)	17	0	5	0	5
Pensions	6	0	8	5	13
Place	15	0	4	1	5
Strategy and Insight	6	0	0	1	1
Safer and Stronger Communities	3	0	0	0	0
Total Open and Overdue Findings	86	4	27	10	41

Governance, Risk and Best Value Committee

10.00am, Tuesday 31 July 2018

Internal Audit Update Report: 1 January – 31 July 2018

Item number 7.2
Report number
Executive/routine
Wards
Council Commitments

Executive Summary

This report provides details of Internal Audit (IA) reviews completed in the period; recent changes to the 2017/18 IA plan; and updates on resourcing; commencement of the 2018/19 Internal Audit plan; and IA priorities.

Internal Audit has now issued a total of 33 2017/18 audit reports to the City of Edinburgh Council (the Council) the Lothian Pension Fund (LPF) and the Edinburgh Integration Joint Board (EIJB), with 19 issued between 1 January and 31 July 2018. This included 15 reports for the Council; 2 for LPF; and 2 for the EIJB.

Of the 19 reports issued to the Council, two have been presented separately to the Committee for scrutiny. The remaining 17 reports include 65 findings (21 High; 34 Medium; and 10 Low).

A total of 6 reports are recommended for referral from the GRBV to the EIJB Audit and Risk Committee. No reports have been referred by the EIJB Audit and Risk Committee during the period.

IA recruitment has been successful and the team is now expected to be at full complement by the beginning of October 2018.

Work has commenced on the 2018/19 annual plan, however, delivery has been impacted by ongoing resourcing challenges. It has been agreed with PwC that resources will be provided in August to support delivery of three 2018/19 reviews.

Internal Audit Update Report: 1 January – 31 July 2018

1. Recommendations

- 1.1 Committee is recommended to:
 - 1.1.1 Note the risks associated with the 21 High rated findings raised in the 17 Council reports and consider if further clarification or immediate follow-up is required with responsible officers for specific items;
 - 1.1.2 Note that the 2 LPF reports have been presented to the Pensions Committee for scrutiny;
 - 1.1.3 Refer the 6 reports noted in Appendix 1 as potentially being of interest to the EIJB Audit and Risk Committee;
 - 1.1.4 Note that no reports were referred by the EIJB Audit and Risk Committee to GRBV at their meetings in February; March and May 2018.
 - 1.1.5 Note the current position with resources and successful recruitment; and
 - 1.1.6 Note progress with the 2018/19 annual plan and recent IA priorities.

2. Background

- 2.1 Internal Audit is required to deliver an annual plan of work, which is scoped using a risk-based assessment of Council activities. Additional reviews are added to the plan where considered necessary to address any emerging risks and issues identified during the year, subject to approval from the relevant Committees.
- 2.2 IA progress and a summary of findings raised in the reports issued are presented to the Governance, Risk, and Best Value Committee quarterly.
- 2.3 All audits performed for the Lothian Pension Fund (LPF) are subject to separate scrutiny by the Pension Audit Sub-Committee and the Pensions Committee, and are included in this report for completeness.
- 2.4 Audits performed for the Edinburgh Integration Joint Board (EIJB) are presented to the EIJB Audit and Risk Committee for scrutiny, with any reports that are relevant to the Council subsequently referred to the GRBV Committee.

- 2.5 Audits performed for the City of Edinburgh Council (the Council) that are relevant to the EIJB will be recommended for referral to the EIJB Audit and Risk Committee by the GRBV Committee.

3. Main report

Audit Findings for the period

- 3.1 A total of 33 2017/18 audit reports have now been issued to the to the Council (27); LPF (4); and the EIJB, with 23 issued between 1 January and 15 July 2018.
- 3.2 This included 19 reports for the Council; 2 for LPF; and 2 for the EIJB.
- 3.3 Of the 19 reports issued to the Council, the Building Standards, and Edinburgh Building Services (Housing Property Services) reports have been presented separately to the Committee for scrutiny.
- 3.4 The remaining 17 Council reports included a total of 65 findings (21 High; 33 Medium; and 10 Low). The majority of the findings raised (40%) were included in the Care Homes Assurance (4 High; 12 Medium; 4 Low) and Drivers Health and Safety (3 High and 6 Medium) audits. Details of completed reports are included at Appendix 1, with individual reports provided in Appendix 2 (following the order in Appendix 1).
- 3.5 The 2 LPF reports have been presented to the Pensions Audit Committee for scrutiny. These reports included a total of 11 findings (4 High; 3 Medium; and 4 Low).
- 3.6 The 2 EIJB reports were presented to the July EIJB Audit and Risk Committee, and it was agreed that these should be referred to the GRBV.

A total of 6 Council reports are recommended for referral from the GRBV to the EIJB Audit and Risk Committee (refer Appendix 1).

Changes to the 2017/18 IA Plan

- 3.7 The Health and Social Care Partnership Care Inspectorate Follow-up review that was included in the 2017/18 audit plan has been replaced with a review of the Edinburgh Mela Ltd at the request of management, given the significant reputational risks associated with the Council's decision to provide funding to support the Mela festival. Given resource constraints it was not possible in the timescales available to undertake both reviews.
- 3.8 It is expected that the Mela Ltd review will be completed in early July. This review has no impact on the Council's 2017/18 Internal Audit annual opinion.

Resourcing

- 3.9 Recruitment has been successful with offers now accepted for all vacant roles
- 3.10 It is expected that the IA team will be at full complement by the beginning of October, with new team members joining on a phased basis (aligned with notice periods) from July onwards.

Progress with 2018/19 Annual Plan

- 3.11 Work on the 2018/19 annual plan has commenced with one audit currently in progress.
- 3.12 Progress with the 2018/19 plan has been impacted by ongoing resourcing challenges, and the priorities noted below.
- 3.13 It has been agreed with PwC that resources will be provided in August to support delivery of three 2018/19 audits.

Internal Audit Priorities

- 3.14 Focus for the last quarter has been directed at finalising the audit reports for the 2017/18 annual plan; recruitment; and launching the new automated follow-up process.
- 3.15 The new system will be launched Council wide in early July, with training delivered during the weeks of 25 June and 2 July focusing on the role and importance of IA; rebranding IA as 'your safety net'; sharing examples of best practice when finalising audit reports and providing updates and evidence to support closure of findings; and introducing the new system.

4. Measures of success

- 4.1 Once implemented, the recommendations contained within these reports will strengthen the Council's control framework.

5. Financial impact

- 5.1 No direct financial impact.

6. Risk, policy, compliance and governance impact

- 6.1 Internal Audit findings are raised as a result of control gaps or deficiencies identified during audits. If agreed management actions are not implemented to support closure of Internal Audit findings, the Council will be exposed to the risks set out in the relevant Internal Audit reports.

7. Equalities impact

- 7.1 Not applicable.

8. Sustainability impact

- 8.1 Not applicable.

9. Consultation and engagement

9.1 Not applicable.

10. Background reading/external references

10.1 [Building Standards Audit Report to GRBV 8 May 2018](#)

10.2 [Housing Property Audit Report to GRBV 5 June 2018](#)

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11. Appendices

Appendix 1 Summary of IA reports issued and findings raised during the period and recommendations for referral to the EIJB Audit and Risk Committee.

Appendix 2 Audit reports issued in period 1 January 2018 to 31 July 2018

Appendix 1 – Summary of IA reports issued and findings raised during the period and recommendations for referral to the EIJB Audit and Risk Committee.

		Findings Raised				Refer to EIJB
Audit Review	High	Medium	Low	Totals		
Council Wide						
1.	Drivers Health and Safety	3	6	0	9	Y
2.	Phishing Resilience	2	1	0	3	Y
Safer and Stronger Communities						
3.	CCTV Infrastructure	2	0	0	2	N
Resources						
4.	CGI Contract management	0	2	0	2	N
Communities and Families						
5.	Foster Care Review	1	2	1	4	N
Strategy and Insight						
6.	Resilience Assurance	2	2	1	5	Y
7.	Project Benefits Realisation	2	0	0	2	Y
Health and Social Care – note that both reviews include management actions owned by Resources (Customer)						
8.	Care Homes	4	12	4	20	Y
9.	Social Work Centre Bank Account Reconciliations	2	0	0	2	Y
10.	Review of Social Care Commissioning	1	1	0	2	*
11.	Health and Social Care Purchasing Budget Management	4	0	0	4	*
Place						
12.	Port Facility Security Plan	1	4	1	6	N
13.	H&S Waste and Recycling	0	4	2	6	N
Lothian Pension Fund						
14.	Payroll Outsourcing	1	0	1	2	N
15.	Pensions Tax	1	1	0	2	N
Totals		26	35	10	71	

* Reports referred to the Governance, Risk and Best Value Committee from the Edinburgh Integration Joint Boards Audit and Risk Committee

Appendix 2 – Audit reports issued in period 1 January 2018 to 31 July 2018

The City of Edinburgh Council

Internal Audit

Phishing Resilience

Final Report

12 July 2018

ICT1702

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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

Phishing attacks are the most common form of cyber threat used against organisations. Phishing attacks involve an attacker sending emails designed to convince the recipient that they need to open an attachment or click on a spoof or hoax web page link. The attachments and links are often designed to either install malicious software (malware) which then infiltrates organisational networks, or trick the user into entering sensitive information (such as a username or password) providing the attacker with subsequent access to sensitive and confidential information.

In October 2017 Hamilton Academical Football Club was affected by a phishing attack and was ultimately defrauded of circa £1M.

Ransomware is a particularly destructive form of malware that catastrophically struck the NHS in May 2017 (the 'WannaCry' attack). The WannaCry malware encrypted data on infected computers and demanded a ransom roughly equivalent to £230 per computer to release the data. This prevented more than one third of English NHS trusts from accessing their systems, resulting in at cancellation of least 6,912 patient appointments, including operations.

The Scottish Government was also hit by two separate ransomware cyber attacks in 2016/17 at the Student Awards Agency Scotland and the National Records of Scotland, with hackers targeting official computers; encrypting sensitive data; and demanding money for the files to be unlocked.

"Whaling" is a unique form of phishing that specifically targets executives and senior management who hold power in organisations; with a significant public profile; and complete access to sensitive data. The term "whaling" refers to the seniority of the targets relative to targeted in typical phishing attacks. The objective of a whaling attack is to trick an executive into revealing personal or corporate data, often through email and website spoofing.

Whaling attacks are more difficult to detect than typical phishing attacks as they are highly personalised and sent to selected targets. Whaling attacks can rely solely on social engineering to fool their targets, and in some cases, will use hyperlinks or attachments to infect victims with malware or solicit sensitive information. Due to the high returns achievable from whaling, cyber criminals spend significant time and effort constructing attacks so that they appear legitimate. Attackers often source information from social media such as Facebook, Twitter, and LinkedIn, profiling targets' company information, job details, and names of co-workers or business partners. Whaling is becoming more successful, and as a result there has been an increase in its popularity.

There has also been a dramatic increase in the last two years in targeted fraud cases where cyber criminals send legitimate-looking emails imitating a real person known to the target. These attacks are known as business email compromise (BEC) fraud, and involve the attacker asking the victim to make bank transfers to accounts under the attacker's control. The sophisticated nature of the campaign highlights the investment that cyber attackers will make to successfully compromise their target.

Given the significant risks and impacts associated with phishing, it is essential that the Council operates effective cyber security technology controls, supported by a strong and effective cultural awareness of phishing to ensure that all employees can identify (or at least question) and report suspicious e mails.

Given the increasing sophistication of phishing and cyber security attacks, it is also important that the Council can analyse the volume and nature of attacks reported in order to ensure that cyber security controls can be appropriately enhanced to ensure that they remain effective.

Finally, it is essential that the Council has established adequately designed cyber security controls that operate effectively to meet the requirements of the [Scottish Government Public Sector Action Plan for Cyber Resilience](#) published in November 2017.

Scope

The objective of this review was to test the knowledge and awareness of phishing across a randomly selected sample of Council employees; Elected Members; and Member's Services teams using a mass phishing simulation technique, and assess the adequacy and effectiveness of established processes enabling employees to report receipt of suspicious e mails.

It should be noted that processes applied by CGI on behalf of the Council in relation to phishing e mails reported by employees were specifically exclude from the scope of this review.

PwC were engaged to perform this work under the terms of our Internal Audit co-source arrangements.

E mail design

Our approach involved designing and issuing three separate phishing scenarios across a random sample of employees. The e mails used in the exercise were tailored to differing degrees of sophistication. The first and second scenarios were limited in sophistication and were designed to test user susceptibility to phishing emails branded by 3rd party entities. These e mails were purportedly issued by:

- a fictitious company named G-Vouchers offering lucrative discounts on popular items; and
- A fictitious courier service named Secure Courier Co. who claimed they had failed to deliver the targeted users package.

The third scenario was specifically designed to simulate whale (also referred to as spear) phishing and targeted Council Executives; Heads of Service; Locality Managers and (importantly) Executive and Business Support Assistants who have access to and manage senior management e mail accounts.

The design of this e mail simulated a genuine internal Freedom of Information (FOI) request, with only a minor misspelling in the sender's e mail address (foi-requests@edinbrgh.org.uk) enabling recipients to identify it as a potential phishing request. Copies of all three e mails sent are included at [Appendix 2 – Simulated Phishing e mails](#).

Sampling

A random sample of 6,017 employees (circa 45% of Council employees with e mail accounts) was selected using an extract from the Council's Global Address List. Further Details of the sample selected are included at [Appendix 3 – Sample of Employees Targeted](#)

The phishing e mails were sent to the employees included in the sample between 24 and 26 January 2018, and results as at 2 February 2018 recorded and analysed to determine:

- The total volume of clicks and responses across the sample of employees; and
- The total number of employees who took appropriate action to report receipt of a suspected phishing e mail.

Scope Limitations

As there is currently no single source of employee data that completely and accurately replicates the Council's organisational structure, it was not possible to perform detailed analysis of phishing

responses across Directorates; Service Areas or employee groups (for example Elected Members and their business support teams; locality teams; or executive support teams).

Consequently, our results are split between learning and teaching employees (who have unique e mail addresses) and other Council employees, with some further manual analysis performed to identify any Corporate Leadership team members or Heads of Service and their executive support teams, and Locality managers who had actioned the phishing e mails.

It should be noted that phishing simulations usually target a smaller sample of employees (circa 500), in comparison to the Council's sample population of circa 6,000 employees given the potential risk employees become aware of larger scale exercises as they progress. This risk was addressed by issuing the e mails over a short time horizon.

2. Executive summary

Total number of findings

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

Summary of findings

Phishing Responses

The results of the phishing simulation demonstrate that that the Council could potentially be exposed to cyber security risk with 9% (528) of the sample either clicking on the links or responding to the phishing e mails.

A significant weakness was identified in relation to knowledge and awareness of whale phishing amongst the Council's senior management and their support teams (who have access to and manage senior management's e mail accounts), with a 29% response rate to the sophisticated whale phishing simulation.

The outcomes of the remaining two scenarios (which were very limited in sophistication) are aligned with the average response rate of 10% when compared to similar organisations, and demonstrated a moderate degree of security awareness from targeted employees.

Learning and teaching staff accounted for 54% (282) of responses to the voucher and parcel delivery scenarios, with 46% (240) from the remaining employees sampled. A summary of the results per simulation is included at Table 1 below:

Table 1: Summary of phishing simulation outcomes

Scenario	Sample Population	Out of Office Responses	Final Sample	Clicked / Replied		Total Responses (%)
				Learning and Teaching	Other	
1) G Voucher Discounts	2,997	198	2,799	113 (4%)	117 (4%)	8%
2) Secure Courier – Failed Delivery	2,999	117	2,882	169 (6%)	123 (4%)	10%
3) Freedom of Information (whale phishing simulation)	21	-	21	6		29%
Totals	6,017			528		9%

Reporting Phishing

Employees who neglect to challenge suspicious emails also increase the Council’s exposure to cyber crime as the Council cannot perform analysis on the volume and nature of e mails received, and implement appropriate measures to ensure that cyber security controls remain effective.

Our results demonstrated that only 1.4% of the 91% of employees who did not respond to the phishing e mails proactively reported receipt of a suspicious e mail. Review of historic reporting monthly reporting volumes established that these were lower than would normally be expected (an average of 17 incidents reported per month between January 2016 and January 2017) given the increasing volume and sophistication of phishing and cyber security attacks.

Additionally, review of the ‘report phishing’ guidance published on the Orb (the Council’s Intranet) established that it cannot be easily located and that the process to report a suspicious e mail is unclear. This could potentially be the root cause of the low volume of suspicious e mails reported by employees.

Finally, there is currently no single source of employee data that completely and accurately replicates the Council’s organisational structure, enabling analysis of employee e mail addresses to support future identification of employee groups for targeted ongoing cyber security training and future phishing simulation testing.

Consequently, 2 High and 1 Medium rated Findings have been raised. It is essential that these weaknesses are addressed in a time manner to ensure that the Council meets the requirements of the Scottish Government Public Sector Action Plan for Cyber Resilience.

Our detailed findings and recommendations are laid out at Section 3: [Detailed findings](#).

3. Detailed findings

1. Targeted Training

Finding

The Council's ICT team has been running a "Stop Think Connect" cyber security awareness programme across the Council which has clearly had a positive impact as 91% of employees did not respond to the simulated phishing e mails.

However, our testing identified a significant lack of knowledge and awareness of whale phishing across Council Executives; Heads of Service; Locality Managers and (importantly) Executive and Business Support Assistants (who have access to and manage senior management e mail accounts) with a 29% response rate to the Freedom of Information whale phishing simulation. These responses included:

- One Corporate Leadership Team member;
- One Head of Service and one Locality Manager;
- One Senior Executive Assistant and one Executive Assistant; and
- One Modern Apprentice

Whilst it is expected that Senior Management will delegate access to, and management of, e mail accounts to their Executive and Business Support Assistants, they must ensure that these employees have a strong knowledge and awareness of phishing enabling them to take appropriate action and prevent inappropriate responses that could expose the Council to risk of cyber attacks.

Additionally, there is currently no mandatory phishing and cyber security training in place for all Council employees who have e mail accounts.

Business Implication

- Risk that the Council is exposed to malware or ransomware attacks that could infect technology networks; and
- Risk that commercial or employee sensitive information is disclosed to cyber criminals by Senior Management.

Finding Rating

High

Action plans

Recommendation

1. Targeted whale phishing training should be designed and provided to Council Executives; Heads of Service; Locality Managers and (importantly) Executive and Business Support Assistants on an ongoing basis; and
2. Generic phishing / cyber security training should be developed and included within induction and ongoing mandatory training for all employees with Council e mail accounts;
3. Phishing / cyber security training should be reviewed and updated annually to ensure that the training content remains aligned with the increasing sophistication of attacks experienced within the Council and across other public sector bodies; and

Responsible Officer

Neil Dumbleton,
Enterprise Architect

4. Ongoing phishing simulation testing exercises should be designed and implemented across all employees and contractors with Council e mail addresses, with the results recorded and analysed to identify and address target training requirements.

Agreed Management Action

Estimated Implementation Date

1. a) Accepted. A Members Briefing email was issued to Councillors and CLT members on 22/3/18. We have provided targeted training to the senior leaders group, using the term spear fishing as we feel this is most appropriate but explained how prominent people are at risk. The term whale phishing is described in our recent awareness poster. We would look to have this marked as completed.

1. Completed
31 August 2018 for IA validation and closure

b) Targeted training in Cyber-Security for a wide range of staff roles is a Public Sector Action Plan for Cyber Resiliency (PScAP) requirement.

2. a) Completed
31 August 2018 for IA validation and closure

ICT and Learning and Organisational Development (L&OD) attended at a workshop with Scottish Government in May 2018, and we believe that our training plans take account of all SG guidance. We subsequently demonstrated our training to them and they would like us to create guidance for Cyber Catalysts.

2b and c) 28 September 2019

We have a training and awareness plan for 2018. This has been issued to the new Cyber and Information Security Steering Group for further comment.

2d) 28 September 2018

2. a) The Phishing Awareness Course developed in conjunction with Learning and Organisational Development has been released via an e mail that includes a link to the training course to:

3. 28 September 2019

- All staff
- Targeted version to senior leaders
- Targeted version to ICT.

4. 31 October 2018

We believe the training course is suitable for varied users, and have adopted an approach where we use the same course for all users but adapt / flavour the communications to bring it alive for the target groups. We would look to deliver this to (say) finance and legal next. Feedback on the course has been overwhelming positive and we would look to have this marked as completed.

Until the fourth finding in this report is addressed which will provide a full population of employees; and their roles and position within the Council combined with their e mail addresses, we remain dependent on existing data such as manual lists and e mail distribution lists to ensure that the course is targeted at appropriate groups of employees.

b) Ongoing training is also a requirement of the Public Sector cyber action plan. ICT now has a Training and awareness plan that exceeds the commitment here. We are on target to deliver this commitment.

c) There is a requirement for the preparation of training courses. Completion of this audit action is subject to assistance from L&OD or a third party and identification of budget.

Resources have so far been available from L&OD to support the Training & Awareness plan. If they are not we would look to escalate. The need for increased awareness is a key theme of the CISSG. We are on target

to deliver this commitment before 28th September so no extension is requested.

d) Consideration will be given to the Council adopting this as mandatory training with output of discussions being provided to internal audit by ICT. The issue of making training mandatory has been raised with L&OD, and a meeting will be arranged to discuss.

3. Accepted. Once such courses are agreed ICT will ensure these are updated annually (or earlier depending on NSCS guidance changes or in response to incidents) in line with best practice advice and e.g. in-line with PScAP recommendations. The courses will be reviewed and updated by the first anniversary date of their release.
4. ICT will prepare costed proposals for ongoing phishing simulation tests. A change request has been raised with CGI to obtain the “utility” costs for an ongoing targeted simulation phishing service. The utility cost (e.g. cost per exercise per 1000 staff) will support implementation of flexible simulation exercises. We can aim for both a series of exercises e.g. one every 4 months OR carry out exercises on demand, say in response to a specific incident. If costed proposals are not feasible, alternative options will be explored.

3. Reporting Phishing

Finding

Reporting Culture

Whilst our testing confirmed that 91% of employees in our sample did not respond to the simulated phishing emails, there was no corresponding increase in the volume of suspicious emails reported as only 1.4% of the 91% of employees proactively reported receipt of a suspicious e mail either via phone or e mail to the CGI helpdesk.

CGI has also confirmed that:

- an average of 17 suspected phishing e mails per month were reported to the Service Desk in the period January 2016 to November 2017;
- 10 suspected phishing e mails were reported in December 2017; and
- 7 were reported in January 2018

Phishing Guidance

A review of the ‘report phishing’ guidance published on the Orb (the Council’s Intranet) established that it cannot be easily located and that the process to report a suspicious e mail is unclear. Specifically:

- The process for reporting phishing is not included prominently on the Orb – the ‘report it’ box on the home page does not include any links to the report phishing process (refer [Orb Home Page](#));
- The process to report phishing does not feature prominently on the ICT home page. Users must navigate their way to the ICT security link via a series of three clicks (from the main Orb home page) to find any references to e mail security; phishing and ransomware. This contrasts with only one click required on a phishing e mail link that could infect Council networks with malware;
- The process for reporting suspicious e mails in the e mail / security phishing page is unclear. Whilst the page includes a contact number and e mail address, it does not specify whether the e mails

should be forwarded or included as an attachment to enable further analysis and investigation (refer [E mail Security / Phishing Guidance](#));

- There is no specific telephone number or e mail address dedicated to reporting suspected phishing e mails. The current telephone number included in the Orb directs employees to the Council’s ICT Security Manager (who may not always be available to take calls) or to a generic ICT security e mail inbox. This is likely to cause confusion as the phishing and ransomware awareness images on laptop start up screens include a phone number and e mail address for the CGI service desk; and
- The final page of the phishing guidance page on the Orb includes a link to an online form ([Related Items – Online Forms on Phishing Page](#)) which is a form that should be used to report a data protection breach, and makes no specific reference to phishing.

Finally, whilst functionality is available to include a "report phishing" icon in the Microsoft Outlook e mail toolbar, enabling users to report receipt of suspicious e mails via one click directly from their inbox, this is not included in the version used by the Council.

Business Implication	Finding Rating
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The Council has insufficient data to monitor the volume and nature of phishing attacks targeted specifically against the Council, and ensures that cyber security controls remain sufficiently effective to combat potential cyber security attacks.

High

Action plans

Recommendation	Responsible Officer
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1. Phishing Guidance on the Orb should be reviewed and refreshed with the links to the revised guidance and ‘report phishing’ telephone numbers and e mail addresses featured prominently on the home page;
2. The revised report phishing process should include step by step guidance to support employees in reporting suspicious e mails and sending them to ICT for further investigation and analysis;
3. Analysis of the nature and volume of phishing attacks reported by employees should be performed and reported to the relevant ICT governance forum; and
4. ICT should investigate and implement (if feasible) the “report phishing” icon in the Microsoft Outlook e mail toolbar. Implementation should be supported by relevant guidance on the Orb.

Neil Dumbleton,
Enterprise Architect for all actions.

Agreed Management Action	Estimated Implementation Date
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1. and 2 - Accepted – these recommendations will both be fully implemented
3. a) Accepted in principle but there are practical constraints. Reports of phishing attempts are made to the CGI Service Desks. To provide analysis, CGI will need to extract data from the call centre records and provide data to the Council’s Security Working Group (SWG). Delivery of such data for existing metrics is subject to an overdue audit already, and this additional analysis might be at a cost to the Council.

We have a commitment from CGI that they will produce the figures. We did this through the Security Working Group and not the change request process as the latter has not been effective in the past.

1. and 2 Completed
31 August 2018 for IA validation and closure
3. a and b) 31 March 2019
4. 20 December 2019

b) If the proposal(s) are acceptable and are approved by the Council, we will aim for provision of phishing analysis to and review by the Security Working Group by March 2019.

4. CGI has agreed to add the icon as part of the EU/Office 365 roll out for both corporate and Learning and Teaching employees, and will amend the core functionality to report phishing attempts to their helpdesk. The risk is not that they don't accept doing it, but that the 0365 project is delayed. We understand this is a firm commitment with target completion date for June 2019.

4. Employee Data

Finding

As part of the Public Sector Action Plan for Cyber Resiliency (published November 2017) The Scottish Government will seek assurances from Scottish public bodies that they have in place appropriate staff training, awareness-raising and disciplinary processes about cyber resilience for staff at all organisational levels (key action 6).

This, together with key action 4, which requires the Council to obtain appropriate independent assurance of critical cyber security controls by end October 2018, will require the Council to identify the full population of employees with e mail addresses and perform analysis of their roles, groups, and levels across the organisation (for example, Elected Members and their support teams; all executive support teams; heads of service; and locality employees).

There is currently no single source of employee data that accurately replicates the Council's organisational structure, enabling simple identification of groups of employees for targeted training or future phishing simulation exercises.

A data extract from the Council's global address list was used to select a random sample of employees for inclusion in the current phishing simulation, with the intention of selecting samples based on Directorates; Service Areas; and other groups so that results could be analysed in detail and provided to these groups for review and action (where appropriate).

This was not possible due to the quality of information recorded in the GAL which included a significant volume of both incomplete and factually inaccurate entries, and prevented accurate analysis.

Business Implication

It may not be possible to meet the requirements of the Scottish Government's Public Sector Action Plan for Cyber Resiliency.

Finding Rating

Medium

Action plans

Recommendation

1. An appropriate system solution (for example a database) that accurately reflects the Council's organisation structure and includes details of all employees with Council e mail addresses should be identified and implemented;
2. The content of the system should be structured to enable analysis of employees at Directorate; Service; and relevant group levels (for example Elected Members; localities; executive assistants) to support future identification of employee groups for targeted ongoing cyber security training and future phishing simulation testing;

Responsible Officer

1. to 4 Neil Dumbleton, Enterprise Architect with support from Katy Miller, Head of Human Resources.

3. An appropriate owner for the system will be established; and
4. Change management processes (linked to employee changes such as new starts; leavers; and movements within the Council) will be established and implemented to ensure that employee data is completely and accurately maintained.

Agreed Management Action

Estimated Implementation Date

The iTrent system (owned by HR) holds details of the organisational structure and the location and reporting lines all for all permanent and fixed term employees. It also has the capacity to record e mail addresses, however this functionality is not consistently used at present. The iTrent system will therefore be used to provide employee data for future phishing simulations once the following actions have been completed.

29 March 2019

1. An automated download of all permanent and fixed term employee e mail addresses will be extracted from active directory and uploaded into the iTrent system;
2. Appropriate reconciliations and checks will be performed to ensure that the data has transferred completely and accurately;
3. A process will be established to ensure that e mail addresses for all new employees is automatically uploaded into iTrent monthly, with appropriate reciliations and checks performed on the data; and
4. A process will be established and tested to confirm that e mail addresses for all agency employees can be provided to support future phishing simulations.

As agency employee data is not recorded in the iTrent system, details of agency employees and contractors, their e mail addressed will be extracted from the active directory application which is used to populate the global address list (GAL).

As line managers are responsible for ensuring that details provided to establish agency / contractor e mail accounts are complete and accurate, and updated to reflect any movement within the Council, there is a risk that the data used to support phishing simulations may not fully complete and accurate.

Appendix 1 - Basis of our classifications

Finding rating	Assessment rationale
Critical	<p>A finding that could have a:</p> <ul style="list-style-type: none"> • 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	<p>A finding that could have a:</p> <ul style="list-style-type: none"> • 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	<p>A finding that could have a:</p> <ul style="list-style-type: none"> • 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	<p>A finding that could have a:</p> <ul style="list-style-type: none"> • 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	<p>A finding that does not have a risk impact but has been raised to highlight areas of inefficiencies or good practice.</p>

Appendix 2 – Simulated Phishing e mails

1. G Vouchers

From: G-Vouchers Deals [mailto:deals@goupon-vouchers.co.uk]

Sent: 18 January 2018 10:36

To: City of Edinburgh Council Employee

Subject: Best Of This Week! Up to 60% Off Toys and Electronics!

G-VOUCHERS



Sphero Star Wars BB-8 with Droid Trainer

£130 ~~£78~~

[View Deal](#)



Samsung Gear S2 Classic Smartwatch

£349 ~~£140~~

[View Deal](#)



PS4 1TB Star Wars Battlefront 2 Deluxe Bundle

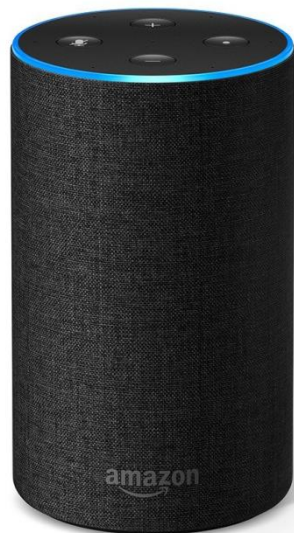
£280 ~~£120~~

[View Deal](#)

Bose QuietComfort 35 Wireless Headphones 2

£330 ~~£148~~

[View Deal](#)



Amazon Echo 2nd Generation

£70 ~~£40~~

[View Deal](#)

Need help? Have feedback? Feel free to [contact us](#).

You are receiving this email because The City of Edinburgh Council is signed up to receive exclusive dicounts from G-Vouchers.

If you prefer not to receive future G-Vouchers emails of this type, you can always unsubscribe with [one click](#).

If you'd like to manage your other subscriptions, [click here](#).

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2. Secure Courier

From: Secure Courier Co. [mailto:yourdelivery@data-scout.co.uk]
Sent: 18 January 2018 10:34
To: City of Edinburgh Council Employee
Subject: ACTION REQUIRED: Package delivery failed



Dear XXXX,

Subject: Delivery Status Changed
Date: March 20, 2017

Your package could not be delivered by our courier service.

REASON: INVALID POSTCODE
PARCEL #: 541874072
SHIPPING SERVICE: PRIORITY MAIL
BOX SIZE: XL

To reschedule a delivery, please [click here](#).

Thank you for using our services.

Kind Regards,
The Secure Courier Co. team

This is an automated reply, so please do not reply to this mailing address.

This message may contain confidential information. If you are not the intended recipient please inform the sender that you have received the message in error before deleting it. Please do not disclose, copy or distribute information in this e-mail or take any action in reliance on its contents, To do so is strictly prohibited and may be unlawful. Thank you for your co-operation.

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This email has been checked for viruses. However, Secure Courier Co. and its constituent companies cannot accept responsibility for loss or damages arising from the use of this email or attachments and we recommend that you subject these to your virus checking procedures prior to use.

3. Freedom of Information

From: FOI Admin [mailto:foi-requests@edinbrgh.org.uk]
Sent: 18 January 2018 11:13
To: City of Edinburgh Council Employee
Subject: [Action Required]: FOI Request

Request Assignment Form

The summary below provides details of an **FOISA** request for information that has been allocated to your service area for action. Please treat with high importance as statutory timescales apply.

Stage 1:- Please consider the requests and questions listed below and respond to the Information Rights Officer within 5 days of receipt of this request.

Stage 2:- Please respond by providing the requested information to the Information Rights Officer by no later than day 15.

Request summary

Cost, health and safety.

Please reply to this email with each section completed.

Please return authorised by **DATE HERE**
Finance team have advised this should be assigned to Health and Safety

Please can you provide me with the total number and total cost of equipment (furniture, computer and other aids) purchased in 2016, to make reasonable adjustments required by the Equality Act 2010.

Stage 1

Request assessment

Each request has to be initially assessed. This will help your service area deal with the request more effectively, and ensure that the Council can meet its statutory obligations under compliance legislation.

Please consider the points listed below and respond to the Information Rights Officer within 5 days of receipt of this request.

1. To ensure that statutory timescales can be met, it is important that information requests are assigned to the correct service area. Can you confirm that you hold the requested information in whole or in part? If in part or no, please suggest areas where the information may be held.
If your response is that no information is held which would fulfil this request in whole or in part please record below.

--

2. Under FOI legislation we can seek clarification and further details if we are not clear about what is being asked for (e.g. date range). Please indicate if you require further clarification?

--

Stage 2

After responding, please continue to collate the requested information, unless instructed otherwise by the Information Rights Officer. **Please return requested information to the Information Rights Officer by no later than day 15.**

If you do not respond, we will assume that the requested information will be provided in full and returned to the Information Rights Officer by no later than day 15.

When providing the requested information, it would be helpful if you could provide an estimate of the total time taken to deal with the request. This will be used for performance and monitoring purposes.

Appendix 3 – Sample of Employees Targeted

Area	Sample Selected	Scenario
Corporate Leadership Team	4	FOI Request
CLT Support	5	FOI Request
Heads of Service / Locality Managers	7	FOI Request
Heads of Service Support	5	FOI Request
Teaching and Learning	1,198	G Vouchers
Teaching and Learning	1,199	Secure Courier – Failed Delivery
Other Employees	1,799	G Vouchers
Other Employees	1,800	Secure Courier – Failed Delivery
Totals	6,017	

The City of Edinburgh Council **Internal Audit**

CCTV Infrastructure

Final Report

2 April 2018

SSC1703

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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 (the Council) operates a close circuit television (CCTV) camera estate across public spaces; housing blocks; schools; bus lanes and Council buildings. The total operational cost of public space is £955,354 with income of £128K generated.

Provision of CCTV services is non-statutory, with the service provided to support public security and the prevention and detection of crime in line with the following Council priorities and pledges:

- 'Safe and empowered communities' (CP4) with the objective of ensuring that 'People and communities are safe and protected'.
- Single Outcome Agreement, (SO4) 'Edinburgh's communities are safer and have improved physical and social fabric'.
- Coalition pledges (P32) 'Develop and strengthen local community links with the police'.

Police Scotland are the main users of CCTV footage to support criminal prosecutions, and use the Council's CCTV services (under the terms of a partnership agreement developed by a sub group of the Police and Fire Scrutiny Committee in 2017) with the objective of reducing crime and antisocial behaviour in communities.

During 2016/17 the Police requested 1,369 CCTV image reviews with 152 resulting in court evidence packages being prepared. Seven portable camera assessments were also performed.

Retention, archiving and destruction of CCTV footage, and sharing footage with third parties is governed by the requirements of the Data Protection Act (1998). These processes will also require to be compliant with the new General Data Protection Requirements due to be implemented in May 2018. There is also a general requirement to work within the parameters of the Human Rights Act, Regulation of Investigatory Powers Act (RIPSA) and finally the Council's Code of Conduct.

Specifically, providers of CCTV services in public spaces require to comply with the requirements of the Scottish Government's National Strategy for Public Space CCTV in Scotland (March 2011),

Boston Networks was recently commissioned to review the condition of the Council's current CCTV estate and its operational status, with the outcomes published in August 2017.

Their report recommended implementation of a CCTV strategy to focus on the location and scope of control centres, and confirmed that significant investment is required to upgrade the technology infrastructure of the estate, recommending investment in an internet protocol (IP) based CCTV estate to replace the current analogue system.

Scope

As the Boston Networks review concluded on the requirement to develop a strategy and upgrade the existing CCTV estate, the scope of our review focused on the controls in place to manage the following CLT top risks:

- Information governance
- Maintaining service with less resource

Testing was undertaken on a sample basis across the period 1st April 2017 to 31st August 2017 across the Public Space, Security, and Concierge service areas.

2. Executive Summary

Total number of findings

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

Summary of findings

Our review established significant strategic and operational control gaps in relation to delivery of CCTV services across the Council. Consequently, two 'High' rated Findings have been raised.

Our first Finding reflects the impact of a lack of corporate CCTV strategy (the service is currently run at a loss across three Service Areas); failure to progress the requirement for significant investment in the CCTV technology infrastructure identified from the Boston Networks review; and lack of a clearly documented corporate plan to ensure that all CCTV operations are compliant with current Data Protection Act requirements, and will be compliant with General Data Protection Regulations effective from 25th May 2018

Our second Finding reflects a number of significant control gaps in Service Area operational processes that have resulted in instances of non-compliance with Data Protection Act requirements, the Council's Information Security Policy and Records Management policies.

Our detailed findings and recommendations are included at Section 3: Detailed Findings. Further details of the testing outcomes for each of the Service Areas reviewed as at 30th September 2018 (Public Space, Security, and Concierge) are included at Appendix 1

3. Detailed Findings

1. CCTV Strategy

Finding	
<p>There is currently no consolidated corporate strategy and standard operational procedures supporting consistent and legislatively compliant delivery of CCTV Services across Service Areas, and no established recharge process to enable recovery of CCTV costs incurred by the Council.</p> <p>There has also been no progress in addressing the failings highlighted in the Boston Network report which highlighted that significant investment in the CCTV technology infrastructure was required to support future delivery of the service.</p> <p>Finally, there is no clearly documented corporate plan to ensure that all CCTV operations will be compliant with General Data Protection Regulations effective from 25th May 2018.</p>	
Business Implication	Finding Rating
<ul style="list-style-type: none"> • Failure to operate consistently and effectively, and risk of potential legislative breaches. • Reputational risk associated with major failure in CCTV infrastructure resulting in inability to provide the Service • Potential financial loss associated with failure to recharge costs. • Potential non-compliance with new GDPR regulations. 	<div style="background-color: red; color: black; padding: 10px; width: 60px; margin: 0 auto;">High</div>

Action plans	
Recommendation	Responsible Officer
<ol style="list-style-type: none"> 1. A corporate CCTV Strategy and standard operational procedures should be designed and implemented. This should include establishment of a centralised CCTV delivery budget and a recharge process to enable recovery of costs and support income maximisation (where possible). 2. Standard processes should be developed for implementation across all service areas providing CCTV services. These should be aligned with applicable legal and regulatory requirements and should include (as a minimum) procedures covering: <ul style="list-style-type: none"> • Approval and requisition of new CCTV equipment, • Prioritisation of requests for cameras in new locations and their allocation across geographical sites, • Identification and repair of damaged equipment, • Retention, archiving and destruction of footage that are aligned with the Council's Records Management policy and Data Protection Act requirements, and • Approval of requests for footage and the process for sharing footage in a secure manner. 	<p>Senior Manager, Community Justice</p>

3. An action plan should be designed and implemented to address the CCTV infrastructure failings highlighted in the Boston Network report, and a request submitted to Finance and the relevant Council Committees for funding to support investment.
4. A corporate CCTV risk register recording the consolidated risks associated with delivery of CCTV services should be prepared. These should include details of action plans to mitigate the risks identified, and appropriate action owners. The risk register should also be subject to regular ongoing review to ensure that risk and action plans remain appropriate.
5. A consolidated asset register should be prepared and maintained to record all CCTV equipment owned by the Council, its condition and location.
6. A corporate business continuity plan should be designed and implemented to support recovery of the CCTV services across all locations in the event of a disaster.
7. A gap analysis should be performed and a corporate plan developed to ensure the service will be compliant with GDPR by 25th May 2018.

Agreed Management Action

Estimated Implementation Date

1. A CCTV working group has been established that is chaired by an Elected Member. The Lead Officer is the Manager, Community Safety. Three sub working groups have also been established. The sub 'Strategy' group has been tasked with developing an overall CCTV Strategy with the objective of 'future proofing' the CCTV service. The strategy will include recommendations for establishment of a centralised CCTV delivery budget and a recharge process to enable recovery of costs and support income maximisation (where possible). It is not yet possible to commit to an agreed implementation date for the strategy which is likely to be longer term. It has therefore been agreed with Internal Audit that the finding will be closed and development and approval of the strategy, with further IA reviews scheduled to consider effective implementation of the strategy.
2. The sub 'Policy and Procedures' group will deliver a standard set of CCTV operational processes and procedures to be implemented across all three CCTV service areas. These will include the areas noted in the audit recommendation.
3. The objective of the sub 'Tactical Working Group' is to oversee and implement the upgrade of public space CCTV in line with Council wide technology and ensure it is compatible for future integration of council service. This will include the identification of funding sources to support the necessary CCTV investment.
4. 5 & 6 It is expected that the strategy document will recommend the establishment of one centralised CCTV operations centre and data centre for the Council. This will be supported by appropriate risk registers; asset registers and resilience plans. The requirement for standardised approaches in these areas will be reflected in the strategy document produced. Meantime, Security are undertaking exercise to

27th September 2019

28th September 2018

27th September 2019

27th September 2019

fully document all security systems (including CCTV) in detailed Asset Registers

7. Information Governance has performed their GDPR readiness review of three CCTV areas, and the questionnaire has been completed. Action plans are currently being developed.

29th June 2018

2. CCTV Operations

Finding

Lack of corporate strategy and standard operational procedures has resulted in three Service Areas (Public Space, Security, and Concierge) managing their CCTV services independently with differing standards of operational processes and controls, with examples of non-compliance with applicable legislation evident in all three areas.

The following control gaps were identified consistently across all three Service Areas, and have been discussed separately with each:

1. Data protection regulations (the Seventh Principle), and the CEC Information Security Policy (ISO/IEC 2700) were non-compliant in Security Services area as the CCTV file server and downloaded CCTV images were stored in an open, regularly unstaffed room that was occasionally open to public access.
2. There is no evidence of regular internal or peer reviews of CCTV operations as required by the National Strategy for Public Space CCTV to ensure compliance with Data Protection Act requirements.
3. Service Area procedures supporting CCTV operations were not up to date and had not been subject to periodic review. and Current records management processes applied within the three service areas are not fully compliant with current Data Protection Act requirements and the Council's Records Management policy. An example of this was that all three service areas had a different document retention process, with Security applying a process of retaining footage until they have been informed that a Police case file is closed; Public Safety retaining footage until told by the court that the footage can be destroyed; and Concierge retaining footage for a year before deletion.
4. Risks associated with the operation of CCTV services have not been identified and recorded on Service Area risk registers.
5. No induction training and ongoing training and development is provided for CCTV team members to ensure they are aware of all applicable legislation; legislative changes and operational processes for the Service Area.

Business Implication

- Financial penalty and reputational damage associated with breach of Data Protection legislation and Council Records Management policies.
- Failure to operate consistently and effectively, and risk of potential legislative and National Strategy breaches.
- Employees may unknowingly breach applicable legislation or Council policies.

Finding Rating

High

Action plans

Recommendation

Responsible Officer

<ol style="list-style-type: none"> 1. Immediate action should be taken to secure access to the Security Services file server and downloaded CCTV images and a request made to the Information Governance team to carry out a review of any new procedure, ensuring compliance with relevant policies and legislation. 2. Internal and peer reviews should be incorporated in operating procedures and performed as per the requirements of the National Strategy for Public Space CCTV to ensure Data Protection Act compliance 3. Service Area procedures should be reviewed and aligned with Corporate CCTV and Records Management procedures (with specific focus on retention periods for CCTV images on systems, and retention of downloaded CCTV footage), and reviewed at least annually. 4. Risks associated with delivery of CCTV services should be identified and recorded on the relevant Service Area risk registers. 5. Induction and ongoing training should be delivered to all CCTV staff and appropriate records maintained of completion. 	<ol style="list-style-type: none"> 1. Security Manager, Property and Facilities Management 2. to 5 - Senior Manager, Community Justice
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Agreed Management Action	Estimated Implementation Date
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<ol style="list-style-type: none"> 1. The server hardware at NPH has been updated and is now secured behind constructed partition with air conditioning. Access is restricted by controlled entry, and the installation of air conditioning should now negate the need to leave the door open in summer to support ventilation. NPH is a 24/7 facility and would not normally be unstaffed. Security of downloaded images has been addressed with a lockable filing cabinet. All procedures have been reviewed with policy guidance updated. These will be included in the ongoing work of the Procedures Sub group of the CCTV Working Group From a DR perspective currently, all NPH alarms can be manually transferred to Waverley Court in the event of a catastrophic failure / loss of service. An upgrade CCTV viewing capability at Waverley Court (WC) is currently being scoped. The existing WC server will also be afforded better protection to future proof and prolong service life. This will include an upgrade to the capacity and capability of the default processes providing limited CCTV monitoring capability at Waverley Court. 	27 th April 2018
<ol style="list-style-type: none"> 2. Public Space supervisors undertake review of staff work on a monthly basis in line with legislation around CCTV Governance. This is to be rolled out across Security and Concierge services. Additionally, the new policies and procedures being developed will include the requirement to record that the reviews have been performed, and document the actions taken to address any gaps identified, and any Data Protection breaches. 	28 th September 2018
<ol style="list-style-type: none"> 3. The 'Policy and Procedures' sub group is developing a standard set of CCTV policy and procedures to be applied consistently across the entire council CCTV Estate. These procedures will include records management requirements for CCTV images held on systems and also downloaded CCTV images. The requirement for an annual review to confirm to incorporate any necessary changes will also be included. 	28 th September 2018

4. The Council's Risk Management team will be engaged to support a review of CCTV risk registers across all three areas, and ensure that the risk registers are refreshed. Risk registers will be standardised where possible. All security related CCTV risks have now been recorded on Property and Facilities Management risk register.

28th September 2018

5. The roll out of the new policies and procedures to be applied across all CCTV operations will be supported by employee briefings and training. The new policies and procedures will also include the requirement for induction training for all new employees and ongoing refresher training (to be delivered by each respective Service Area lead).

30th November 2018

Properties and Facilities Management has prepared a training matrix. A training provider has been also identified and training course dates established throughout 2018 for service users. A security information page is also being prepared for publishing on the Orb.

Appendix 1 – Service Area Testing Outcomes as at 30th September 2018

Objective	Risks	Consolidated RAG Status	Public Space RAG status	Security RAG status	Concierge RAG status
CCTV services are subject to annual review to confirm that ongoing service provision and associated costs and benefits remains aligned with the Council's strategic objectives	Service may become misaligned with strategic objectives.	There is no consolidated strategy for provision of CCTV services across the Council, and the outcomes of the Boston Networks consultancy review have not been progressed.	No annual review performed of provision of CCTV Services by Public Space.	No annual review performed of provision of CCTV Services by Security.	No annual review performed of provision of CCTV Services by Concierge.
Processes and procedures are regularly reviewed and updated to reflect legislative changes.	Process and procedures are out of date leading to breaches in legislation and regulation.	There are no established Council wide procedures supporting delivery of CCTV services.	There are no regular reviews of existing processes and procedures to ensure that they remain aligned with applicable legal requirements.	There are no regular reviews of existing processes and procedures to ensure that they remain aligned with applicable legal requirements.	There are no regular reviews of existing processes and procedures to ensure that they remain aligned with applicable legal requirements.
Supporting rationale is provided for all requests for installation of cameras.	Expenditure on CCTV assets is unnecessary and inappropriate.	There is no established Council wide process for prioritising requests for purchase of CCTV equipment	Additional equipment cannot be ordered as the current assets are now obsolete. Lack of action on Boston report is a big risk for this area	There is no established process for prioritising the purchase of CCTV equipment.	No information has been provided, therefore assessed as a control gap and rated red.
A clear prioritisation process has been established to support allocation of the estate across public spaces.	CCTV service does not support the needs of CEC or other users	No clear process has been established across the Council for prioritisation of allocation of equipment across geographic locations.	There is a lack of evidence that the Regulation of Investigatory Powers Act (RIPSA) requirements are followed for Police requesting provision and use of the Mobile camera units. There was a lack of evidence showing how the rest of the camera use was prioritised. Community Improvement Partnerships discuss crime and antisocial	Current Security Services CCTV equipment is functional, but in need of significant investment in to fully network the system and enhance monitoring capability at NPH. to support ongoing service provision. requests cannot be met. There are increasing concerns that current	The Calder project was ringfenced Housing Property Capital provision. It is being used only for the upgrade and improvement of CCTV provision with the three Calder, but does not cover remaining concierge services. Any additional requests cannot be met. .

Appendix 1 – Service Area Testing Outcomes as at 30th September 2018

Objective	Risks	Consolidated RAG Status	Public Space RAG status	Security RAG status	Concierge RAG status
			behaviour statics and allocate redeployable cameras were there is a need, request form and process in place	contractual arrangements with SPIE will not fully deliver the maintenance of existing systems.	
A process has been established to identify all damaged CCTV cameras and ensure that they are repaired in a timely manner	CCTV infrastructure becomes unfit for purpose.	There is no established Council wide process to support identification and repair of CCTV equipment.	SPIE are contracted to maintain the infrastructure as and when required. There is a structured process in place for requesting maintenance but when a camera is damaged beyond repair the only way to maintain this is to decommission a lesser used working camera and utilise its parts.	Camera faults are reported daily through a formal process and these faults are either repaired by the Security Officer with the technical skills to do so or it is reported to Property and Facilities Management who then in turn contact SPIE to maintain. There are significant delays between the date reported and the date this is passed to Property and Facilities Management for action.	All cameras are reviewed as part of the night shift duty check. Any faults are reported and the cameras that have broken down are being replaced with new digital technology.
CCTV footage is generated and stored in a secure environment with access restricted to only authorised personnel.	Footage is not protected in accordance with Data Protection Legislation and CEC's Information Security Policy, and is accessible by unauthorised personnel	There is no Council wide policy or process detailing the requirements for secure storage of CCTV footage.	<ul style="list-style-type: none"> An ad hoc storage process is applied. Access restrictions are documented and communicated. There is independent review of activity in place but this is not documented or formalised. 	<ul style="list-style-type: none"> The server for the Security CCTV area is in an open office and when the weather is warm the main security door is wedged open enabling access by any member of the public walking in off the street. This is where the footage downloaded for Court packages is also kept in drawer cabinets which are not locked. 	<ul style="list-style-type: none"> Footage is generated onsite in the concierge office. Any images removed are stored in a locked cupboard. The disk the images are recorded on remains in place and is recorded over every 30 days.

Appendix 1 – Service Area Testing Outcomes as at 30th September 2018

Objective	Risks	Consolidated RAG Status	Public Space RAG status	Security RAG status	Concierge RAG status
A process has been established to ensure that all requests from third parties for access to / copies of CCTV footage are formally approved.	Images and Data are shared inappropriately with no audit trail of transactions.	There is no Council wide process supporting approval of third party requests for access to copies of CCTV footage.	<ul style="list-style-type: none"> There is a very robust process in place for the receipt and response to third party requests for access to footage. This process has not been assessed against recent legislation but formal approval for the request is obtained and retained. 	There is a process in place for requesting footage but there is no evidence that this has been signed by the Police to confirm evidence of receipt.	<ul style="list-style-type: none"> There is a written procedure included within the request forms showing the official process in place for Concierge staff and Police to follow. Requests are made in writing but there is no formal approval from the officer requesting the footage or for the Concierge making the copy. The process is not governed by a policy or aligned regularly with legislation. There is no SLA established with the Police to ensure consistent application of the process for requesting access to footage.
Processes and Procedures are in place providing guidance on the retention, archiving and destruction of CCTV footage	Lack of compliance with regulatory requirements (Data Protection Act) and Council Records	There is no formal Council wide procedure covering retention, archiving and destruction of CCTV footage in line with applicable regulatory requirements and Council policies.	<ul style="list-style-type: none"> There is a good procedure in place but it has not been formally documented. There is a gap around the destruction of CCTV footage, there is confusion 	<ul style="list-style-type: none"> There are no documented processes and procedures in place. All training is based on verbal update and 'on the job' experience. 	<ul style="list-style-type: none"> Footage downloaded and retained for evidence by the Police is subject to review and destruction. Images captured by cameras is kept for 31

Appendix 1 – Service Area Testing Outcomes as at 30th September 2018

Objective	Risks	Consolidated RAG Status	Public Space RAG status	Security RAG status	Concierge RAG status
	Management policies.		over where this responsibility lies.		days in accordance with the legislation however there is no official guidance for this and the process applied is not consistent with the other CCTV service areas.
Footage is retained, archived, and destroyed in line with policies and procedures	Breach of CEC policies and procedures resulting in fines and penalties.	There are no established Council wide procedures to ensure that footage is retained and archived in line with policies and procedures.	There is a good process in place for obtaining, retaining, and archiving footage, but there is no process in place for destroying footage resulting in the archive room almost reaching maximum capacity.	There are no written or communicated process in place applying the principles of CEC's Records Management Policy	There is a process in place for obtaining, retaining, and archiving footage but there are no policies and procedures to link this too and there is nothing in place to govern destruction of data.
CCTV footage can only be provided to approved parties and shared through secure channels	Breach of Data Protection act by inappropriate sharing of CCTV data	There are no established Council wide procedures to ensure that footage is only provided to approved parties and shared securely.	There are effective procedures in place to ensure footage is only provided to approved parties and is shared securely.	Footage is only provided to Police and will be shared via cd however this procedure is not documented and linked with current CEC Records Management policy	Process in place but not documented and linked to relevant legislation
An asset register has been established and regularly updated to reflect additions and disposals, record locality of all CCTV cameras and infrastructure.	Assets are lost or misappropriated without recourse through lack of asset management	There is no consolidated Council wide asset register detailing the CCTV equipment owned the Council, or the condition and location of the equipment.	There is no Public Space asset register, however SPIE are obliged to review the public Space CCTV and provide the section with a list of all equipment held. This has not been adequately completed. Complete, asset register is in place, awaiting photographic	There is no Security Services asset register,	There is a log of all cameras and equipment for the Calder Flats Concierge service

Appendix 1 – Service Area Testing Outcomes as at 30th September 2018

Objective	Risks	Consolidated RAG Status	Public Space RAG status	Security RAG status	Concierge RAG status
			evidence of condition of each camera		
Risk registers for all service areas include relevant CCTV related risks	Preventable risks may occur due to lack of risk management	There is currently no risk register supporting provision of CCTV Services across the Council, and the Boston consultancy report recommendations have not been progressed.	Appropriate CCTV risks are included in the Public Space risk register.	There are no risk registers in place for the Security Service.	There are no risk registers in place for the Concierge Service.

Appendix 2 - Basis of our classifications

Finding rating	Assessment rationale
Critical	<p>A finding that could have a:</p> <ul style="list-style-type: none"> • 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	<p>A finding that could have a:</p> <ul style="list-style-type: none"> • 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	<p>A finding that could have a:</p> <ul style="list-style-type: none"> • 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	<p>A finding that could have a:</p> <ul style="list-style-type: none"> • 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	<p>A finding that does not have a risk impact but has been raised to highlight areas of inefficiencies or good practice.</p>

Appendix 3 – Terms of Reference

Safer Stronger

Terms of Reference – CCTV Infrastructure Management and Maintenance

To: Harry Robertson, Interim Head of Service, Safer and Stronger

From: Lesley Newdall, Chief Internal Auditor

Date: 8th September 2017

Cc: Michelle Miller, Interim Chief Officer for the Health and Social Care Partnership

Bruce Strang, Chief Information Officer

Kevin Wilbraham, Record and Information Compliance Manager

Shirley McLaren, Community Justice Senior Manager

Will Boag, Security Manager

Jennifer Hunter, Tenant and Resident Services Manager

Alistair Gaw, Executive Director of Communities and Families

Stephen Moir Executive Director of Resources

Paul Lawrence Executive Director of Place

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

The City of Edinburgh Council (CEC) operates a close circuit television (CCTV) camera estate across public spaces; housing blocks; schools; bus lanes and Council buildings.

The total cost for the CCTV services provided by the Council is £833K and generates income of £128K. The police are the main users of CCTV footage to support criminal prosecutions.

Retention, archiving and destruction of CCTV footage is governed by the requirements of the Data Protection Act (1998) and will also require to be compliant with the new General Data Protection Requirements due to be implemented in May 2018. The Data Protection Act also governs sharing of CCTV footage with third parties.

Boston Networks was recently commissioned to review the CCTV estate used across the Council and its operational status, with the outcomes published in August 2017.

The report recommended implementation of a CCTV strategy to focus on the location and scope of control centres, and confirmed that significant investment is required across the estate to establish an effective and efficient service. The report also recommended moving from an historic analogue to an internet protocol (IP) based CCTV estate.

Scope

As the Boston Networks review has concluded on the requirement to develop a strategy and upgrade the existing CCTV estate, the scope of our review will focus on the controls in place to manage the following CLT top risks:

- Information governance

The City of Edinburgh Council

- Maintaining service with less resource

Testing will be undertaken on a sample basis for the period 1st April 2017 to 31st August 2017.

Limitations of Scope

The scope of our review is outlined above. Following publication of the Boston report our review will not assess the quality of the current CCTV estate infrastructure.

Approach

Our audit approach is as follows:

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

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

Sub-process	Control Objectives
Strategic alignment	<ul style="list-style-type: none"> • The CCTV service is subject to annual review to confirm that ongoing service provision and associated costs and benefits remain aligned with the Council's strategic objectives. • Risk registers for all service areas include relevant CCTV related risks.
Estate allocation and maintenance	<ul style="list-style-type: none"> • An asset register has been established and regularly updated to reflect additions and disposals, and record the location of all CCTV cameras and infrastructure. • Supporting rationale is provided for all requests for installation of cameras. • A clear prioritisation process has been established to support allocation of the estate across public spaces. • A process has been established to identify all damaged CCTV cameras and ensure that they are repaired in a timely manner.
Use and retention of CCTV footage	<ul style="list-style-type: none"> • CCTV footage is generated and stored in a secure environment with access restricted to only authorised personnel. • A process has been established to ensure that all requests from third parties for access to / copies of CCTV footage are formally approved.
Data Protection Act compliance	<ul style="list-style-type: none"> • There are documented processes and procedures in place supporting retention, archiving and destruction of CCTV footage. • There are documented procedures in place to ensure that CCTV footage is only provided to approved parties, and is shared in a secure manner. • Processes and procedures are regularly reviewed and updated to reflect legislative changes. • Footage is retained, archived and destroyed in line with policies and procedures.

- | | |
|--|--|
| | <ul style="list-style-type: none"> The location of all CCTV footage is recorded and updated to reflect issue to and receipt from third parties. |
|--|--|

Internal Audit Team

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

Key Contacts

Name	Title	Role	Contact Details
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Robert Meikle	Security Services	Key Contact	0131 529 7077
Jennifer Hunter	Concierge Services	Key Contact	0131 529 7532
Harry Robertson	Community Safety Senior Manager	Departmental contact	0131 553 8237
Michelle Miller	Safer Stronger	Head of Service	0131 553 8520

Timetable

Fieldwork Start	11/09/17
Fieldwork Completed	27/09/17
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:

- Risk registers for all three areas
- Budget statements for 1 April to 30 August
- Latest Regulation of Investigatory Powers Act Scotland (RIPSA) 2000 report
- Policy documentation
- Procedures for management of CCTV data/images
- Asset register for Criminal Justice, Security and Concierge CCTV services.

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

CGI Contract Management – Programme Management

Final Report

6 July 2018

ICT1702

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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 are 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

CGI is the City of Edinburgh Council's (the Council's) strategic technology service provider to whom the Council has outsourced operational management and delivery of its key ICT systems and infrastructure.

The Council's ICT vision is to deliver technology solutions that are based on understanding and responding to customer needs. The ICT & Digital (ICT&D) transformation programme (the Programme) is therefore aligned with the Council's strategic objectives and comprises a number of significant transformational technology projects designed to deliver the vision, and circa 500 smaller projects and change requests. The Council is fully dependent on CGI as their technology partner to deliver the Programme.

Since the contract commenced in 2015, CGI has underperformed on agreed contractual commitments. Transformation projects have often missed the original delivery dates, and, in some cases, the revised delivery date. This has meant that the Council has been unable to realise the benefits and/or savings envisaged.

As a result of performance issues experienced, the Council has escalated the situation to CGI Senior Management, and the Council's Governance, Risk, and Best Value Committee and, in January 2018, the framework governing management of the CGI relationship and their delivery of the Programme was refreshed.

At the time that this review commenced (April 2018), the Council and CGI had been developing improved programme monitoring governance processes for 3 months and ICT management had advised that governance practices had improved.

A review of Project and Programme Management and Benefits Realisation was completed in January 2018, and raised a High rated finding in relation to programme management. The agreed management response included an action to implement and embed standard programme management standards and processes, including RAID management and reporting across the Council's Portfolio of Change.

Management has advised that Programme reporting (including the risks; issues; and dependencies or RAID log) is consolidated with progress reporting for each of the projects included in the Council's Portfolio of Change, and forms part of the ongoing reporting provided to the Council's Change Board.

Scope

Given the criticality of Programme delivery for the Council, this review was scoped to assess the adequacy of the design of the Council's refreshed governance model in place to oversee CGI Programme delivery during the period January – March 2018, during April 2018.

Scope Limitations

Note that scope was limited as follows:

1. only the governance processes in place to monitor CGIs delivery of the transformation programme were included, other aspects of CGIs project management and service delivery were excluded from scope; and
2. due to the short timeframe under review and the ongoing development of governance processes and controls in place, this review was limited to an assessment of the design of governance controls. It was not possible to test their operating effectiveness.

To the extent that documentation for individual projects was reviewed in relation to the governance processes described, this review targeted the following 2 projects selected based on their stage of completion and stakeholder group impacts:

- Customer Transformation; and
- End User Computing.

2. Executive summary

Total number of findings

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

Summary of findings

Our review confirmed that the Council's refreshed governance model established to enable oversight of CGI Programme delivery is generally well designed with some moderate control gaps. Consequently, two medium and one low rated finding has been raised.

This outcome reflects the governance improvements implemented in the first quarter of 2018; management's awareness of the gaps in the design of the governance framework, and the ongoing need for improvement; and the significant level of effort in early 2018 to improve the relationship between the Council and CGI. Specifically:

- Senior CGI staff assigned to the Programme have changed entirely in 2018 following escalations to the CGI CEO at the end of 2017;
- CGI performance issues have been escalated by senior management to the Council's Governance, Risk and Best Value Committee;
- a 3 day off-site Council and CGI working group was held at the end of April, resulting in a number of agreed collaborative actions for change;
- ICT has improved the escalation process with additional fortnightly programme status and fortnightly risk review meetings to focus on some of the detail that is causing delays and poor quality deliverables; and
- ICT have worked with CGI to improve the quality of governance documentation through improved templates and quality review activities.

The need to further improve the recently refreshed CGI governance model is reflected in our first Medium finding, which identifies the need to clearly define how the model will operate, and the requirement to set expectations regarding the quality and timeliness of documentation to be provided by CGI to governance forums. There is also opportunity to move towards a more effective partnership working model via co location (where possible).

Our second Medium finding highlights the need to ensure that all relevant Council employees have access to update the ICT and Digital programme (the Programme) risks, issues and dependencies (RAID) log maintained by CGI, and that CGI are clear on the Council's expectations regarding its completeness and quality.

The content of the RAID log should also be improved to provide a more holistic view of risks, issues and dependencies across the Programme, providing the Council's Change Board with a clearer view of their potential impact across the entire Portfolio of Change.

We also noted a general lack of reporting to governance on benefits realisation. As this has already been raised in our review of Project and Programme Management and Benefits Realisation, completed in January 2018, it has not been raised again.

Our detailed findings and recommendations are laid out at Section 3: [Detailed findings](#).

3. Detailed findings

1. Joint governance model

Finding

Whilst the Programme governance reset has been beneficial and successful with a clear governance structure defined supported by good quality terms of reference, we have identified the following areas where further improvement is required:

Operating model definition and documentation

There is a written, mutual understanding of the combined CEC and CGI operating model (as documented in the Operational Framework Document), however, details in the governance section of the document are sparse.

During the review we noted the following ambiguities in the current governance process:

- lack of clarity on the process for collating and reporting Programme risks to governance committees;
- ICT staff performing quality review tasks that we would anticipate CGI would perform internally – e.g. relating to risk documentation, report preparation, dashboard template design; and
- a plan to bolster PMO capability within the ICT team where this is a service provided by CGI.

Quality of Governance Documentation *(note that these issues are self-identified by ICT)*

- papers are not always submitted by CGI on the agreed mailing date which undermines the effectiveness of the process as there is insufficient time for ICT to review the papers in advance of scheduled meeting dates;
- the Programme dashboard presented at the Programme Board is not a holistic view of the Programme, but a compilation of several project dashboards. This does not enable the Board to focus on the overall effectiveness and status of transformation including interdependencies between projects. Additionally, the quality of the RAID log taken to this Board should also be improved (as per finding 2 in this report)
- the Programme Board is a one hour meeting which does not provide sufficient time to review all of the transformation work in progress; and
- the Partnership Board reviews a report that is one month old i.e. the details discussed are not current but are statuses as at one month prior.

Business Implication

- Potential duplication of effort; additional costs; and lack of clarity re roles and responsibilities;
- effectiveness of programme delivery could be adversely impacted if governance processes do not operate effectively; and
- the Council’s ability to deliver transformation is not optimised.

Finding Rating

Medium

Action plans

Recommendations

1. The revised governance operating model should be fully documented and agreed with CGI. The model should cover committee operating rhythms; roles and responsibilities of key staff; PMO responsibilities and

Responsible Officer

Derek Masson,
Programme and Delivery
Manager, ICT Solutions

<p>deliverables; detailed governance processes; risk reporting and benefit monitoring; and the requirement to regularly review and refresh terms of reference and meeting schedules for the governance bodies;</p> <ol style="list-style-type: none"> A more relevant cut off date should be agreed for papers to be presented to governance committees; Sufficient time should be afforded to Programme Board meetings to allow for full review, discussion, and challenge on the papers provided by CGI; and Information should be presented at a Programme level in dashboard form, providing a holistic view across the Programme, to enable effective review, challenge and escalation where appropriate. 	
<p>Agreed Management Action</p>	<p>Estimated Implementation Date</p>
<ol style="list-style-type: none"> Recommendation agreed. In partnership with CGI, the existing Governance Operational Framework document will be expanded to include detailed coverage of the areas highlighted above; Recommendation agreed. A governance papers receipt tracker will be created, with any issues arising reported to the Partnership Board. Reporting packs are produced as at relevant month end, however, an addendum will be created to cover any significant updates relevant to the interim period between month end and the required date of the governance papers submission; Recommendation agreed. The duration of the Programme Board meetings will be extended to two hours; and Recommendation agreed. Programme Governance reporting will be presented to the Programme Board in a dashboard format. 	<p>31 October 2018</p> <p>31 October 2018 (Commencing as per September month end reporting pack.)</p> <p>31 August 2018</p> <p>31 October 2018</p>

2. Completeness and quality of Programme RAID log

Finding

Programme risks, issues, and dependencies are recorded in and reported from the CGI risk management system (RiskIT) by CGI project teams. Council staff do not have access to this system, and are secondary users of Excel excerpts generated from RiskIT provided by CGI. Consequently, Council employees are unable to contribute directly to a single source RAID log for the Programme

The RAID log provided by CGI, is a compilation of individual CGI project level technology RAID logs, with no clear evidence of programme level RAID entries or RAID entries which are non-technology items. The resulting output is, therefore, not a holistic CGI Transformation Programme RAID log.

The ICT team has identified a need to improve the quality of CGI RAID documentation to enable better understanding and communication between CGI; ICT; Council project teams and effective reporting to governance committees.

Our review of RAID logs dated March 2018, supports this view and identified the following issues with the RAID log content:

- poorly defined / ambiguous language;
- lack of explicit response - i.e. treat, accept, avoid or monitor;

- lack of clear actions with deadlines; and
- inconsistencies in the quality and type of information captured

CGI is the owner of the Programme RAID log and is responsible for quality of documentation. The Council does have a responsibility, however, to ensure that the content is of sufficient quality to enable effective reporting, monitoring and decision making.

ICT has implemented a fortnightly risk review meeting, providing a dedicated forum for ICT and CGI to review RAID logs together. However, improved quality at source is still something that CGI and CEC should work on.

Business Implication

Finding Rating

- The RAID log is incomplete;
- No holistic view of risks; assumptions; issues and dependencies across the Programme, and lack of understanding of the content of the RAID log and any potential impact on project / Programme delivery; and
- Risk of incomplete or inaccurate reporting to the Council’s Change Board.

Medium

Action plans

Recommendation

Responsible Officer

1. All CGI and Council project and programme management employees should have access to and be able to contribute to one single consolidated Technology Transformation Programme RAID log;
2. An agreed format for the structure of the RAID log and quality of content should be agreed between the Council and CGI. If possible, the structure of the RAID log should be aligned with the RAID log produced for the Council's Portfolio of Change;
3. ICT should provide robust ongoing challenge re the quality of RAID documentation, and where this isn't of sufficient quality, should request review and revision by CGI; and
4. ICT should liaise with the Council’s Strategic Change and Delivery Team to ensure that the refreshed ICT & Digital Programme RAID documentation is fully aligned with existing RAID reporting across the Council’s Portfolio of Change, supporting ongoing consolidation of RAID reporting for presentation to the Council’s Change Board.

Derek Masson,
Programme and Delivery
Manager, ICT Solutions

Agreed Management Action

Estimated Implementation Date

1. Recommendation agreed. The option for all CGI and Council project and programme management employees to be granted access to RiskIT, for the purposes of contributing to a single Programme RAID log will be explored. Failing this, an alternative means will be found to satisfy the requirements of the recommendation.
2. Recommendation agreed. Agreement will be reached between CGI and the Council on the structure and required content quality of the Programme RAID log. This will be recorded in a document which will also include risk parameter definitions and be approved by the Programme Board.

All actions to be completed by 31 October 2018.

3. Recommendation agreed. Ongoing challenge regarding the quality of the Programme RAID log will be facilitated at the bi-weekly Programme Risk meetings, with appropriate escalation to the Programme Board if required.
4. Recommendation agreed. ICT Solutions will liaise with the Council's Strategic Change and Delivery Team with a view to ensuring the RAID reporting across the Technology Transformation Programme is fully aligned with existing RAID reporting across the Council's Portfolio of Change.

Appendix 1 - Basis of our classifications

Finding rating	Assessment rationale
Critical	<p>A finding that could have a:</p> <ul style="list-style-type: none"> • 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	<p>A finding that could have a:</p> <ul style="list-style-type: none"> • 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	<p>A finding that could have a:</p> <ul style="list-style-type: none"> • 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	<p>A finding that could have a:</p> <ul style="list-style-type: none"> • 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	<p>A finding that does not have a risk impact but has been raised to highlight areas of inefficiencies or good practice.</p>

Appendix 2 – Terms of Reference

To: Stephen Moir, Executive Director, Resources
Bruce Strang, Chief Information Officer

From: Lesley Newdall, Chief Internal Auditor

Date: 19th March 2018

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

Background

CGI are the City of Edinburgh Council's (the Council's) strategic technology service provider and the Council have outsourced operational management and delivery of its key ICT systems and infrastructure to CGI.

The Council's ICT vision is to deliver technology solutions that are based on understanding and responding to customer needs. The ICT & Digital (ICT&D) transformation programme (the Programme) is therefore aligned with the Council's strategic objectives and comprises a number of significant transformational technology projects designed to deliver the vision, and circa 500 smaller projects and change requests. The Council is fully dependent on CGI as their technology partner to deliver the transformation programme.

Since the contract commenced, CGI have underperformed on agreed contractual commitments. Transformation projects have often missed the original delivery dates, and, in some cases, the revised delivery date and this has meant that the Council has been unable to realise the benefits and/or savings envisaged. As a result of performance issues experienced, the Council has escalated the situation to CGI Senior Management, and the Council's Governance, Risk, and Best Value Committee and, in January 2018, the framework governing management of the CGI relationship and their delivery of the Programme was refreshed.

Scope

Given the criticality of the Council's ability to deliver the Programme, this audit has been scoped to assess the effectiveness of the Council's approach to managing the contractual relationship with CGI, with specific focus on the Council's refreshed governance model and processes that facilitate oversight of the CGI Programme delivery.

To the extent that documentation for individual projects requires to be reviewed in relation to the governance processes described, this review will be targeted at the following 3 projects selected based on their stage of completion and stakeholder group impacts:

- Barclay Card;
- Customer Transformation; and
- End User Computing.

Limitations of Scope

- Interviews and follow up meetings with stakeholders will be limited to those we determine to be key or where we require further information to clarify processes and controls; and

- Only those processes, controls and activities within the control of the Council are included in scope. We will not review or comment on processes, controls or activities that are owned by CGI.

Approach

Our review will involve:

1. Desktop review of governance framework documents;
2. Discussion with the ICT management team and project stakeholders to understand the operation of the new governance framework across the Programme and individual projects; and
3. Review of Programme and project documentation that supports operation of the governance framework.

Sub-process	Focus Area
Programme governance	<p>We will:</p> <ul style="list-style-type: none"> • Review the new CGI governance framework applied by the Council and CGI with focus on oversight of CGI programme delivery; • Assess how the governance framework is designed to identify and escalate risks, issues, and dependencies in CGI's Programme delivery; • Determine that governance arrangements specify clear roles and responsibilities at all levels for both the Council and CGI and allows for effective and timely decision making throughout the duration of the Programme; and • Obtain and review a sample of key documents to confirm that the Programme governance framework is effectively and consistently applied.
Project Costs	<p>We will:</p> <ul style="list-style-type: none"> • Consider how the governance framework ensures that costs associated with change requests are either covered by the output based specification (OBS) aspect of the CGI contract, or should be separately costed on a commercial basis; • Confirm that the governance framework includes monitoring of CGI costs across the programme; • Sample test costs associated with the three technology projects in scope to confirm that all additional costs in relation to CGI deliverables have been reviewed and approved by the Council; and • Verify that there is an audit trail from the additional billed costs sampled (above) to approved change order or budget variance order.
Risks, Issues and Dependencies	<p>We will:</p> <ul style="list-style-type: none"> • Obtain and review the Programme risk, issues and dependencies register(s); • Assess how the Council confirms that Programme risks, issues and dependencies are effectively identified; assessed; escalated; managed and mitigated by CGI; • Review the Council's process for monitoring Programme risks, issues and dependencies to ensure they are actioned appropriately prior to closure; and • To validate understanding obtained above, obtain and review risk, issues and dependencies registers for three technology projects and sample test a subset of key risks, issues and dependencies to ensure that they are

	appropriately managed and escalated through both the project and Programme governance structure as required.
Resource planning	<p>We will:</p> <ul style="list-style-type: none"> • Determine how the Council ensures that CGI has allocated appropriate resources across the Programme and to individual projects; • Review how issues in resource planning and resource utilisation are escalated through governance; and • Test for three technology projects that resource issues have been escalated in line with the governance model.

Internal Audit Team

Name	Role	Contact Details
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Timetable

Fieldwork Start	20 th March 2018
Fieldwork Completed*	13 th April 2018
Draft report to Auditee**	13 th April 2018
Response from Auditee	27 th April 2018
Final Report to Auditee	4 th May 2018

* Agreed timescales are subject to the following assumptions:

- All relevant documentation, including source data, reports and procedures, will be made available to us promptly on request.
- Staff and management will make reasonable time available for interviews and will respond promptly to follow-up questions or requests for documentation.

- The subset of stakeholders selected for follow-up discussions will be available to conduct these discussions during weeks commencing 3rd April and 9th April.

** Draft report will be in the form of draft findings on 13th April. Draft report will be available on 20th April.

The City of Edinburgh Council

Internal Audit

Foster Care Review

Final Report

11 May 2018

CF1702

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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 Looked After and Accommodated Children service is currently developing a new strategy focusing on early and intensive intervention to ensure that fewer children and young people become 'looked after'. The new strategy will consider the increasing child population; the implications of Self Directed Support; Children and Young People (Scotland) Act 2014 requirements; and the increasing number of Unaccompanied Asylum-Seeking Children.

A key element of this strategy is ensuring that where a child requires to be 'looked after', appropriate kinship or foster care arrangements are established with suitable kinship or foster carers directly engaged by the Council, reducing the need to source care arrangements from costly external providers.

Vetting, Approval, and Agreement Processes

Standard processes are applied to ensure that all potential foster and kinship carers are thoroughly vetted; formally approved by Agency Decision Makers (ADMs) following assessor and panel recommendations; and that formal care agreements supporting the arrangements are signed.

Foster and kinship carer vetting is performed by Social Workers with the outcomes recorded in assessment reports. Vetting involves confirmation of identity; completion of relevant protection of vulnerable groups (PVG) disclosure checks; receipt and review of personal references; and completion of local authority, household, and background checks per LAC regulation requirements.

All completed assessment reports and supporting recommendations for foster and kinship arrangements should be signed by the Assessing Social Worker and reviewed and signed by a Family Based Care (FBC) or Kinship Care Team Leader. For foster carers, the report should also be shared with and signed by the applicants prior to panel review and approval.

A formal agreement is signed by both the foster and kinship carer and the Council prior to placement of children, to confirm that both parties fully understand their respective responsibilities.

Payments to Carers and Arrangements for Young People

Foster and kinship carers are paid by the Council as self-employed individuals. The amount paid is based on a standard table of rates. Different rates apply according to the nature of care provided and age bands. Additional ad hoc payments are also made to cover additional costs incurred (for example holidays or travel).

All payments made to carers are authorised by Social Workers and processed by the Carer Payment Team (CPT) who report through Resources. Social Work Practice Teams are also required to review unauthorised payment reports in advance of payment runs to confirm that all placement changes they requested have been completely and accurately processed by the CPT.

Continuing care legislation requires that authorised arrangements for payments in respect of young people over 18 years must be established prior to the young person's 18th birthday.

Social Workers are responsible for ensuring that these arrangements are established on time by completing authorisation requests and supporting questionnaires in Swift. The CPT monitor and ensure that this workflow progresses to Senior Managers for authorisation, and process new payment rates once approved.

Scope

The scope of this review assessed the design and operating effectiveness of the key controls established to support management of foster care provision and carer payments, and mitigate the following risks:

- harm to children in our care and their carers;
- increased use of higher cost service provision;
- failure to manage budgets; and
- non-compliance with applicable legislation.

Testing, where appropriate, was performed for the period October 2016 to January 2018.

The full terms of reference are included at appendix 2.

2. Executive summary

Total number of findings

Critical	0
High	1
Medium	2
Low	1
Advisory	1
Total	5

Summary of findings

Significant progress is evident in relation to the implementation of the looked after and accommodated children (LAAC) transformation, with reports to the Education, Children & Families and GRBV committees in August and December 2017 confirming that many of the targets had been achieved or exceeded, with a reduction in the number of children in foster care; an increase in kinship care placements, and a reduction in the use of secure care. However, the service was behind target to reduce the percentage of independent (non-Council) foster care and residential care placements.

As part of the Council balance of care strategy, foster care is proactively promoted with the objective of establishing appropriate foster care arrangements directly with the Council. To support vulnerable, looked after children, (either through kinship or foster care) it is essential that thorough and legislatively compliant vetting and approval processes are established and consistently applied, with clear carer agreements in place that are signed by both carers and the Council. It is also important to ensure that the costs associated with foster and kinship care are effectively managed, including completeness and accuracy of payments to carers.

Our review of the foster and kinship care vetting, approval and agreements process identified some significant control weaknesses that could potentially result in approval of carers who have not been thoroughly vetted; and potential non-compliance with applicable Looked After Children Legislation.

It should be noted however, that effective post carer approval monitoring and review processes have been established, and are consistently applied to ensure that carers are fully supported and continue to meet children's needs. All placement referrals are actively prioritised and monitored at weekly management and panel review meetings until an appropriate solution for the child is identified.

Our review of payment processes also identified some moderate control weaknesses (notably failure by Social Workers to evidence review of weekly and 4 weekly unauthorised payment reports) that could result in unauthorised or inaccurate payments being made. Whilst some control weaknesses have been identified, we noted that there are comprehensive payments process notes in place, and that effective reconciliation controls are applied to confirm that payments recorded in SWIFT are accurately transferred across to the Oracle purchase ledger for final payment. There are also effective controls in place supporting the addition and removal of foster and kinship carers.

Additionally, we identified that financial arrangements for continuing care are not being consistently established and reviewed by Social Workers as required per applicable legislation; and that the process to recover overpayment of carer payments is not consistently applied.

Consequently, one High; two Medium and one Low rated findings have been raised. An Advisory recommendation has also been included, highlighting best practice improvement opportunities identified. Our detailed findings and recommendations are laid out at Section 3 below.

3. Detailed findings

1. Foster & Kinship Care Vetting, Referral, Approval, and Agreements

Finding

A sample of ten foster care and ten kinship care arrangements were selected and reviewed to confirm that the vetting and assessment and approval processes had been completed as per established processes and applicable Looked After Children regulatory requirements. Care agreements were also reviewed to confirm that these had been completed and signed by both parties.

A sample of ten assessment of need and risk forms were selected and reviewed to confirm that kinship care placements had been considered and discounted prior to a request for foster care placements.

The following Significant control gaps have been identified:

- 1. Foster Carer Vetting** – In one instance, the required checks had not been fully completed, despite the carer being granted approval in principle. No placements had yet been approved for this carer due to a post panel disclosure.

For a further four cases, the assessment reports were incomplete and did not include the outcomes of all checks performed, although evidence was available elsewhere for three of the four cases (e.g. SWIFT and paper files) that satisfactory checks had been completed.

- 2. Kinship Carer Vetting** – In one case, a family member disclosure was outstanding and the final decision was subject to acceptable medical checks for another family member. The Referring Social Worker noted that she was not aware that the disclosure should have been progressed by the Practice Team, and this is now being actioned.

A second assessment report was also incomplete as not all relevant health assessment information had been included, however it was confirmed that this information was passed to the Agency Decision Maker (ADM) with the report.

- 3. Foster Carer Assessment and Decisioning** – applicant review and approval of assessment forms was not evident in 60% of the sample reviewed, and there was no evidence of Social Worker and Team Leader sign off for 50% of the sample.

- 4. Kinship Carer Assessment and Decisioning** – two assessment reports (20% of the sample) did not include the names of the Social Workers who had performed the assessment or the Team Leader who had performed the review. Names were type signed in word documents for the remaining 8. There was also no evidence of electronic sign off supporting eight ADM decisions; names were also type signed.

- 5. Foster Carer Agreements** - Five of ten agreements had been signed by both the Council and the carer, and three had been signed by the carer only. Two agreements were not found. One of these, was not finalised as a post panel disclosure has resulted in no placements being offered, however,


one could not be located as no paper file had been created and a child had been placed with carers without an agreement being in place.

6. Kinship Carer Agreements - No evidence was provided to confirm that kinship agreements are routinely completed and signed by both parties. Of the nine Practice Team Social Workers contacted, only three responded, and confirmed that agreements were not in place. Two committed to rectifying the omission, and one signed agreement has subsequently been put in place. In one case, it was noted that the family were not willing to progress with kinship arrangements.

7. Review of Carer Agreements – Kinship and foster carer agreements have not been revised since October 2009, when current LAC regulations came into force. LAC guidance requires the content of agreements to be reviewed at intervals by authorities.

Current agreement templates are between the Children and Families Department and carers, which does not accurately reflect the current Council structure.

8. Assessment of Need and Risk Forms - The Practice Team Social Worker (PTSW) is required to tick a box on the referral form to confirm their Line Manager agreement to the referral, however this process does not provide adequate evidence of Line Manager review and approval.

Business Implication	Finding Rating
<ul style="list-style-type: none"> • Potential foster and kinship carers are not thoroughly vetted; • Incomplete assessment reports are presented to the panel and ADM for approval and decision; • Foster and kinship carers are not fully aware of their own and the Council’s responsibilities; • Potential non-compliance with LAC regulations; and • Referrals for foster care placement are submitted without appropriate authority. 	

Action plans

Recommendation	Responsible Officer
<p>1. And 2. Existing foster and kinship carer vetting processes should be reviewed, updated, and implemented across all Social Work teams. The processes should specify all necessary checks to be performed and the requirement to record and retain the outcomes. Document retention methods that meet current Data Protection and future General Data Protection Requirements should also be included in the revised process documentation.</p> <p>3. And 4. Assessment reports and agency decisions should not be approved until all necessary vetting has been fully completed. A formal review of all assessment reports should be performed by line management prior to submission to panel and ADM to confirm that all vetting outcomes are completely and accurately reflected in the report. Additionally, assessment reports should be signed as evidence of this review.</p> <p>5. And 6. A check should be established to confirm (prior to any placements being offered) that foster or kinship care agreements signed by both the carer and the Council are in place, and that a copy of the signed agreement has been issued to the carer and securely retained by the Council.</p>	<p>Family Based Care Team Manager (Foster Care) - 1, 3, 5 & 7</p> <p>Family Based Care Team Manager (Kinship Care) – 2, 4, 6 & 7</p> <p>Senior manager for Children’s Practice Teams - 6 & 8</p>

7. Existing foster and kinship care template agreements should be reviewed and refreshed (at least annually) to confirm that their content remains aligned with applicable Looked After Children (LAC) legislation and current Council structure.
8. The Line Manager of the PTSW should be copied into the email referral to evidence their agreement and approval of the referral.

Agreed Management Action

Estimated Implementation Date

1. Foster Care Vetting

Family Based Care process for checking carers has been updated and revisions included in service End to End procedures. Specific actions include all statutory checks (PVG, Medical and Local Authority) having to be requested immediately at recruitment screening stage and three months prior to Carer Review. This will eliminate checks not being available as evidence for Fostering Panels. FBC Team Leader quality assurance checklists for foster care assessments have been updated to require sight of signed copies of assessment reports prior to Panel submission. Team Leaders will review in supervision that signed copies of all completed assessment reports are held in the Carers paper file.

31 May 2018

2. Kinship Carer Vetting

Assessment reports are checked by the Team Leader before forwarding to panel and/or ADM. This will ensure that statutory checks are included as well as being referred to in the assessment. Team leaders will also ensure that all submissions are signed by the assessor and countersigned by themselves. Team leaders will be informed from now that they will sign all assessments. Assessors are, in the main, engaged outwith FBC and commissioned via a fixed fee format for their completed assessments. Some are employees of CEC and others are not. A plan will be developed to enable them to create and use an electronic signature or similar sign off method.

30 September 2018

3. Foster Care Assessment and Decisioning

FBC Team Leader quality assurance checklists for foster care assessments have been updated to require sight of signed copies of assessment reports prior to Panel submission. Team Leaders will review in supervision that signed copies of all completed assessment reports are held in the Carers paper file and required in End to End processes. Additional, regular file auditing undertaken internally with this the service will quality assure procedures are being implemented.

31 May 2018

4. Kinship Assessment and Decisioning

Kinship assessors will be asked to sign and include their name with all of their assessment submissions. Team Leaders will also be asked to sign and include their name when endorsing the assessment. This will be incorporated into Kinship processes.

30 September 2018

5. Foster Carer Agreements

End to End procedures specify that a Carer Agreement must be signed by the carer and CEC, a copy provided to the carer and the original held on file.

30 June 2018

6. Kinship Carer Agreements

Procedures to be reviewed and updated to specify that a Carer Agreement must be signed by the carer and CEC, a copy provided to the carer and the original held on file.

30 September 2018

6. **5 & 6** Formal checks will be implemented (prior to placements being offered) to ensure that all foster and kinship carer agreements have been signed by both the carer and the Council, and that a copy of the signed agreement has been issued to the carer and securely retained by the Council.

7. Review of Carer Agreements

The content of the current Carer Agreement is compliant with requirements of Schedule 6 of the Looked After Children (Scotland) Regulations 2009. The contents of this document will be reviewed alongside the development of revised information to support Continuing Care placements.

31 May 2018

The Kinship carer agreement document will be reviewed separately to this but within the same timescale.

31 May 2018

8. Assessment of Need and Risk Forms

The process of Line Manager agreement will be reviewed to provide evidence of approval for the referral, Team Leaders will be copied into the email referral to Intake.

30 June 2018

2. Carer Payments

Finding

1. Payments to Carers

A sample of 25 ad hoc payments were selected for review from the monthly business objects reports that detail all additional payments made. Review of the sample established that:

- In one case, Senior Manager authorisation for continued extra weekly payments of £393.74 could not be found and it was noted that authority may have been verbal. A future review date required for this payment had also not been recorded in Swift. This has now been corrected.
- Payment review dates are not consistently provided to the CPT by Social Workers, and confirmation that additional payments should continue is not consistently provided in advance of the specified review or end date.


2. Social Worker Review of Payments

Social Work Practice Teams are required to review unauthorised payment reports in advance of weekly and four weekly payment runs to confirm that all changes they requested have been completely and accurately processed by the CPT.

Evidence of checks performed should be recorded on a tracker and any issues identified raised with the CPT and addressed prior to release of payments. If there are no issues, this should be recorded on the tracker to evidence completion of the review.

Review of four weekly and one four weekly trackers across four Practice Teams and the disability team (25 entries across 5 trackers) confirmed that:

- Team sections within the 5 unauthorised payment reports tested had not been reviewed as required prior to payment in 14 of 25 instances;
- There was no evidence of completion of any checks by one Practice Team; and
- Only one team from the five had checked the four-weekly report selected for review.

Business Implication	Finding Rating
Unauthorised or inaccurate payments are made to carers that may not be recovered.	
Action plans	
Recommendation	Responsible Officer
<ol style="list-style-type: none"> 1. Authorisation should be provided by FBC and Practice Team Managers in advance of any additional payments being made. Evidence of authorisation should be retained by the CPT. 2. An escalation process should be established and implemented to ensure that updates, and approvals for extensions to additional payments are provided by FBC and Practice Team Managers or Team Leaders to the CPT prior to the review / end date recorded on SWIFT. 3. The requirement for Practice Team Business Support to review unauthorised payment reports and evidence their review via the tracker should be reinforced. Practice Team Managers should also review the trackers prior to payment to ensure that all Social Work team members have performed the necessary review. Any instances where the review has not been performed prior to payment should be addressed via the performance management process. 	Neil Kirkpatrick, Business Support Team Manager – 1, 2 & 3
Agreed Management Action	Estimated Implementation Date
<ol style="list-style-type: none"> 1. CPT are currently revising their processes. Going forward, all payment updates will be provided by Social Workers on Carer Fee Payment forms rather than via email, and future review dates noted on this form for entry to Swift. This process is still being embedded. 2. The CPT will run a report with payment review dates on a monthly basis for the month ahead and send it to the appropriate Team Manager and Team Leader highlighting the need for a member of their team to review the service/payment and complete the appropriate paper work as required. 3. The CF Central Business Support Team Manager has issued an email reminding all Business Support Team Managers that this process is necessary to confirm completeness and accuracy of carer payments and request their team's weekly returns. The weekly returns will be copied to the relevant CPTM when emailing to the CPT. The CPT will track the returns and liaise with the appropriate teams when information is not received. 	<p>31 May 2018</p> <p>31 May 2018</p> <p>31 May 2018</p>

3. Arrangements for Young People

Finding

Eight entries were selected from a December 2017 report produced by the CPT detailing costs for all young people 17 and over. Review of this sample established that:

- One 18-year old was incorrectly categorised as a mainstream placement rather than 18+ Foster Care, as an authorisation request and questionnaire provided was not supported by adequate information.
- One questionnaire had been completed and entered into Swift, but had not been set up as a workflow request for authorisation, and had therefore been missed. This has now been escalated for review.
- Two approved 18+ placements had future review dates recorded in Swift, however, this date field is not currently monitored. One of the cases was due for review in the month tested and had not been actioned yet.

In addition to the above testing, it was noted that for 20 placements correctly categorised as 18+ Foster Care on this report, three were not supported by evidence of LAC Manager approval, and seven had expired approvals on SWIFT.

Whilst placements with external providers were not included within our scope, it should be noted that these issues also apply to these arrangements. As at December 2017, we identified four external placements for 18-year olds that were incorrectly categorised as foster care provision rather than 18+ foster care.

Business Implication

Appropriate arrangements are not established as per the timeframes specified in continuing care legislation.

Finding Rating

Medium

Action plans

Recommendation

1. Existing processes should be reviewed and refreshed with appropriate management oversight implemented to ensure that future plans for young people are prepared, reviewed and implemented within the required regulatory timeframes.
2. A review of all young people aged 17 and over should be performed to confirm appropriateness of existing arrangements and address any instances of missed reviews based on the dates recorded in SWIFT.
3. Trigger dates based on dates of birth should be recorded in Swift for each placement, and an exception report designed, implemented, and provided to Social Work Practice Teams to ensure that future reviews are completed on time.

Responsible Officer

Neil Kirkpatrick,
Business Support Team
Manager – 1 & 3

Looked After Children
Service Manager - 2

Agreed Management Action

1. As of March 2018, the process includes the +18-year authorisation report being sent to CPTMs for them to review any placements without the required authority and action as appropriate.

Estimated Implementation Date

31 May 2018

2. All placements of 17-year olds to be reviewed and taken to the CPTM meeting to discuss requirement and timescales.	31 July 2018
3. There is an exception report available through Business Objects detailing any +18-year placements recorded on Swift incorrectly as Looked After and Accommodated Children. This report is on the Business Support Team report matrix to be run weekly. The Business Support Relationship Manager has this diarised to run quarterly and liaise with any teams that need placements updated on Swift.	31 May 2018

4. Recovery of Overpayments

Finding

Carer payments are paid weekly or four weekly in advance. Where a foster placement ends and there is a subsequent placement, any overpayment is offset against future payments for the next placement. For kinship carers where placements are made for specific children, overpayments consistently occur when the placement ends.

A payment booklet issued to all carers notes that overpayments must be repaid within eight weeks.

Where an overpayment requires to be recovered, a letter detailing the amount due is issued to the carer. No timescale is specified for receipt of payment. If no payment is received, a reminder letter is issued noting that a debtor account will be raised in the Council Accounts Receivable system if the debt is not settled in 14 days. Outstanding payments remain on an exception report until settled.

Five overpayments in respect of kinship care totalling £3,567.15 in value were selected from a prepayment run exception report as at 05/10/17. A total of 99 overpayments in respect of 48 foster, kinship and respite carers, and prospective adopters with a value of £53,622.60 were included in this report. The most historic overpayment included in the report that had not been recovered was for £596.34 and dated back to August 2016.

Review of this sample established that appropriate action to offset or recover overpayments was being taken, however:

- In two cases, reminder letters had not been issued as at mid-January 2018 in respect of overpayments to July and October 2017 for £416.83 and £456.36 respectively
- For an overpayment to May 2017 for £822.29, overpayment and reminder letters were issued in June and August 2017, however, an accounts receivable debtor account was not raised until October 2017.

Business Implication	Finding Rating
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Overpayments are not effectively monitored to ensure prompt settlement of debt.



Action plans

Recommendation	Responsible Officer
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- | | |
|---|---|
| 1. Existing processes in relation to recovery of overpayments should be reviewed, updated, and implemented. Process changes should include the requirement for enhanced weekly review of exception reports to | Neil Kirkpatrick,
Business Support Team
Manager - 1,2,3 & 4 |
|---|---|

<p>ensure that overpayment and reminder letters are issued, and debtor accounts created on a timely basis;</p> <ol style="list-style-type: none"> 2. A timescale for receipt of payments should be detailed in the first overpayment letter issued, and this due date used to inform the timely issue of a reminder letter if required; 3. The overpayment process outlined in the carer payment booklet should be reviewed. Consideration should be given to reducing the current eight week repayment timescale; and 4. Sample checks should be performed by management monthly to confirm that the overpayments process is being consistently applied. 	
Agreed Management Action	Estimated Implementation Date
1. The process will be updated to reflect overpayment letters being sent within 2 weeks of the overpayment being realised. A weekly report of overpayments will be run and passed to FBC Team Manager for timescale of payment from the carer.	30 June 2018
2. The initial overpayment letter will be updated to request that payments be received within the timescales set out by FBC Team Managers as detailed below.	30 June 2018
3. Timescales of repayments will be agreed by FBC Team Manager dependent on individual circumstances. The rates booklet will be updated to reflect this change. Any write off is to be authorised by Senior Manager.	30 June 2018
4. The process will be updated with the Business Support Team Manager / Officer conducting a monthly spot check of the overpayment process.	30 June 2018

5. Best Practice Improvement Opportunities

Finding	
<p>Use of Electronic Signatures</p> <p>Given the high volume of documents that require to be signed as part of the foster and kinship vetting; approval; agreement, intake referral; and payment processes, significant benefit would be gained from implementation and use of electronic signatures.</p>	
Business Implication	Finding Rating
Processes could be completed without a record being held to evidence that the required level of review and formal sign off has been performed.	<div style="background-color: #e0e0e0; padding: 10px; width: fit-content; margin: 0 auto;"> Advisory </div>
Action plans	
Recommendation	Responsible Officer
Implementation of electronic signatures should be considered across FBC and Social Work Practice Teams.	Freeha Ahmed, FBC Business Support Team Manager

	Neil Kirkpatrick, Practice Teams Business Support Team Manager
Agreed Management Action	Estimated Implementation Date
A review of all documents requiring approval will be performed to determine the feasibility of implementing electronic signatures for all authorising managers. Where electronic signatures are implemented, the original signature will be retained on the managers H drive to ensure that they cannot be copied and / or used inappropriately.	30 September 2018

Appendix 1 - Basis of our classifications

Finding rating	Assessment rationale
Critical	<p>A finding that could have a:</p> <ul style="list-style-type: none"> • 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	<p>A finding that could have a:</p> <ul style="list-style-type: none"> • 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	<p>A finding that could have a:</p> <ul style="list-style-type: none"> • 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	<p>A finding that could have a:</p> <ul style="list-style-type: none"> • 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	<p>A finding that does not have a risk impact but has been raised to highlight areas of inefficiencies or good practice.</p>

Appendix 2 – Terms of Reference

Communities & Families

Terms of Reference – Foster Care Review

To: Alistair Gaw, Executive Director of C&F

From: Lesley Newdall, Chief Internal Auditor,

Date: 21st September 2017

Cc: Andy Jeffries, Scott Dunbar, Neil Bruce, Russell Sutherland, Sean Bell, Nicola Harvey, Louise McRae, Jane Brown, Brendan O'hara

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

The primary strategic objective for looked after & accommodated children (LAAC) is to shift the balance of the Service from relatively high cost, external providers to high quality local services, and to deliver consistent early and intensive intervention approaches so that fewer children and young people (C&YP) need to be accommodated. Where C&YP do need to be accommodated, to make sure they are accommodated within existing Council (CEC) LAAC services.

A transformation programme to achieve this change commenced in 2013. Regular progress updates are provided to the Education, Children & Families and Governance Risk & Best Value committees.

The latest update reported that many of the targets had been achieved or exceeded, including an overall reduction in the LAAC population; a reduction in the number of children in foster care; an increase in kinship care placements, and a reduction in the use of secure care. However the service was behind target to reduce the percentage of independent foster placements and reduce use of residential care placements.

As a result, the service is in the process of developing a new strategy and targets to continue to reduce the need for children to become Looked After taking into account factors such as the rising child population; the implications of implementing Self Directed Support; the requirements of the Children and Young People (Scotland) Act 2014; and the increases in Unaccompanied Asylum Seeking Children.

Scope

The scope of this review will be to assess the design and operating effectiveness of the controls in place for the management of foster care provision and payments to carers, to mitigate the risks of:

- harm to children in our care and their carers;
- increased use of higher cost service provision;
- failure to manage budgets; and
- non-compliance with legislation.

These risks are encompassed in a key strategic / operational risk included in the C&F SMT risk register in relation to the balance of care: 'Much of the cost of care of children and young people is demand-led and relies on expensive external providers. If the balance between enabling and commissioning levels of care is not optimal the Council may not be able to sustain adequate levels of service. There has been an increase in unaccompanied asylum seekers which is increasing the need, this includes asylum seeking children. The impact of any imbalance of care could increase violent incidents further'.

Our audit approach is as follows:

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

Testing, where appropriate, will be undertaken for the period October 2016 to September 2017.

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

Sub-process	Control Objectives
Manage supply	<ul style="list-style-type: none"> • An appropriate strategy is in place to manage the balance of care for looked after children; • Appropriate vetting processes in place ensure that in-house carers recruited meet required service standards; • Processes are in place to collate and assess all needs and risks in relation to each looked after child; • All identified needs and risks are provided to family based care to ensure that kinship care and foster care placement decisions best meet the needs and welfare of the looked after child; • Emergency placements can be accommodated when required; • Robust processes are in place to re-allocate resources effectively where placements come to an end; and • All relevant sections are notified in a timely manner where a child ceases to be looked after.
Support & Monitor	<ul style="list-style-type: none"> • Appropriate support is given to in-house foster carers, kinship carers and the looked after children in their care for the duration of placements; and • There are regular reviews of placements and plans in place to ensure that they continue to fulfil the child's needs and welfare.
Management of Welfare Concerns	<ul style="list-style-type: none"> • Robust child protection processes apply where allegations are made against foster / kinship carers.
Payment	<ul style="list-style-type: none"> • All allowances and fees paid to in-house and kinship carers are in line with agreed rates in place; • All payments made are subject to review and regular reconciliation; and • Payments are stopped on time when a placement ends.
Governance	<ul style="list-style-type: none"> • All relevant policies and procedures are up to date and complied with; • Processes are in place to ensure compliance with applicable legislation; and • Key risks identified are subject to ongoing review by the Senior Management Team.

Limitations of Scope

The scope of our review is outlined above and is limited to a review of foster care provided by the Council, and kinship care. Additionally, the following areas are specifically excluded from scope:

- Records management - social work records within Children & Families are currently being audited separately, and
- External foster care providers - this area was subject to audit review in 2016.

Internal Audit Team

Name	Role	Contact Details
Lesley Newdall	Chief Internal Auditor	0131 469 3216
Hugh Thomson	Principal Audit Manager	0131 469 3147
Christine Shaw	Internal Auditor	0131 469 3075

Key Contacts

Name	Title	Role	Contact Details
Andy Jeffries	Interim Head of Children's Services	Review Sponsor	0131 469 3388
Scott Dunbar	Service Manager Looked After Children	Key Contact	0131 469 3123
Neil Bruce	Team Manager, Family Based Care	Key Contact	0131 529 2137
Russell Sutherland	Team Manager, Family Based Care	Key Contact	0131 469 3076
Louise McRae	Business Support Manager, Customer	Key Contact	0131 529 2109
Brendan O'hara	Senior Accountant, C&F	Key Contact	0131 469 3620

Timetable

Fieldwork Start	18 th September 2017
Fieldwork Completed	13 th October 2017
Draft report to Auditee	27 th October 2017
Response from Auditee	10 th November 2017
Final Report to Auditee	17 th November 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 Directorate and Senior Executive Officer. The Senior Executive Officer 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:

- Any relevant documented processes.

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

Project & Programme Management and Benefits Realisation

Final Report

30th January 2018

CW1701

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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

Delivery of effective transformation and change is essential to ensure that the City of Edinburgh Council (the Council) can deliver on its pledges and strategic objectives whilst maintaining and improving the services it delivers at a lower cost and with less resources.

Audit fieldwork involved a review of project governance across 4 significant projects included in the Council's portfolio of change between July and November 2017, and a themed review of project benefits that was completed in October 2017. The conclusions detailed in our [Executive Summary](#) represent the consolidated themes emerging from these reviews, and are based on evidence provided during that period.

Strategy and Insight Management have advised that they are developing a new approach to the management of change. We have not assessed the adequacy of their plans, however the new approach forms the basis of their management responses to our Internal Audit findings and recommendations.

At the time of the Audit the Council's Portfolio of Change consisted of 26 projects in the implementation phase, with a further 17 significant potential change projects identified. There are also a significant number of (unquantified) projects being delivered by Service areas that were not tracked via the Council's Portfolio of Change.

The Portfolio and Governance (P&G) team within Strategy and Insight is responsible for oversight of the Council's Portfolio of Change, and providing portfolio progress updates to the Council's Change Board (essentially the Corporate Leadership Team) and elected members at the Governance, Risk, and Best Value Committee (GRBV).

Identification of expected benefits is a key requirement to support the decision as to whether proposed projects should be approved and implemented. A benefit can be financial or non-financial and is defined as a tangible and measurable effect resulting from a proposed project or business change. Expected benefits should always be clearly defined, allocated owners and documented in the project business case.

Ensuring effective delivery of the change required to achieve realisation of the benefits identified is a key aspect of project management. Benefits management within projects involves implementing the necessary business changes to support delivery of the benefits identified and recorded in the business case; tracking benefits during the life of the project to ensure they remain relevant; and (importantly) reviewing them post implementation to confirm that all expected benefits have been realised. This would normally be achieved by completion of a formal post implementation review within a year of formal project / programme closure.

The rebased 2017/18 Internal Audit plan approved by GRBV in November 2017 includes seven project reviews. Four of these have now been completed, with a number of project governance themes identified and raised as Findings. The four projects reviewed were:

1. Ross Bandstand
2. Customer Transformation
3. St James
4. Zero Waste

A review of project benefits realisation is also included in the plan.

The themes resulting from the four project reviews and outcomes from the benefits realisation review have been consolidated and are included in this report.

Scope

The scope of the project management and benefits realisation reviews assessed the design and operating effectiveness of project governance controls established to mitigate the following key CLT risk:

- Transformation and change agenda.

Benefits testing was performed on a sample basis across current and completed projects within the Change Portfolio and projects being delivered by Service Areas for the period 1st September 2016 to 31st August 2017, and our report reflects the position as at 31st August 2017

2. Executive summary

Total number of findings

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

Summary of findings

Given the current scale of transformation across the Council, it is essential that an adequate and effective project and programme management framework is established to support consistent application of standard project management principles across all projects and programmes, and support effective management of transformation risk.

A key element of effective project and programme management is ensuring that the necessary business changes are delivered to enable realisation of expected benefits. Given the significant cost challenges currently facing the Council (circa £21m savings required in 2018/19 and a further £140m over the next five years) it is crucial that effective benefit management is consistently applied and embedded.

Additionally, once projects or programmes have been approved, benefits should be monitored at various stages throughout the project lifecycle to ensure that they remain valid, and also post implementation to confirm that all outstanding benefits are being delivered in line with the benefit realisation plan as part of ongoing operational activities.

Our review of project governance and benefits realisation has identified a number of significant control gaps in the existing project and programme management framework, and across projects and programmes being delivered both within the Council Change Portfolio and independently by service areas. These control gaps could adversely impact effective delivery of projects and realisation of associated benefits, and immediate action is required to ensure that these are addressed.

Consequently, two 'High' rated Internal Audit findings have been raised (further detail is included at [Section 3: Detailed findings](#)).

In parallel to this review The Portfolio and Governance Team (P&G) within Strategy and Insight has confirmed that they have been developing a revised Portfolio Management approach (including best practice project and programme management standards) with the objective of supporting consistent delivery and governance of Council projects. The framework will also propose a benefits management approach. The Internal Audit recommendations included in this report should be incorporated within this framework.

3. Detailed findings

1. Programme Management

Findings

The Portfolio and Governance (P&G) team within Strategy and Insight is responsible for oversight of the Council’s Change Portfolio, providing portfolio progress updates to the Council’s Change Board (essentially the Corporate Leadership Team) and elected members at the Governance, Risk, and Best Value Committee (GRBV).

The P&G team also includes several skilled and qualified programme and project managers who are responsible for managing and supporting delivery of a small number of significant business change projects and programmes. Currently, the criteria applied to determine whether a project should be included in the Change Portfolio or delivered by a service area is based on both the cost of the project and/or reputational sensitivity. There is therefore a number of projects (not yet quantified) in progress across service areas that are being delivered by employees with potentially limited project management experience, or by external 3rd party project management specialists on a contractual basis that are not subject to oversight by the P&G team and the Council’s Change Board

Our review of four projects within the Change Portfolio established that whilst standard project management principles exist, they are not applied consistently across projects within the Portfolio.

Consolidated reporting prepared by P&G and provided to the Change Board and GRBV is based on updates provided by individual projects and programmes within the Change Portfolio, however these updates are inconsistent in terms of content and level of detail provided. Additionally, P&G reporting does not include projects outwith the Change Portfolio that are being delivered by service areas that could potentially be categorised as ‘Significant’ based on a broader set of criteria for inclusion in the Change Portfolio.

Review of project governance across four of the projects included in the Change Portfolio established that projects are not being managed consistently, and identified several thematic control gaps. These included:

- Standard business cases are not consistently produced. Project approval is often granted based on a paper presented to Council committees;
- Failure to identify, record and monitor project benefits (refer Finding 2);
- Lack of clearly defined project plans that reflect project critical paths and key project dependencies;
- Failure to identify, record, monitor and report project risks, issues, and dependencies;
- Project governance minutes (e.g. steering group meeting minutes) do not consistently record attendees or meeting outcomes.
- Weaknesses in the management and oversight of third parties involved in projects to ensure that their delivery is in line with contractual requirements;
- Lack of secure arrangements supporting transfer of commercially sensitive and confidential information to and from third party suppliers involved in projects;
- Lack of project management tools to support effective delivery of high risk or large scale projects (for example MS Project). Several projects are managing their project plans in Microsoft Excel which is not always adequate to support high risk or large scale changes.
- Project close reports are not consistently completed when a project is closed.

Business Implication

The potential risks and business implications associated with our Findings are:

- Failure of high risk projects being delivered by service areas as they are not subject to oversight by P&G team; the Council’s Change Board and

Finding Rating

High

relevant Council scrutiny committees; and are supported by staff with insufficient understanding and training in effective project management and delivery of projects;

- Projects are not effectively and consistently managed with the potential for risks, issues, and dependencies to crystallise and adversely impact project delivery;
- Consolidated reporting provided by P&G to the Change Board and GRBV is incomplete and inaccurate;
- Third party supplier deliverables are not aligned with contractual requirements or Council expectations;
- Breach of Data Protection Act requirements or leakage of commercially sensitive information; and
- Areas for improvement or best practice are not identified, recorded, and shared when projects close.

Action plans

Recommendations

Responsible Officer

1. Existing criteria to determine whether a project should be included in the Change Portfolio should be reviewed and enhanced. The revised criteria should be based on a thorough assessment of the risks associated with projects and will be reviewed and approved by the Change Board and GRBV;
2. All projects currently outwith the Change Portfolio should be reviewed and assessed to establish whether they should be included based on the revised assessment criteria;
3. SRO's who are accountable for delivery of significant change projects should assess within the business case whether there is sufficient skills, capability, and capacity within their Service Areas to effectively deliver the project and programme in line with the recommendations set out in this report. S&I should work with SRO's to support them in this regard and the outcomes together with any specific requests for project management support should be reported to the Change Board for consideration and approval.
4. A standard project management approach should be developed and applied by all projects being delivered across the Council. This should include (but not be restricted to) guidance on how to: manage external suppliers involved in project delivery; manage risks, issues and dependencies; and prepare key project plans and governance documents.
5. Standard project management standards and processes should be owned and maintained by P&G, with P&G providing oversight to confirm that it is consistently applied;
6. P&G reporting to the Change Board and GRBV should be reviewed and enhanced to demonstrate progress with all projects being delivered across the Council based on an appropriate set of standard monitoring metrics.
7. Where projects will involve transfer of commercially sensitive or private sensitive data between the Council and third parties, the Information Governance Unit (IGU) should be consulted and details included in project Privacy Impact Assessments (PIAs). Where required, secure data transfer and storage arrangements should be established with third parties prior to commencement of projects. This requirement should be included in the project guidance made available by P&G to all service

Portfolio and Governance Manager, Strategy and Insight

<p>areas, and considered as part of the business case approval process for all significant projects included in the portfolio of change.</p> <p>8. Provision of an appropriate range of project management tools to support effective project management and consolidated change Portfolio reporting by P&G should be made available to all significant, high risk and large scale projects across the Council.</p>	
<p>Agreed Management Action</p>	<p>Estimated Implementation Date</p>
<p>1. New Criteria is in place and implemented to evaluate change initiatives and whether projects and programmes are tracked via the Council's Change Portfolio. This evaluates initiatives against the following criteria: strategic contribution; financial impact; level of risk; service improvement; political impact; citizen/community impact; and staff/culture impact. This prioritisation matrix will inform what change initiatives should be considered for inclusion in the Portfolio. The Change Board will ultimately agree what is tracked via the portfolio. The matrix has been presented to CLT and Corporate Policy & Strategy Committee on 5 Nov 2017 and is being applied to all new change initiatives. Formal communication still to be undertaken across all service areas.</p> <p>2. Work is already underway and a proposed portfolio of projects was presented to the Change Board in December. This will continue to be refined through engagement at Directorate Senior Management Team meetings. The portfolio will of course continue to change as some projects are closed and new projects come on stream.</p> <p>3. The proposed Delivery Unit in S&I will provide support and guidance where required to SRO's to ensure resource requirements are captured as part of the change initiatives business case. Guidance will be prepared by S&I's Change Team and included in business case templates provided.</p> <p>4. Standards and processes are developed. Implementing and embedding these will take time (and will require support from senior management across all service areas). It is proposed that key standards are made mandatory for portfolio projects and programmes, i.e. business cases, PID (Project), PDD (Programme), status reporting, RAID Management, and Project/Programme Closure initially.</p> <p>A project toolkit will be published on the Orb. It is proposed that certain documents in this toolkit will be mandated for use by those initiatives within the Portfolio as detailed above. Projects and programmes out with the portfolio will be advised to use but not mandated.</p> <p>5. The Organisational Review within S&I will establish a new Delivery Unit responsible for the governance and oversight of all significant change projects and they will be responsible for ensuring consistent standards around reporting. Furthermore, there will be a role for the proposed delivery unit to provide ongoing oversight that these standards are being applied consistently across the Portfolio of Change.</p> <p>6. Reporting arrangements to both the Change Board, CP&S and GRBV have been reviewed and agreed. A new dashboard was presented at the Change Board in December and will be refined over the next few months. A workshop with GRBV is also planned and feedback from this will be incorporated within our revised reporting proposals. The proposed delivery unit will have responsibility for identifying, documenting and providing visibility of lessons learned and themes that can be applied to any new projects and programmes. Responsibility for</p>	<p>1. 30.06.18</p> <p>2. 30.06.18</p> <p>3. 30.03.18</p> <p>4. 30.03.18 – 30.03.19.</p> <p>5. 30.04.19</p> <p>6. 30.06.18</p>

undertaking lessons learned exercise remains the responsibility of individual projects and programmes.	
7. Project guidance will be updated to reflect the requirements of the recommendation in conjunction with the IGU.	7. 30.03.19
8. A project toolkit will be available on the Orb that includes key templates. To standardise approach some of the templates should be mandated but all will be available for any project to use. Guidance will also be available on the orb in relation to procuring MS Project 2016 software.	8. 30.06.18

2. Benefits Realisation

Findings

Whilst a consolidated portfolio governance report including benefits monitoring is produced for the Council's Change Board, our review of the controls in place supporting identification, monitoring, and post implementation review of project benefits across a sample of current and completed projects across the Council identified the following control weaknesses:

- There is no consolidated benefits realisation plan covering all projects within the Council's Change Portfolio enabling consolidated benefits monitoring (including the contribution of any financial benefits to costs saving targets) at portfolio level during the life of the project and post implementation;
- Benefits are not currently specified as a criterion to determine whether a project should be included in the Change Portfolio;
- There is a lack of clarity across projects regarding the definition and classification of benefits. Training materials covering benefits have been produced by P&G, but have not been shared across all projects;
- When produced, project business cases do not consistently include details of expected project benefits;
- Baseline measurements (the position prior to implementation of the change) are not always recorded, or are not sufficiently granular to support a post implementation review to confirm that expected benefits have been realised;
- Project update reports prepared by individual projects and submitted to P&G to support consolidated Change Portfolio reporting do not include an appropriate level of detail in relation to benefits; and
- There is limited monitoring of benefits following project completion and transition into business as usual service delivery to confirm that all expected benefits have been achieved.

Business Implication

The potential risks and business implications associated with our Findings are:

- Consolidated benefits across the Change Portfolio cannot be monitored or their total contribution to financial savings assessed;
- Projects that are expected to deliver significant benefits will not be supported by P&G or reported to the Change Board as part of the Change Portfolio;
- Project benefits are not completely and accurately assessed and recorded;
- Projects are approved that will not deliver benefits and are not aligned with the Council's strategic objectives;
- Benefits delivered cannot be measured as the baseline measurements have not been accurately recorded;

Finding Rating

High

- Incomplete and inaccurate benefits reporting provided by P&G to the Change Board or GRBV; and
- Inability to accurately assess whether benefits have been realised post implementation.

Action plans

Recommendations

1. A consolidated benefits realisation plan covering all Change Portfolio projects should be implemented and reported to the Change Board and GRBV to support effective monitoring of benefits across the portfolio;
2. Benefits should be included as a criterion for inclusion of a project within the Change Portfolio;
3. P&G should prepare guidance in relation to the definition of benefits and the requirement to identify, record and monitor benefits throughout the life of the project and post implementation;
4. Standard business cases that detail expected project benefits, should form the basis for approval of all projects by the Change Board and relevant Council committees;
5. Project management methodology should include the requirement for business cases to be submitted to P&G for review prior to submission to the Change Board and Council committees to confirm that benefits have been identified, quantified and recorded with ownership allocated.
6. Baseline measurements should be recorded in all business cases. Assumptions and calculations supporting the baseline measurements for all projects within the Change Portfolio should be recorded and reviewed by P&G;
7. P&G should specify their expectations regarding benefits for inclusion in all progress updates received from Project Managers; and
8. The requirement for completion of Post implementation reviews and development and implementation of processes enabling measurement and reporting of post implementation benefits by Service Areas for all projects within the Change Portfolio should be included in the P&G project governance guidance. The P&G oversight process should also include the requirement to confirm that benefits have been identified and are being effectively monitored and reported.

Responsible Officer

Portfolio and Governance Manager, Strategy and Insight

Agreed Management Action

1. Agreed. However, responsibility for Benefits Realisation will remain responsibility of the agreed Benefit Owners.
2. Agreed. Unless there is an approved Business Case with Benefits identified, verified and owned then a proposed change initiative should not even reach the Portfolio. It would be stopped at an earlier 'gate' in the change delivery process. For current projects and programmes within the Portfolio, Project and Programme Managers to provide benefits realisation plans and current status on a monthly basis as part of status/highlight reporting to P&G.
3. Agreed. This will be part of the toolkit that will be published on the Orb.
4. Agreed
5. A Working Group has been set up that comprises representation at Head of Service level across departments. This group has a role in reviewing business cases prior to submission to the change board. This group and

Estimated Implementation Date

1. 31.09.18
2. 30.03.18
3. 30.03.18
4. 30.08.18
5. 28.06.18

change board would only be involved in review of significant change business cases.

- | | |
|--|-------------|
| 6. Guidance will be included as part of the Benefits Management approach re baseline measurements. | 6. 30.06.18 |
| 7. Expectations are set out in the highlight report that portfolio projects and programmes complete monthly. However, there is scope to review this section and if required make changes. | 7. 31.03.18 |
| 8. P&G to schedule and undertake post implementation reviews. Annual schedule to be agreed between P&G and SRO's for Portfolio Projects and Programmes, either recently closed or scheduled to close within the next six months. Additionally, P&G will develop guidance for Benefits Management which will be available on the Orb. | 8. 31.06.18 |

Appendix 1 - Basis of our classifications

Finding rating	Assessment rationale
Critical	<p>A finding that could have a:</p> <ul style="list-style-type: none"> • 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	<p>A finding that could have a:</p> <ul style="list-style-type: none"> • 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	<p>A finding that could have a:</p> <ul style="list-style-type: none"> • 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	<p>A finding that could have a:</p> <ul style="list-style-type: none"> • 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	<p>A finding that does not have a risk impact but has been raised to highlight areas of inefficiencies or good practice.</p>

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

This assurance review was 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 are many 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.

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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	3	1	-	4
A1. Care Home Portfolio				
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	1	7	3	11
B1. Health & Safety Controls				
B2. Property and Statutory Inspection Controls	2	4	-	6
Information Governance	-	6	1	7
C. Records Information and Compliance				
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
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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
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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
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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 than £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
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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
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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
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- 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 completed 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
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- 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
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- 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
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- 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
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- 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
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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
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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
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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
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- 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
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- 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
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- 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
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- 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
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- 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
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- 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
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- 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
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- 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
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- 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
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- 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
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- 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
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- 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
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- 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
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- 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
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- 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
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- 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
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- 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
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- 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
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- 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
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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
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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
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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
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- 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
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- 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
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- 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.	<p>A self assurance framework will be designed and implemented that will validate effective operation of controls in place to manage these risks.</p> <p>The Health and Social Care Partnership Operations Manager will be accountable for development; implementation and ongoing operation of the framework.</p> <p>Development and implementation support will be requested from Business Support and Quality Assurance and Compliance.</p>	Interim Chief Officer, Health and Social Care	30 th 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	28 th 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	28 th 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.	<p>A new risk was added to the Edinburgh Integration Joint Board risk register in relation to Gylemuir.</p> <p>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</p>	Chief Nurse, Health and Social Care	28 th 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	30 th 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	30 th 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: <ul style="list-style-type: none"> • 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	31 st March 2018

	<ul style="list-style-type: none"> Recruitment and training of all care and business support teams prior to opening. 			
A1.4 Closure of Care Homes	<p>We recommend that a checklist is created to guide managers through the process of closing a care home. This should include:</p> <ul style="list-style-type: none"> 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). <p>This checklist should be suitable for use when closing any Council unit, not just care homes.</p>	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	31 st 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.	<p>This piece of work was completed as part of the restructure of budgets to reflect the locality operating model in September 2017.</p> <p>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.</p> <p>Business support will also be providing more support to Unit Managers in relation to ongoing budget management.</p>	Senior Accountant, Finance, Health, and Social Care	28 th 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	28 th 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	28 th 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	28 th 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	28 th 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	28 th 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	31 st 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	31 st 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	31 st 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	31 st 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	28 th 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	28 th 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	28 th February 2018 31 st 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	30 th 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	28 th 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	28 th February 2018
	Revised safe limits should be communicated to all Care Homes.	List distributed to all homes	Business Support Team Managers	28 th 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	30 th 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	31 st 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	28 th 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	28 th 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	30 th 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	28 th 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	28 th 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	30 th 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	30 th 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	28 th 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	28 th February 2018 for Business Support employees 30 th June 2018

	Six monthly and annual performance conversations should be completed for all employees and the outcomes recorded on the iTrent human resources system.	<p>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.</p> <p>Health and Social Care Teams Will ensure that annual performance conversations (once completed) are recorded on the iTrent system.</p>	Business Services Manager, Health and Social Care Business Support Managers Business Support Officers Operations Manager, Health and Social Care	28 th February 2018 for Business Support employees 30 th 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.	<p>Business Support Teams Business Support Officer planned program in place</p> <p>Health and Social Care Teams Will ensure that managing attendance workshops have been attended by all H&SC line managers in Care Homes.</p>	Business Support Managers	30 th June 2018 30 th 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.	<p>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 Domestic and Handymen reporting to them</p> <p>The Business Support Officer is required to monitor and report through the Customer process on a monthly basis.</p> <p>The staff nurse / charge nurse to be appointed at Gylemuir will ensure that this is performed for all NHS staff.</p>	Business Support Managers Unit Managers Chief Nurse, Health and Social Care	30 th June 2018 for Business Support employees 30 th 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	28 th 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	31 st March 2018

		commencing 15 th 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	31 st 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	28 th 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	28 th 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	28 th 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	28 th 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	30 th 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	28 th 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	28 th 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 Unit Managers	28 th 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	28 th 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.	<p>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.</p> <p>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.</p>	Business Support Managers	28 th 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	28 th 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.	<p>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.</p> <p>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.</p>	Business Support Team Managers	28 th 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	28 th 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	28 th February 2018 28 th 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	28 th 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	30 th 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	31 st 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	28 th 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	30 th 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	30 th 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 be discussed at the newly established Health and Safety Group.	Hospital and Hosted Services Manager Operations Manager, Health and Social Care	30 th 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	28 th 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	28 th 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	28 th 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.	<p>Business Support Teams Employee Assistance Programme information has been provided to all Business Support team members.</p> <p>Health and Social Care Teams Information will also be provided by Locality and Unit Managers for all non business support team members.</p>	<p>Business Services Manager, Health and Social Care</p> <p>Operations Manager, Health and Social Care</p>	<p>28th February 2018</p> <p>30th April 2018</p>
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.	<p>Started by Unit Manager & Business Support Officer.</p> <p>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.</p> <p>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.</p> <p>Completion will be monitored monthly.</p>	Business Support Team Managers	30 th 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	28 th 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	30 th 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	30 th 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	28 th 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	30 th 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	30 th 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	28 th 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	28 th 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	30 th 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	21 st 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	21 st 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	30 th 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	30 th 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	30 th 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	30 th 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	28 th 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	28 th 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	21 st 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	30 th 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	30 th 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	21 st 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	30 th June 2018

Appendix 1- Basis of our Ratings

Internal Audit and Information Governance Ratings

Finding rating	Assessment rationale
Critical	<p>A finding that could have a:</p> <ul style="list-style-type: none"> • 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	<p>A finding that could have a:</p> <ul style="list-style-type: none"> • 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	<p>A finding that could have a:</p> <ul style="list-style-type: none"> • 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	<p>A finding that could have a:</p> <ul style="list-style-type: none"> • 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	<p>A finding that does not have a risk impact but has been raised to highlight areas of inefficiencies or good practice.</p>

Health and Safety Ratings

Recommendation rating	Assessment rationale
High	<p>A recommendation that if not carried out could have a:</p> <ul style="list-style-type: none"> • 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	<p>A recommendation that if not carried out could have a:</p> <ul style="list-style-type: none"> • 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	<p>A recommendation that if not carried out could have a:</p> <ul style="list-style-type: none"> • 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 status 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	Yellow	Red	Green	Yellow	Yellow	Yellow	Red	Yellow	Green	Red	3	5	2
Workforce Controls	Green	Red	Green	Yellow	Red	Yellow	Red	Green	Yellow	Red	4	3	3
Resilience	Green	Green	Green	Yellow	Green	Yellow	Green	Yellow	Yellow	Green	0	4	6
IT	Yellow	Green	Green	Yellow	Yellow	Red	Yellow	Yellow	Yellow	Yellow	1	7	2
Regulatory	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	0	0	10
Health and Safety Controls	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	0	10	0
Property & Statutory Inspection Controls	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	0	10	0
Records Information & Compliance	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	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 Governance 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. <i>Evidence: Signature/email</i>
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. <i>Check current staff at Care Home agrees to SAG Team records</i>
Welfare Fund Governance	
2.1	There is a constitution for the Welfare Fund. <i>Confirm standard constitution is used.</i>
2.2	The Welfare Fund Committee has met at least once in the past year. <i>Minutes of AGM.</i>
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. <i>Obtain copy.</i>
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. <i>Cash book or basic accounting system.</i>
3.2	For an appropriate sample of each category verify that total income expected was banked intact. <i>Cash book to bank statement. No expenditure before cash is banked if Welfare Fund income.</i>
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. <i>(Sample of 5: invoice, authorisation)</i>
4.2	Scrutinise Welfare Fund expenditure to ascertain that it is properly authorised. <i>(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.)</i>
4.3	Confirm that cheques are not presigned at any point. <i>Review all current cheque books in use to confirm</i>
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. <i>Describe process from receipt to banking.</i>
5.2	Confirm that income (cash) is banked at appropriate intervals. <i>Select from cash book and follow through to bank</i>
5.3	Confirm that cash is held securely and in compliance with insurance limits. <i>Verify insurance limit before visit.</i>
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). <i>Segregation of duties: if prepared by BSO, check reviewed & authorised by Unit Manager.</i>
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. <i>Check Imprest, Welfare Fund and Outings Fund.</i>
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 reconciliation.
Income	
2.1	Ascertain whether prime records exist that ensure all income is known and recorded. <i>Cash book or basic accounting system.</i>
2.2	Verify that residents records are updated accurately each week with personal allowances received from Social Care Finance Team. <i>Sample of 5 from Social Care Finance sheet to residents records.</i>
2.3	Verify that residents records are updated accurately with Family contributions. <i>Sample of 5 from receipt book to residents record to cash tin balance/ bank pay-in.</i>
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. <i>Sample of 10.</i>
3.2	Confirm that cheques are not presigned at any point. <i>Review all current cheque books in use to confirm</i>
3.3	Confirm all bank signatories are current members of staff.
Resident Assets at Death	
4.1	Confirm that Property / cash form is completed. <i>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.</i>
Bank Reconciliation	
5.1	Bank accounts are reconciled within month of month end. <i>Check 2 x weekly recs.</i>
5.2	Reviewed and authorised by Business Support Officer (signed & dated). <i>Segregation of duties: if prepared by BSO, check reviewed & authorised by Unit Manager.</i>
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. <i>Check residents savings petty cash.</i>
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. <i>Check for the Unit Manager, Business Support Officer & a Team Leader.</i>
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? <i>Check agency staff training file.</i>
4.2	Have satisfactory ID checks been obtained for agency staff on duty today/tonight? <i>Check agency staff training file.</i>
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? <i>View contingency box</i>
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-aid training is up to date (<i>training records verified</i>).
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

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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 Craggs 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 Craggs 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 Craggs 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 Craggs 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

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;

Finding Rating

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.

28 June 2019

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.

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.

31 May 2018

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

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; | Senior Business Support Manager (actions 1 – 6) |
| 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; | Corporate Finance Senior Manager (action 7). |
| 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 | |

<p>appropriate. The BSO should ensure that insurance conditions regarding cash limits and key storage are consistently applied; and</p> <p>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.</p>	
Agreed Management Action	Estimated Implementation Date
<p>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-Learning module. It is our intention to self-audit periodically that these actions are being adhered to.</p>	31 May 2018
<p>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-Learning module. It is our intention to self-audit periodically that these actions are being adhered to.</p> <p>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.</p>	30 April 2018
<p>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.</p>	31 May 2018
<p>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.</p>	30 April 2018
<p>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.</p>	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.

28th June 2018 (subject to Council approval)

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.

Appendix 1 - Basis of our classifications

Finding rating	Assessment rationale
Critical	<p>A finding that could have a:</p> <ul style="list-style-type: none"> • 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	<p>A finding that could have a:</p> <ul style="list-style-type: none"> • 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	<p>A finding that could have a:</p> <ul style="list-style-type: none"> • 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	<p>A finding that could have a:</p> <ul style="list-style-type: none"> • 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	<p>A finding that does not have a risk impact but has been raised to highlight areas of inefficiencies or good practice.</p>

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: 21st 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Imprest funds (especially cash) are administered in accordance with Council Policies.

	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 Families)	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.

City of Edinburgh Council

Internal Audit

Edinburgh Integration Joint Board - Review of Social Care Commissioning

Final Report

20 July 2018

EIJB1702

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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	
<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>	
Business Implications	Findings Rating
<ul style="list-style-type: none"> 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 	
Action plans	
Recommendation	Responsible Officers
<p>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:</p> <ul style="list-style-type: none"> Analyse the current level of services provided at the appropriate levels (e.g. for the full service; and by individual localities; clusters and hubs); 	

<ul style="list-style-type: none"> • 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. <p>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</p> <p>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.</p>	
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. Management Capacity and Roles and Responsibilities

Finding	
<p>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.</p> <p>Additionally, employees with extensive knowledge of client demographics and commissioning are scheduled to leave the Partnership in June 2018.</p> <p>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.</p> <p>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.</p>	
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	

<p>experience within the partnership to support delivery of the commissioning plans as per the Improvement Plan and support ongoing commissioning processes;</p> <ol style="list-style-type: none"> 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. 	
<p>Agreed Management Action</p>	<p>Estimated Implementation Date</p>
<p>These recommendations will be addressed within scope of the strategic management action detailed in the Executive Summary at Section 2.</p>	

Appendix 1 - Basis of our classifications

Finding rating	Assessment rationale
Critical	<p>A finding that could have a:</p> <ul style="list-style-type: none"> • 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	<p>A finding that could have a:</p> <ul style="list-style-type: none"> • 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	<p>A finding that could have a:</p> <ul style="list-style-type: none"> • 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	<p>A finding that could have a:</p> <ul style="list-style-type: none"> • 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	<p>A finding that does not have a risk impact but has been raised to highlight areas of inefficiencies or good practice.</p>

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	<p>The Partnership should produce a revised and updated joint strategic commissioning plan with detail on:</p> <ul style="list-style-type: none"> • 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.mcqinty@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

The City of Edinburgh Council

Internal Audit

**EIJB1701 – Health and Social Care Partnership
Purchasing Budget Management**

Final Report

20 July 2018

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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.

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 issues 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	
<p>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.</p> <p>Locality Management has advised that they are aware of these issues.</p> <p>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.</p> <p>We understand that a 'purchasing realignment group' has been established to resolve allocation of budgets across the localities.</p>	
Business Implication	Finding Rating
<ul style="list-style-type: none"> 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. 	<div style="background-color: red; color: white; padding: 10px; width: 60px; margin: 0 auto;">High</div>
Action plans	
Recommendation	Responsible Officer
<ol style="list-style-type: none"> 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. 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. The budget monitoring process should include, but not be restricted to: <ul style="list-style-type: none"> 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 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. 	Chief Finance Officer

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
<ul style="list-style-type: none"> • Non-compliance with the requirements of the Social Care (Self-directed Support) (Scotland) Act 2013; • 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; 	<div style="background-color: red; color: white; padding: 10px; display: inline-block;">High</div>

- 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.

7) A communication should be sent to all providers specifying that invoices should include client names; reference numbers; and accurate hourly service rates charged;

4) 8 and 10 Neil Jamieson, Senior Manager, Customer

12) John Arthur, Senior Manager, Business Support

- 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

- | | |
|---|--|
| <ul style="list-style-type: none"> 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. 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. 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. | <ul style="list-style-type: none"> 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 |
|---|--|

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 2 – 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. There was also no process documentation 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 be 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 processes 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
<ul style="list-style-type: none"> • 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; • 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; 	<div style="background-color: red; color: black; padding: 10px; width: 60px; margin: 0 auto;">High</div>

<ul style="list-style-type: none"> Current processes supporting generation of key documents via the mail merge process are unsustainable. 	
Action plans	
Recommendation	Responsible Officer
<p>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.</p> <p>These processes should include (but not be restricted to) responsibilities and accountabilities and hand offs between the teams involved.</p> <p>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;</p> <p>2) The process for recording client reviews in Swift should be specifically documented; implemented and consistently applied; and</p> <p>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.</p>	
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	<p>A finding that could have a:</p> <ul style="list-style-type: none"> • 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	<p>A finding that could have a:</p> <ul style="list-style-type: none"> • 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	<p>A finding that could have a:</p> <ul style="list-style-type: none"> • 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	<p>A finding that could have a:</p> <ul style="list-style-type: none"> • 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	<p>A finding that does not have a risk impact but has been raised to highlight areas of inefficiencies or good practice.</p>

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 managers 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	<p>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.</p> <p>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.</p> <ul style="list-style-type: none"> • 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	<p>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:</p> <ul style="list-style-type: none"> • 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			<ul style="list-style-type: none"> • 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	<p>Allocated workers include:</p> <ul style="list-style-type: none"> • Senior Social Workers <p>Responsible for the management of all social work teams; allocation of assessments; reviews; and other tasks across the community and hospital sites.</p> <ul style="list-style-type: none"> • Social Workers • Occupational therapist • Community Care Assistant <p>Responsible for assessments; support planning; and review of people in hospital and in the community.</p> <p>A number of allocated workers were contacted during the course of the audit review to clarify key stages of the end to end process.</p>
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	<p>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:</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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	<p>Locality Manager notes that a check is required to ensure that the use of Locality Managers signatures is compliant with Standing Orders.</p> <p><u>Action to be taken</u></p> <p>The Senior Accountant, (Finance) was copied in to advise.</p>
10-12 January 2018	<p>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".</p> <p><u>Action to be taken</u></p> <p>SMU staff to manually 'delete' the electronic signature of the member of staff who has left the organisation from the 'spot contract'.</p>
17-23 January 2018	<p>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.</p>
30 January 2018	<p>Internal Audit met with SMU Business Manager to discuss the interim process and discuss some of the difficulties that the team are having.</p> <p>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.</p>
01 February 2018	<p>Internal Audit contacted the Locality Manager's to establish whether there has been a decision on the SMU spot contract process.</p>
01 February 2018	<p>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.</p>
02 February 2018	<p>Hub Manager NW Locality provides confirmation (via email) of the checks undertaken prior to signing off the SMU Spot Contract.</p>
07 February 2018	<p>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.</p>
07 February 2018 07 February 2018 cont.	<p>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.</p> <p>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.</p> <p><u>Action to be taken</u></p> <p>The four Locality Managers to agree a process for the signing of SMU spot contracts at Locality Forum of 15 February 2018.</p>
07 February 2018	<p>SMU Business Manager requests confirmation from the Operations Manager (Risk and Compliance) of the process to be followed within NE Locality.</p>

Date	Description of events
	<p>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.</p> <p>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.</p>
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	<p>IA updated the Interim Chief Officer re lack of response from Locality Managers to previous audit correspondence of 01 February.</p> <p>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.</p>
08 February 2018	<p>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.</p> <p>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.</p>
09 February 2018	<p>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.</p> <p>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.</p>
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	<p>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).</p> <p>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.</p>
15 February 2018	<p>IA attended the Locality Managers Forum with the Operations Manager (Risk and Compliance), Business Services Manager and each of the Locality Managers.</p> <p>Operations Manager (Risk and Compliance) discussed the proposed interim spot contract process. Locality Managers noted that they would require time to review the</p>

Date	Description of events
	<p>proposed process documentation presented at the meeting and that a decision would be made at the following weeks Locality Managers Forum.</p> <p>The SE Locality Manager noted that she was unaware that the electronic signature was being used for the signing of the SMU Spot Contracts.</p> <p>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.</p>
21 February 2018	<p>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.</p>
26 February 2018	<p>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.</p> <p>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.</p>
27 February 2018	<p>Internal Audit informs Operations Manager that ISFs are being electronically signed by former Senior Manager within the Transactions Team (Resources).</p> <p>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.</p>
27 February 2018	<p>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.</p>
27 February 2018	<p>The Transactions Team Manager provides email evidence of correspondence issued to Locality Managers dated 19 January 2018 and 16 February 2018.</p> <p>A response was received to the email dated 16 February from the SE Locality Manager.</p>
27 February 2018	<p>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.</p> <p>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.</p> <p>Locality Manager has noted that she is unaware that the electronic signatures were being used.</p>
01 March 2018	<p>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).</p>
05 March 2018	<p>Email correspondence between the Operations Manager and SE Locality Manager to obtain current position regarding the electronic signature on Care Home Contracts.</p>

Date	Description of events
	SE Locality Manager advised that she is liaising with Transactions Team Manager regarding this issue.
16 April 2018	<p>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.</p> <p>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.</p>
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	<p>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.</p> <p>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.</p>
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 Services agreed that this was the correct approach.
20 April 2018	<p>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:</p> <ul style="list-style-type: none"> • 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) <p><u>Action to be taken</u></p> <p>Objective: to produce 'end to end' interim flow processes for Chief Officer and Head of Customer Services and IT approval.</p>
23 April 2018	Short life working group meeting held.
26 April 2018	<p>Operations Manager issued draft "Interim Purchase Budget Management Process for Localities" document to IA for comment.</p> <p>IA Comments were returned to the Operations Manager</p>
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	<p>ICT Solutions issue newly formatted draft contract documentation for consultation to Short Life Working Group.</p> <p><u>Action to be taken</u></p> <p>Short Life Working Group to provide confirmation that the newly formatted draft contract documentation can go ‘Live’ within the Swift system.</p>
09 May 2018	<p>IA contacted Legal Services to obtain confirmation of advice provided.</p> <p>Legal Services confirm that no written advice had been supplied to H&SCP</p> <p>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.</p>
09-10 May 2018	<p>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.</p>
10 May 2018	<p>At an introductory meeting with the newly appointed Chief Officer; IA updated Interim Chief Officer of current issue regarding delegated authority.</p>
14 May 2018	<p>Interim Chief Officer requests clarification from IA of the detail of the current issue which was provided via email.</p> <p>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.</p> <p>Interim Chief Officer confirmed that new Chief Officer and Chief Finance Officer will determine a way forward with the process.</p>
17 May 2018	<p>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.</p> <p>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.</p> <p>The above process requires to be discussed and agreed with the Partnership’s Chief Officer.</p>
24 May 2018	<p>Operations Manager issued email to Committee Services which includes Delegated Authority Letters for both Locality and Cluster Managers within the Partnership.</p>

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	<ul style="list-style-type: none"> • 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
	<ul style="list-style-type: none"> • 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.
<p>2. Management of waiting lists (including provision of Performance Management Information)</p>	<ul style="list-style-type: none"> • 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.
<p>3. Completion, review, and approval of initial assessments, support plans, and future reviews, including costs,</p>	<ul style="list-style-type: none"> • 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 managed 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.
<p>4. Completeness and accuracy of care packages and costs recorded on Swift</p>	<ul style="list-style-type: none"> • 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
	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • All payments made (arranged and managed 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	<ul style="list-style-type: none"> • 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
Lesley Newdall	Chief Internal Auditor	lesley.newdall@edinburgh.gov.uk 0131 469 3216 (x 43216)
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Key Contacts

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

The City of Edinburgh Council

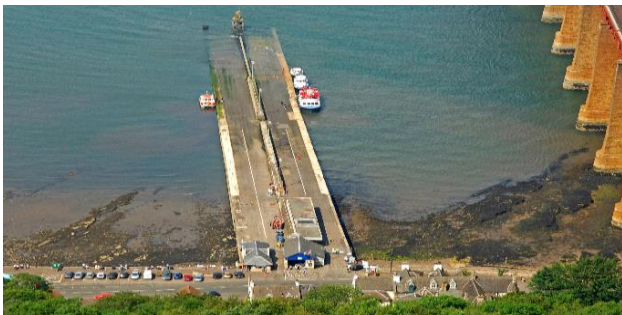
Internal Audit

Review of Hawes Pier Port Facility Security Plan (PFSP)

Final Report

18 May 2018

MIS1701



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This Internal Audit review is undertaken as part of the City of Edinburgh Council's Internal Audit plan for 2017/18. It is not designed or intended to be suitable for any other purpose and should not be relied upon for any other purpose or by any other party. 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 are 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 (the Council) owns, manages and maintains the Hawes Pier (the Pier) port facility in South Queensferry. The Pier is a 300m long gradual slipway facility with security fencing and a double gate which is situated at the head of the pier.

Security at port facilities in the UK is governed by legislation and guidance including the Ship and Port Facility Security Regulations (2004), and is subject to oversight by the Maritime Security & Resilience Division of the UK Department for Transport (DfT).

As owner of the Pier, the Council is responsible for ensuring an appropriate Port Facility Security Plan (PFSP) is in place, and that security arrangements are consistently and effectively applied in line with DfT requirements.

The DfT has the authority to undertake planned or unannounced visits / inspections as they consider appropriate, and also require an annual independent audit of the PFSP (for example, by the relevant local authority Internal Audit team).

The PFSP for Hawes Pier is a c.40-page document (classified as OFFICIAL-SENSITIVE) which covers all aspects of security. The PFSP is prepared and maintained by the Council (using a standard DfT template) and is subject to annual review and approval by the DfT.

One of the key PFSP requirements is a designated Port Facility Security Officer (PFSO) – a Council employee who has responsibility for managing and overseeing security arrangements at the Pier, principally on the days when cruise ships are visiting.

The Pier is used by:

- Visiting cruise ships to ferry passengers on and offshore using smaller boats (these larger cruise ships are unable to dock directly at Leith or Rosyth due to their size);
- Leisure boat firms who operate from offices on the Pier and provide a range of short cruises (principally from April to October);
- The Royal National Lifeboat Institution (RNLI) operates a lifeboat station from buildings on the Pier;
- BP plc has a small office and storage facility on the pier and transfers personnel and equipment to the nearby Hound Point oil terminal (BP plc sub-contractors also use the pier); and
- Members of the public / watersport enthusiasts also use the pier.

The presence of a cruise ship in the Firth of Forth presents an increased risk of a security incident. Consequently, the Pier is designated by the DfT as a Temporary Restricted Area (TRA) during such visits.

The cruise ship season is principally from April to October, and in 2017 a total of 18 cruise ships used the Pier, generating net income (after direct costs) of c.£350K. Visits usually last one day but occasionally involve anchoring overnight.

The PFSP outlines the range of security measures and requirements which the DfT expect to apply at the Pier when cruise ships visit.

When cruise ships visit, a third-party security company (Profile Security) is engaged by Denholm Wilhelmsen (a shipping agent acting on behalf of the visiting cruise liner company) to perform an extensive range of important security tasks. The range of tasks performed are included at Appendix 2.

Scope

Our review was completed as at 28 February 2018, with the objective of assessing whether the PFSP content remains compliant with DfT requirements, and confirming that the security controls detailed in the plan are consistently and effectively applied. Our work involved:

- Review of the content of the plan;
- Obtaining an understanding of overall security arrangements through discussions with key personnel;
- Reviewing management of key security risks;
- Review of systems documentation and walkthrough tests to evaluate the design of established controls; and
- sample testing of key procedures and controls.

Our work also involved a visit to the Pier on 19 September 2017 to review and observe the security arrangements in place for the visit of the cruise ship Caribbean Princess.

2. Executive Summary

Total number of Findings

Critical	-
High	1
Medium	4
Low	1
Advisory	-
Total	6

Summary of Findings

Whilst our review has not identified any significant instances of non-compliance with DfT security requirements at the Pier and no significant security breaches have occurred, we have identified one significant and four moderate risk and control gaps that require to be addressed.

The significant risk identified relates to the Council's reliance on Profile Security, a third-party security company engaged by Denholm Wilhelmsen on behalf of the visiting cruise line company, to perform an extensive range of important security tasks for cruise ship visits. These third-party security arrangements are not supported by a formal contract or service level agreement with the Council. Whilst the Council's PFSO oversees all security checks performed by Profile Security, there is a risk that the Council will be held accountable by the DfT for any significant security breaches that occur due to weaknesses in Profile Security activities.

There has also been a significant delay in recruiting a new PFSO. The role has been vacant since December 2017 and initial recruitment was unsuccessful. The risks associated with this ongoing vacancy (failure to maintain the PFSP and ensure that security arrangements are consistently and effectively applied on an ongoing basis) are mitigated to an extent as the PFSO role is not full time, and there are two employees with relevant experience within the Council who could cover cruise ship visits in the short term.

We also established that:

- Security exercises and drills have not been performed as per DfT requirements;
- Actions arising from the DfT inspection on 8 August 2017 have not yet been fully addressed;
- The PFSP has not been reviewed and updated (where required) on a six-monthly cycle as per DfT requirements; and
- There were a number of procedural and documentation exceptions evident in security processes for the Caribbean Princess visit on 29 September 2017 that require to be addressed.

Consequently, 1 High, 4 Medium and 1 Low rated findings have been raised.

Our detailed findings and recommendations can be found at Section 3 - [Detailed Findings](#).

3. Detailed Findings

1. Third Party Security Arrangements

Findings

The Port Facility Security Officer (PFSO) is responsible for completion of security checks when cruise liners visit, however, security checks are currently performed by Profile Security (a third-party security company engaged by a shipping agent on behalf of the visiting cruise liner).

Whilst good working arrangements appear to have been established between Profile Security and the PFSO, there is no established contract or service level agreement supporting operation of these security arrangements. The Council also has no visibility of the contractual arrangements in place between Profile Security and the Shipping Agent.

The main activities performed by Profile Security are recorded in a Council document titled 'Hawes Pier Security Requirements', however, this document has not been signed to confirm formal agreement of security responsibilities between both parties.

Additionally, the current working arrangements with Profile Security are not referred to in the Port Facility Security Plan (PFSP),

Business Implications

Risk that the Council will be held accountable by the DfT for any significant security breaches that occur due to weaknesses in Profile Security activities.

Findings Rating

High

Action plans

Recommendation

Appropriate contractual arrangements should be established in relation to the current working arrangements with Profile Security (and supported by an appropriate and effective supplier management framework),

Responsible Officer

Head of Place Management

Agreed Management Action

Agreed

1. The PFSO will draft a document titled "Hawes Pier Cruiseliners Security Procedures – Requirements", to reflect the City of Edinburgh Council's (PFSO) expectations as required by DfT of the security company on a cruise liners arrival at Hawes Pier (Complete);
2. Shipping agent / Security company will be sent the "Hawes Pier Cruiseliners Security Procedures – Requirements" document for verbal agreement prior to the cruiseliner season.
3. The Hawes Pier Cruiseliners Security Procedures – Requirements", document will be sent to the CEC Legal team for review. On successful review, the legal team shall prepare a letter to be sent to the shipping agent (Denholm Wilhelmsen), making a formal legal agreement between the shipping agent and CEC that this document will form part of the contract between the shipping agent and the security company for cruiseliner arrangements at Hawes Pier, South Queensferry.

Estimated Implementation Date

31/05/2018 to enable IA follow-up.

31/05/2018

28/09/2018

2. Port Facility Security Officer Vacancy

Finding

The Port Facility Security Officer (PFSO) is a key designated role established to meet DfT security requirements, and it is the responsibility of the Council as the port facility owner to recruit an appropriate skilled and qualified individual.

The PFSO role has been vacant since December 2017. Whilst the post was advertised in late 2017 no suitable candidate was identified. The post has now been re-advertised with a closing date 20 February 2018, and had not been filled as at the conclusion of our audit work (28 February 2018).

The PFSO role is not full time given the limited number of cruise ship visits, and is combined with Transport Technician responsibilities in the Council's Flood Prevention team. The successful candidate must complete specific internal and external training, and obtain Counter Terrorism Check clearance from the DfT.

The principal activities of the role involve:

- Management and maintenance of the PFSP and attendance at appropriate Committee and liaison meetings;
- Ensuring that security arrangements specified in the PFSP are applied on the specific days when cruise ships are visiting;
- Being on call and able to respond in the event of incidents.

The PFSP does identify two current Council employees who performed the role previously and are suitably qualified and cleared to ensure that security arrangements are effectively applied in the event of a cruise ship visit.

Business Implications

- Potential non-compliance with DfT security requirements; and
- Potential financial loss or reputational damage if cruise ships are unable to use the facility;
- The PFSP is not refreshed and maintained; and
- Inability to respond in the event of a security incident.

Findings Rating

Medium

Action plans

Recommendation

1. Management should demonstrate ongoing compliance with DfT requirements, despite the extended vacancy.
2. If recruitment issues persist, management should consider outsourcing PFSO responsibilities to a suitable external organisation, with DfT approval obtained in advance to support this approach; and
3. In the interim, management should ensure that appropriate coverage of the role is provided. Refresher training may be appropriate for the two Deputy PFSOs to ensure they can fulfil the role at short notice, if required.

Responsible Officer

Head of Place Management

Agreed Management Action

Agreed,

Estimated Implementation Date

1. Arrangements will be put in place for an Engineer from the Flood team to backfill the Port Facility Security Officer role in the interim until a new candidate can be appointed. (Complete)	31/05/2018 to enable IA follow-up.
2. The PFSO role shall be advertised via myjobscotland. On finding a successful applicant, security clearance and training will be applied for / provided asap for an immediate start date. A preferred candidate has been found, and a provisional job offer has been made on the basis that security clearance and training can be obtained / completed. We are hopeful that the candidate will be in place by the 10/05/2018.	01/06/2018
3. Employ additional deputies. An advert shall be sent around the department requesting volunteers to become PFSO deputies, to assist with this role in the future. Three volunteers have already been identified. There are no plans to undertake refresher training for existing PFSO's, the 3 volunteers have now completed and passed the DfT approved PFSO training, we currently await counter terrorism clearance for the deputies.	01/07/2018

3. Compliance with Dft requirements for security exercises

Findings	
<p>The DfT expects that a 'security exercise' should be completed at least every 18 months to ensure ongoing compliance with the established legislation included in the PFSP. The exercise can comprise a variety of approaches including live, simulation, desktop or seminar-type exercises.</p> <p>The most recent exercise was conducted on 2 September 2016 and involved co-ordination with Police Scotland, the Maritime and Coastguard Agency and other relevant parties.</p> <p>A further exercise is therefore required to be completed by February 2018 to ensure ongoing compliance with legislation and to meet DfT expectations. As at 13 February 2018, no security exercise had been planned. It is acknowledged that this delay may be attributable to the ongoing PFSO vacancy.</p>	
Business Implications	Finding Rating
Potential non compliance with applicable legislation and increased security risk profile if effectiveness of security controls is not regularly tested.	Medium
Action plans	
Recommendation	Responsible Officer
Management should ensure that a security exercise is planned and undertaken as soon as practical.	Head of Place Management
Agreed Management Action	Estimated Implementation Date
Agreed, A desktop security exercise was undertaken between the Port Facility Security Officer and the security company on the 14/02/2018 (Complete).	31/05/2018 to enable IA follow-up.

4. Exceptions identified from Internal Audit Site Visit – September 2017

Findings

Internal Audit visited the Pier on Tuesday 19 September 2017 to review security arrangements in place for the visit of the cruise ship Caribbean Princess. Our review did not highlight any significant issues with security arrangements, but did identify the following moderate control exceptions:

1. The PFSP includes a requirement to undertake quarterly security drills to test specific elements of the security plan. Our review established that only 3 drills had been performed and documented during the 2017 calendar year;
2. The control recording sheets and templates used by Profile Security for tasks such as security sweeps, vehicle searches and issue of passes are different and less detailed than the templates included in the PFSP. Whilst our review on the day indicated that tasks were being carried out as required, the templates and formats in the PFSP should be used to ensure compliance and full robustness at all times (for example specifically recording that the relevant areas of a vehicle have been searched).
3. The Security Inspection Sheets used by the PFSO were pre-signed with blank entry dates; The entry on the PFSO's Security Inspection Sheet template for the visit of the Caribbean Princess on 19 September 2017 appeared incorrect (recording site inspections on the 19th and 20th instead of the 18th and 19th). Our inquiries indicated that this is likely to have been a documentation error and that the inspections were in fact conducted on the correct dates. Nevertheless, this represents a failure in terms of security control documentation and would be identified as such by a DfT inspection.
4. At the time of our visit, we noted limited documentation on file to record and demonstrate the use of Temporary Traffic Restriction Orders (TTROs) although we did note that arrangements for TTROs were in place on the day of our visit. Management subsequently provided details of TTROs. These had been arranged appropriately at the time and were not created subsequently, but could not be located on the date of our site visit.

Business Implications	Finding Rating
Potential DfT assessment failure in relation to security control documentation, and non compliance with the Councils operational security processes.	Medium
Action plans	Responsible Officer
Recommendation	Responsible Officer
Management should ensure that the procedural and documentation exceptions identified above are addressed and that documentary evidence is retained on file to demonstrate this.	Head of Place Management
Agreed Management Action	Estimated Implementation Date
Agreed, 1. The timescales for drills are identified in the plan, we will ensure that a drill is undertaken quarterly in the future. The importance of this will be highlighted to the new PFSO. A drill has already been completed for the first quarter January - March, the next drill will be undertaken between April – June 2018.	31/05/2018
2. All recording sheets and templates will be reviewed and put in place in advance of the arrival of the first Cruise liner on 10th May 2018.	31/05/2018

3. This was an error by the PFSO, greater care will be undertaken in the future. The training course will briefly cover security sweeps and their importance, including recording information.	31/05/2018
4. Due to the size and number of TTRO's notices / schedules, we do not keep a hard copy on file, these are available on the internal hard drive, a page will be added to the PFSO folder providing the relevant file path.	31/05/2018

5. Implementation of Department for Transport recommendations

Findings	
<p>The DfT undertake regular announced and unannounced inspection visits. The most recent inspection at the Pier was on 8 August 2017 for the visit of the cruise ship Koningsdam.</p> <p>The subsequent DfT report highlighted two areas of 'non-conformity' and two areas where 'improvement was desirable' that have not yet been fully addressed. These related to:</p> <ul style="list-style-type: none"> • Ensuring that crew lists are received in advance of arrival; • Updating the wording of the PFSP to reflect (1) new passengers may join a cruise at Hawes Pier (albeit very rarely) and therefore require to be searched; and (2) treatment of vehicles already parked in the restricted area; • Better co-ordination of pass issue arrangements for visitors to the ship; and • Being more specific in the PFSP about how patrols are recorded and where this documentation will be retained. <p>Management has advised that these matters are being addressed, and that the delay is due to the ongoing PFSO vacancy.</p>	
Business Implications	Finding Rating
Potential non compliance with applicable legislation, and failure to address DfT recommendations on a timely basis could increase the risk of legal action or result in further recommendations from DfT.	Medium
Action plans	
Recommendation	Responsible Officer
All recommendations raised by DfT should be fully actioned and addressed as soon as possible, with actions taken recorded and retained on the PFSO file going forward.	Head of Place Management
Agreed Management Action	Estimated Implementation Date
<p>Agreed,</p> <p>The PFSO will ensure that all recommendations made by the DfT from the last inspection have be actioned and addressed.</p> <p>The Port Facility Security Plan was reviewed and updated on the 21st February 2018 and subsequently accepted and approved by the DfT on the 6th March 2018. Complete</p>	31/05/2018 - to enable IA follow-up

6. Content and Format of Port Facility Security Plan

Finding

Review of the PFSP identified a number of areas where the content requires to be updated, amended or clarified, and instances where additional documentation is required to improve the overall quality of the document. These include:

- Undertaking the required six-monthly review and refresh of the PFSP with evidence of review documented (last version update noted was 22 February 2017);
- Details of new or acting PSFO arrangements to be included along with confirmation of training being successfully completed;
- Renewal dates of Counter Terrorism Check (CTC) clearance for staff who can act as Deputy PSFO to be updated;
- Hawes Pier is not a restricted area (RA) but a temporary restricted area (TRA) – the PFSP includes numerous references to the 'RA' as opposed to the 'TRA' – clarifying this would improve the readability and consistency of the document;
- Section 11 (Checks and Searching) should be reviewed to clarify the wording and make sure that the distinctions between search requirements for passengers; other users of the pier; and for items such as unaccompanied baggage are consistent and correct
- Section 18 (PFSP Audit) should be updated to reflect that audit procedures will be undertaken by the Council's Internal Audit team.

Business Implication	Finding Rating
These changes will ensure that the PFSP is more up to date, consistent, complete and accurate in advance of the next DfT review.	Low
Action plans	
Recommendation	Responsible Officer
Management should update the PFSP in line with the points noted above.	Head of Place Management
Agreed Management Action	Estimated Implementation Date
Agreed, All points identified will be implemented within the current Port Facility Security Plan. (PFSP) The Port Facility Security Plan was reviewed and updated on the 21st February 2018 and subsequently accepted and approved by the DfT on the 6th March 2018. Complete. The minor errors with regards to TRA / RA will be rectified during the 6-monthly review.	31/05/2018 - to enable IA follow-up. 21/08/2018

Appendix 1 - Basis of our classifications

Finding rating	Assessment rationale
Critical	<p>A finding that could have a:</p> <ul style="list-style-type: none"> • 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	<p>A finding that could have a:</p> <ul style="list-style-type: none"> • 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	<p>A finding that could have a:</p> <ul style="list-style-type: none"> • 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	<p>A finding that could have a:</p> <ul style="list-style-type: none"> • 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	<p>A finding that does not have a risk impact but has been raised to highlight areas of inefficiencies or good practice.</p>

Appendix 2 – Security activities performed by Profile Security for cruise ship visits

The following security activities are performed by Profile Security for cruise ship visits

- Being present on site when cruise ships are visiting;
- Conducting security sweeps during the day of visit;
- Ensuring entry gates are locked with no access by unauthorised personnel;
- Undertaking body and bag searches for anyone entering the pier who is not a cruise ship passenger and who does not have a full pass (for example, BP employees are exempt from searches if they have their normal pass but a member of the public would require to be searched);
- Issuing temporary passes to the restricted area to credible visitors (who must show a passport or driving license);
- Conducting vehicle searches and issuing vehicle passes for all vehicles entering the pier area; and
- Distributing boarding passes provided by the Ship's Security Officer (SSO) to cruise passengers named on a pre-defined list supplied to the PFSO in advance of the cruise ship arriving.

It should be noted that the Ship's Security Officer has responsibility for searching cruise ship passengers on their return to the cruise ship – passenger searches are not undertaken by Profile Security.

The City of Edinburgh Council **Internal Audit**

Waste and Cleansing Health and Safety Review

Final Report

11 July 2018

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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 Health and Safety at Work Act etc. 1974 (HSWA) is the main piece of UK (H&S) legislation. It places a duty on all employers "to ensure, so far as is reasonably practicable, the health, safety and welfare at work" of all their employees.

The City of Edinburgh Council (the Council) provides an extensive range of services to its citizens, many of which involve manual tasks and use of heavy machinery. The Council has an established H&S policy that should be supported by operational procedures, risk assessments and controls across all Service Areas.

Provision of waste collection and operation of household waste recycling centres is a key service that is exposed to significant occupational H&S risks. Consequently, it is essential that H&S controls are consistently applied, with any instances of non-compliance urgently identified and resolved. Effective H&S compliance across waste and recycling operations is also a current specific area of focus for the Health and Safety Executive.

The Council provides waste collection (including recycling) and street cleansing services across the City and currently operates three household waste recycling centres at Craigmillar; Seafield; and Sighthill. The Council's H&S team assessed H&S compliance at each of the 3 recycling centres in November and December 2017, and Seafield refuse collection in August 2017, as part of the rolling H&S audit programme, and noted a number of areas of non-compliance (most notably in relation to refuse collection at Seafield which had been operational since March 2017) and a number of areas for improvement (H&S training; objective setting; and 'emergency procedures').

Within Place, there have been three RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013) reportable incidents raised to the Health and Safety Executive (HSE) in 2018 so far. All three incidents were sustained by employees working in refuse collection and one of these incidents was classified as a Major/'Specified' Injury. In 2017, there were four major/'Specified' and 15 over-7-day RIDDOR reportable injuries in Place – all with the exception of one were sustained by employees working in refuse collection or street cleansing.

As at the time of our review (06 April 2018), a number of structural and operational changes to Waste and Cleansing were in progress. These changes provide important context to our review and our findings and recommendations have therefore been developed with these changes in mind.

Firstly, following the merger of waste and cleansing services in 2016, there are continued efforts to provide a more efficient service. Waste and Cleansing are currently in the process of moving to a locality model whereby the services will be divided east and west across the city, with each side managed by a Waste and Cleansing Operations Manager. In March 2017, some waste and cleansing employees moved into a newly built depot at Seafield in the east of Edinburgh. This includes a household waste recycling centre and a waste transfer station. At present, a similar depot is under construction at Sighthill and this will be the main depot servicing the west of Edinburgh. Management advised that this model will allow waste and cleansing services to become more efficient with less time spent travelling across the city.

Secondly, the shift pattern for waste collection employees is due to change in October 2018, subject to staff consultation. Currently, two core shift patterns are operated within Waste. Employees work either four days on and four days off; or early / late, alternating between an early shift (6am-2pm) and a late shift (2.30pm-10.30pm) Monday to Friday. Waste and Cleansing plan to change the early / late shift pattern by removing the late shift and moving to a four-day week with a longer working day. This will

decrease the number of hours worked in the dark which should reduce the risk of slips, trips and falls. Aligned to the new shift pattern employees would be required to attend three nine-hour training days per annum. This approach will also be extended to employees on four on four off patterns to ensure all employees within the service are fully trained and fully competent to carry out the requirements of their post. Management advised that this should also reduce Waste and Cleansing's reliance on agency workers as the focus will be on having a smaller workforce of primarily permanent staff.

Scope

The objective of the review was to provide assurance that H&S risk is effectively managed across the Council's waste and cleansing service.

The review was performed by PwC Health and Safety specialists, and assessed the design adequacy and operating effectiveness of the H&S framework established across waste and recycling and street cleansing to provide management with assurance that the Council's H&S policy and associated controls are consistently applied, with all areas of non-compliance addressed and resolved in a timely manner.

The review also incorporated a review of follow-up actions to ensure that recommendations raised by the Council's Health and Safety Team in their recycling and refuse collection audits completed between August and December 2017 have been effectively implemented.

For the full terms of reference see appendix 2.

2. Executive summary

Total number of findings

Critical	-
High	-
Medium	4
Low	2
Advisory	-
Total	6

Summary of findings

Whilst no significant breaches in H&S legislation across the Council's waste and cleansing service were observed, a number of moderate health and safety control gaps were identified during the course of our review. It is worth noting that majority of these findings had already been identified by Corporate H&S but have not yet been actioned.

Consequently, four medium and two low rated Findings have been raised covering the following areas:

- 1) Significant incident/emergency procedure – there is currently no significant incident/ emergency procedure in place for Waste and Cleansing. This was also identified during a resilience internal audit review and the development of a Council wide incident/emergency procedure is currently being considered by the Council's Resilience Team.
- 2) Operational health and safety roles and responsibilities – these are not clearly defined or formally documented. One area where this lack of clarity is apparent is the distinction between the roles and responsibilities of Operations and Area Managers (as building occupiers) and Property and Facilities Management.
- 3) Health and safety training – whilst a proactive approach to H&S training is evident across waste and recycling, further improvement is required as mandatory and voluntary training is not clearly defined and online training records are incomplete.
- 4) Supervisory assurance – there is limited opportunity for supervisors to actively check Waste and Cleansing crews in the course of shifts and crew inspections are considered to be infrequent.
- 5) H&S audit approach – a collaborative approach to H&S performance audits, carried out by the Corporate H&S team, was lacking as there was no opportunity for H&S audit findings, actions, and timescales to be discussed with a waste and cleansing representative before audit reports were finalised.
- 6) H&S metrics – H&S performance in Waste and Cleansing is not monitored or analysed locally within the service. The Corporate H&S advisor reviews all H&S incidents within Place. However, there is a need for greater ownership to review data within the service itself.

Additionally, review of follow-up actions from 2017 recycling and refuse collection audits conducted by the Council's Health and Safety Team confirmed that some progress had been made in attempting to

close out the actions. However, a significant number of actions remain open (see Finding 5 below). There was a total of 160 actions with 74 marked as complete as at the time of the audit (06 April 2018).

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

Finally, our review of H&S risk management within Waste and Cleansing and discussions with the Corporate H&S team identified a number of areas of good practice which are summarised below:

- Corporate H&S have advised that the Council's Wider Leadership Team (WLT), comprising Directors, Head of Services, and Senior Managers (including Tier 3 managers in Waste and Cleansing), will complete or have completed IOSH Leading Safely training. We would consider this to be leading practice and this will help to deliver an even more robust 'tone from the top' on H&S across the council.
- Our discussions with individuals highlighted that the Waste and Cleansing leadership team show a commitment to H&S, delivering a robust 'tone from the top'.
- It is apparent from interviews with site management and staff that there is a strong positive H&S culture throughout the service area.
- In recognition of under-reporting of near misses, the Corporate H&S team has published and communicated guidelines for managers and employees to promote incident and near miss reporting. These guidelines clearly distinguish what constitutes an incident and a near miss. Additionally, we understand that there will be two workshops specifically for Waste and Cleansing employees to promote the benefits of incident reporting and encourage reporting.
- All RIDDOR reportable incidents are reported to the HSE by the Corporate H&S team to ensure accuracy and consistency of reporting.
- Efforts are being made to maximise operational efficiency across Waste and Cleansing to allow more time for H&S training and for supervisory assurance, e.g. introduction of a locality model and a four-day week for individual bin collections.
- In recognition of an ageing workforce, Waste and Cleansing has developed a comprehensive training package for new supervisors who have been internally recruited.

3. Detailed findings

1. Significant incident / emergency procedure

Finding


The lack of a Council wide significant incident/emergency response and reporting framework was identified during a recent internal audit review of Resilience and is currently being considered by the Council's Resilience Team, however, our review confirmed that Waste and Cleansing do not appear to have a clearly defined significant incident and escalation procedure.

Whilst we were made aware of a bomb threat procedure, many individuals we spoke to were unaware of there being a significant incident procedure within Waste and Cleansing. Of the 8 people we spoke with, 2 were unfamiliar with the bomb threat procedure. Discussions with individuals highlighted that

there may be procedures for specific events, e.g. as part of risk assessments, and that key members of management rely on their experience to know what to do in the event of an emergency.

Waste and Cleansing H&S audits make reference to a 'risk notification procedure' which has the same objective as the significant incident procedure and specifies the protocols to be applied in case of any serious imminent H&S risks. Individuals that we spoke to were unfamiliar with this procedure and were unclear what it should entail.

As part of the close out of the H&S audit actions, a note has been made against the risk notification procedure action that Resilience are working on a Council wide framework. From discussions with management, neither the Council wide framework or local waste and recycling procedures have been formally developed, documented, and communicated to staff.

Business Implication	Finding Rating
<ul style="list-style-type: none"> In the event of a serious incident that is not a bomb threat, it is not currently clear what procedure should be followed within Waste and Cleansing; There may be significant reputational implications for the Council, if a serious incident is not handled appropriately due to the lack of a Waste and Cleansing emergency procedure; and Sufficient controls to mitigate a serious incident may also not be known and/or put in place which may increase the risk of injury as a result. 	

Action plans

Recommendation	Responsible Officer
<ol style="list-style-type: none"> As a matter of priority, seek support from Resilience to understand the requirements of a significant incident and escalation procedure, and develop a procedure for Waste and Cleansing with an agreed title that clearly sets out the procedure that should be followed in the event of a significant incident. This should include responsibilities and arrangements relating to notification, evacuation, escalation etc. Once developed, ensure that this is clearly documented, communicated to all staff and that relevant individuals are appropriately trained. Ensure that the existing bomb threat emergency procedure is clearly communicated to all relevant staff. E.g. via toolbox talks. 	<p>Andy Williams, Waste, and Cleansing Service Manager</p>

Agreed Management Action	Estimated Implementation Date
<ol style="list-style-type: none"> Arrange workshop with Resilience to understand the requirements of significant incident and escalation procedures. Develop the procedure and arrange tool box talks with staff to cascade the procedure; and In conjunction with colleagues in Resilience develop an emergency procedure, to include a specific bomb threat procedure, for Waste and Cleansing Services. Once developed to ensure that procedures are communicated to all staff via toolbox talks; and 	<ol style="list-style-type: none"> 28 September 2018 28 September 2018

2. Operational health and safety roles and responsibilities

Finding

The clear definition and communication of roles and responsibilities for H&S within the Service Area is a requirement under the Council Health and Safety Policy (see 4.5). The Council's Health and Safety Strategy and Plan 2018-2020 also includes an Aim to 'provide clarity on H&S roles and responsibilities' across the Council

Through our conversations with Waste and Cleansing Operations and Area Managers, it is apparent that operational H&S roles and responsibilities are not clearly defined or communicated. We understand that there is currently no document in place which sets out the operational roles and responsibilities at each depot.

In particular, the split of H&S responsibilities between Property, Facilities Management and the Building or Site H&S Responsible Person is in need of clarification. Concerns were raised that the Site Responsible Person has been required to undertake activities that they did not feel they had the knowledge or competence to undertake, e.g. lightning rod conductor inspections and water pressure checks. Similarly, actions from recent H&S performance audits had been allocated to the Waste and Cleansing Operations/Area Managers, e.g. relating to lift inspections, legionella risk assessments and emergency lighting, but should instead be the responsibility of and actioned by the Corporate Property and Facilities Management team. We understand that some of these actions have now been transferred over, however it is evident that a document that clearly sets out operational H&S roles and responsibilities is required.

Business Implication

- H&S risks, particularly around building safety, may not be effectively managed if operational roles and responsibilities are not clearly defined and communicated;
- H&S controls may be insufficient, e.g. relating to statutory inspections of buildings. Without appropriate maintenance and repair regimes carried out by competent persons, this could result in injury or disease to internal/external customers; and
- There may also be potential financial, legal and reputational implications if the Council is found to be non-compliant.

Finding Rating

Medium

Action plans

Recommendation

1. Identify H&S site and equipment checks to be carried out;
2. Agree responsibilities for carrying these out between waste and cleansing, property services and facilities management;
3. Clearly define the H&S roles and responsibilities for each waste and cleansing site in an 'Operational roles and responsibilities' document. Involve relevant stakeholders, e.g. Facilities Management, Waste and Cleansing Operations Managers and Area Managers, so that expectations can be set out and disagreements resolved before finalising; and

Responsible Officer

Andy Williams, Waste, and Cleansing Service Manager and Mark Stenhouse (Property FM)

4. Ensure that this document is clearly communicated and made accessible to all relevant persons.	
Agreed Management Action	Estimated Implementation Date
1. and 2 - In conjunction with Property and Facilities Management produce list of site and equipment checks to be carried out and agree responsibilities; and 3. and 4 - Co-develop H&S Roles and Responsibilities for each site and provide to relevant Managers on site	1 and 2. 31 July 2018 3 and 4. October 2018

3. Supervisory assurance

Finding

Waste and Cleansing supervisors currently have reduced capacity to carry out supervisory assurance (checking). We would consider supervisory checking to be a critical aspect of the assurance model as this should be the first level of ensuring crew tasks are carried out to the expected standards of safety. We understand that each supervisor has between 30 and 40 persons under their supervision for each shift. A supervisor will carry out a briefing at the beginning of a shift, which will include issuing paper work and carrying out crew checks, e.g. ensuring that appropriate Personal Protective Equipment (PPE) is worn. Ideally, the supervisor should then carry out random spot checks, while the crews are out and about during the course of the shift.

However, due to a significant office-based workload relating to customer complaints, sickness absence management, and incident investigations for example, there is limited time for supervisors to go out and check their crews throughout the shift. At present, it is apparent that crew inspections, when carried out, are informal and supervisors do not complete an inspection checklist. This highlights a weakness in Waste and Cleansing's first line of assurance as routine crew inspections are limited and are not recorded.

We understand that the introduction of the locality model and four day week should make it easier for supervisors to reach their crews and perform inspections, as crews will be operating in a smaller geographical area. In addition, there are plans to revise supervisor responsibilities. Management advised that there will be an office-based supervisor per shift, (e.g. focusing on responding to customer complaints and managing the RouteSmart software system) and two mobile supervisors to perform assurance on crews, carry out risk assessments and to perform incident investigations.

Business Implication

- Once Waste and Cleansing employees have left the depot, there is a risk that safe working practices are not being adhered to, e.g. employees may not be wearing full PPE. H&S controls may therefore be insufficient and the risk of injury may be increased for internal and external customers; and
- There may also be moderate reputational implications for the Council as there may be increased customer complaints if unsafe behaviour is witnessed, e.g. reckless driving.

Finding Rating

Medium

Action plans

Recommendation	Responsible Officer
<ol style="list-style-type: none"> 1. Continue with plans to introduce two mobile supervisors per shift with responsibility for carrying out crew inspections. If supervisors have increased contact with their crews, this will provide opportunity to call out unsafe working practices and identify where additional training is required; 2. Introduce a formal work inspection template to ensure that supervisory assurance is recorded, thorough and consistent. Results of this assurance activity could then be used to identify trends and if necessary, linked into training; and 3. As previously advised by the Corporate H&S team, continue to increase the accountability of drivers (Crew leaders), e.g. if unsafe behaviour is identified, both the employee concerned and the driver are held accountable and may be reprimanded accordingly. This should encourage drivers to act as another line of defence in H&S assurance and to call out unsafe working practices. 	<p>Andy Williams, Waste and Cleansing Service Manager</p>
Agreed Management Action	Estimated Implementation Date
<ol style="list-style-type: none"> 1. To hold briefings with all Drivers / Crew Leaders to reinforce H&S roles and responsibilities; 2. To ensure the first phase of the mobile supervisor model is linked to implementation of the 4 day week; and 3. To ensure that a suitable checklist is developed to coincide with mobile supervisor roll out. 	<ol style="list-style-type: none"> 1. 31 July 2018 2. 21 December 2018 3. 21 December 2018

4. Health and safety training

Finding

Waste and Cleansing proactively commissioned a bespoke manual handling training course in 2017 which has been rolled out across Waste and Cleansing. Additionally, the Service Area identified a need for training in violence and aggression and a course was sourced by HR L&D and has been rolled out. There is also a suite of H&S training courses delivered by the Corporate H&S Team and Waste and Cleansing employees are encouraged to attend. Waste and Cleansing Operations and Area Managers, however, perceive that training is often delivered in response to an incident. For example, a near miss or incident relating to reversing, may trigger a toolbox talk to be delivered across the service area on that specific topic.


We understand that Corporate H&S and Waste and Cleansing are working together to develop training matrices that set out training needs for specific roles across the service area, with training matrices being created in collaboration with Zero Waste Scotland as part of the SWITCH Forum (Scottish Waste Industry Training, Competency, Health & Safety)¹. We understand that Waste and Cleansing are also looking to introduce a dedicated internal training officer which should help to make H&S training more proactive.

Management explained that for employees working in Waste in particular, it is difficult to find the time to carry out training around service delivery. However, we understand that the change in shift pattern

will help to alleviate this problem. Each employee should have two to three days a year which can be solely dedicated to training once Waste and Cleansing moves to a four-day week.

- We identified that the distinction between mandatory and voluntary training is not always clear. Additionally, it is unclear what the implications are for employees that do not complete mandatory training. For example, we understand that manual handling training is mandatory, however it was noted that some employees had not undertaken this training – many cited that they did not feel they needed the training or that it was not relevant to them.
- We understand that attendance at all H&S courses delivered by the Corporate H&S Team, or external H&S courses administered by HR, is recorded on iTrent (by Business Support in HR L&D Team). However, the Council’s online training record system, iTrent, is not consistently kept up to date for Waste and Cleansing employees, e.g. attendance at the bespoke manual handling training delivered in 2017 had not been recorded on iTrent Records suggested that some employees were last trained on manual handling in 2003. It is difficult to distinguish whether training is required or whether the records just need updating. Additionally, a council wide issue is that the iTrent system does not automatically flag when training is due to expire. It is therefore a manual process to check individual employee profiles to see what training they require and this can be a challenging process, where records are also not up to date.
- We understand that training for existing supervisors has been ad hoc and informal up to this point. Management highlighted that finding the time to train existing supervisors has been challenging, as it is necessary to find appropriate cover to maintain service delivery. However, Waste and Cleansing are introducing a formal training package for eight existing Council employees to become trainee supervisors. This training is being delivered as part of Waste and Cleansing’s succession planning, as we understand there is an ageing workforce with many due to retire in the next decade. Whilst we would consider this supervisor training package to be good practice, this highlights a gap in the training provision for existing supervisors.


¹ <http://www.zerowastescotland.org.uk/content/switch-forum>

Business Implication	Finding Rating
<ul style="list-style-type: none"> • With incomplete training records and a lack of monitoring of mandatory training, there is a risk that some employees do not have the appropriate level of formal training to carry out their roles safely. This may result in a heightened risk of injury for those employees, those they work with and to external customers. • The council may be held liable if an incident should occur involving an employee that is found to be insufficiently trained. 	 <p>Medium</p>

Action plans	
Recommendation	Responsible Officer
<ol style="list-style-type: none"> 1. Continue with plans to adopt a more proactive approach to training, e.g. by creating training matrices for individual job roles, appointing a dedicated training officer and through dedicated training days as part of the new shift pattern. 2. Within the new training matrices, ensure that mandatory and voluntary trainings are clearly defined. For mandatory training, clearly state when training is due to expire/how often refresher training should be carried out. 3. Define a procedure to be followed if employees have not completed mandatory H&S training and outline potential implications, e.g. 	<p>Andy Williams, Waste, and Cleansing Service Manager</p>

<p>disciplinary action. Ensure that this procedure is communicated to employees as required.</p> <p>4. Consider offering key elements of the new supervisor training package to existing supervisors to address any known gaps and promote consistent standards of supervision.</p>	
Agreed Management Action	Estimated Implementation Date
<ol style="list-style-type: none"> 1. Develop Business Case for training officer roles and, if approved, recruit; 2. Identify within training matrix the training that is core and non-core; 3. Work with HR to define procedure for training compliance. Ensure Training consultation with staff covers non-attendance; 4. Review training delivered to substantive Supervisors against the induction package for Trainee Supervisors. Develop and carry out plan to fill knowledge/training gaps for substantive supervisors 	<ol style="list-style-type: none"> 1. 28 September 2018 2. 28 September 2018 3. 31 October 2018 4. 31 October 2018

5. Health and safety metrics

Finding	
<p>Waste and Cleansing H&S metrics are not currently monitored or analysed locally within the service on a regular basis.</p> <p>We understand that a quarterly H&S dashboard for the Place Directorate is produced by Corporate H&S team. The dashboard includes metrics on employee incidents, near misses and RIDDOR reportable incidents, alongside an overview of audit activities and H&S training statistics.</p> <p>There is also a monthly Waste H&S working group, attended by a representative from Corporate H&S and from Trade Unions, during which H&S matters and performance is discussed.</p> <p>There is currently no specific H&S dashboard produced for Waste and Cleansing, but Corporate H&S have explained that service areas are able to generate this by running reports directly from the SHE Assure system, enabling management to review and discuss health and safety performance more frequently.</p>	
Business Implication	Finding Rating
<ul style="list-style-type: none"> • Regular proactive monitoring and analysis of H&S performance metrics could help to identify where improvements need to be made within Waste and Cleansing, e.g. repeated near misses may highlight weak controls, allowing the Council to rectify this before an incident occurs. • Incident and near miss trends may highlight where training could be improved, e.g. via toolbox talks. • Regular discussion of H&S performance at all levels, e.g. as part of crew briefings before a shift, will help to improve awareness of key H&S issues and solidify a positive culture around H&S. This could help to reduce the number of incidents and near misses on the ground due to raised awareness, and would also be likely to encourage reporting of incidents and near misses. 	 <p>Low</p>

Action plans

Recommendation	Responsible Officer
<ol style="list-style-type: none"> 1. Consider implementing a monthly action to download the latest H&S metrics for Waste and Cleansing off the SHE Assure system and circulate these, alongside any trend analysis, to all relevant persons in Waste and Cleansing, e.g. Head of Service, Operations and Area Managers, Supervisors. 2. Encourage regular proactive discussion of H&S performance, e.g. as part of the Waste and Cleansing performance review meetings and as part of Supervisor briefings before each shift. 	<p>Andy Williams, Waste, and Cleansing Service Manager</p>
Agreed Management Action	Estimated Implementation Date
<ol style="list-style-type: none"> 1. Request reporting training for Waste & Cleansing Managers on reporting functions within SHE and include monthly H&S performance and trend reports on Operations and Senior Management Team meeting agendas 2. H&S performance to be included within Looking Ahead conversations 	<ol style="list-style-type: none"> 1. 31 July 2018 2. 31 July 2018 (May for Senior Managers)

6. Corporate Health and safety audit approach

Finding

In 2017, a number of Corporate H&S audit reports were issued following audits of the following sites: Seafield Depot, Seafield Household Waste Recycling Centre (HWRC), Craigmillar Depot and Sighthill HWRC. Our discussions with Operations and Area Managers have highlighted a number of concerns relating to the audit approach and follow up of related actions.


We understand that the Corporate H&S team, specifically the H&S Advisor for Place, has proactively engaged with each site and offered support on the audit actions, e.g. via dedicated meetings, over the phone and via email. However, we understand that there was no consultation with each site before each audit report was finalised to discuss the findings, actions, and timescales for action close-out. Individuals raised concerns that some findings were not felt to be relevant, that the actions were not always clear or necessarily assigned to the right persons and that the timescales were unrealistic. There was no opportunity to discuss or raise these concerns prior to the audit reports being finalised.

Corporate H&S management were aware of this issue and (at the time of our review) were implementing appropriate actions to ensure that this was addressed.

Across all four Waste and Cleansing audits, there are a total of 160 actions with 74 marked as complete as at 16th March 2018. An employee has been assigned to focus on closing out the actions of these audits, but even with numerous consultations with the Corporate H&S team, the sheer number of actions and occasional lack of clarity, e.g. on who should own the action or what a finding/action actually means, has meant that this process has not been straightforward. For example, as mentioned in Finding 4, there was a lack of understanding of what a risk notification procedure (Action 14.4/14.5) was meant to include and who should own this action.

Additionally, we understand that there was a lack of understanding on an action relating to emergency lighting for the Seafield HWRC site (Action 13.15), i.e. whether there was actually any emergency

lighting in place. It was also highlighted that many actions should either sit with Facilities Management or at least required guidance from this team, e.g. relating to fire alarm inspections and maintenance records and emergency procedures for lift breakdowns.

Business Implication	Finding Rating
<ul style="list-style-type: none"> A formal consultation process with all relevant persons, e.g. Corporate H&S, Operations and Area Managers, Corporate Property/ Facilities Management, etc. would allow for the Council to: a) discuss draft findings and actions in order to raise any areas for clarification or identify concerns/disagreements; b) ensure actions were appointed to the right persons; and c) allow for reasonable and practicable timescales for completion to be agreed. 	
Action plans	
Recommendation	Responsible Officer
<ol style="list-style-type: none"> For future H&S audits, adopt a more collaborative approach and ensure that relevant stakeholders have been appropriately engaged before finalising reports, e.g. via a close out meeting. This will provide an opportunity to give clarification, discuss any disagreements, ensure that actions are allocated to the right persons and allow timescales to be agreed. This should help to facilitate the prompt close out of actions and ensure that any weaknesses identified by the audit are promptly addressed. 	Susan Tannahill, Head of Health and Safety
Agreed Management Action	Estimated Implementation Date
<p>This gap was identified prior to this audit, and action has already been taken to ensure that all H&S audit reports are issued in draft for comment prior to being finalised, to ensure consistency across the Council. The Corporate Health and Safety Team will continue to provide specialist advice and guidance to support the service to close audit actions.</p>	<p>This action has been closed by management and validated by IA prior to issuing the final report.</p>

Appendix 1 – Basis of our classifications

Finding rating	Assessment rationale
Critical	<p>A finding that could have a:</p> <ul style="list-style-type: none"> • 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	<p>A finding that could have a:</p> <ul style="list-style-type: none"> • 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	<p>A finding that could have a:</p> <ul style="list-style-type: none"> • 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	<p>A finding that could have a:</p> <ul style="list-style-type: none"> • 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	<p>A finding that does not have a risk impact but has been raised to highlight areas of inefficiencies or good practice.</p>

Appendix 2 – Terms of Reference

Place

Terms of Reference – Health and Safety – Waste and Recycling

To: Paul Lawrence, Executive Director, Place

From: Lesley Newdall, Chief Internal Auditor

Date: 2 April 2018

Cc: Gareth Barwell, Head of Place Management
Andy Williams, Waste and Cleansing Service 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. The review will be performed by PwC specialists under the terms of the current Internal Audit co-sourcing agreement.

Background

The Health and Safety at Work Act etc. 1974 (HSWA) is the main piece of UK health and safety legislation. It places a duty on all employers "to ensure, so far as is reasonably practicable, the health, safety and welfare at work" of all their employees.

The City of Edinburgh Council (the Council) provides an extensive range of services to its citizens, many of which involve manual tasks and use of heavy machinery. The Council has an established Health and Safety policy, that should be supported by operational procedures, risk assessments and controls, across all Service Areas.

Provision of waste collection and operation of household waste recycling centres is a key service that is exposed to significant occupational health and safety risks. Consequently, it is essential that health and safety controls are consistently applied, with any instances of non-compliance immediately identified and resolved. Effective Health and Safety compliance across waste and recycling operations is also a current specific area of focus for the Health and Safety Executive.

The Council provides waste collection (including recycling) and street cleansing services across the City and currently operates three household waste recycling centres at Craigmillar; Seafield; and Sighthill. The Council's Health and Safety team assessed health and safety compliance at each of the recycling centres in December 2017 as part of the rolling H&S audit programme, and noted a number of areas of non-compliance (most notably in relation to refuse collection at Seafield which had been operational since March 2017) and a number of areas for improvement (health and safety training; objective setting; and 'emergency procedures').

Scope and Approach

The objective of the review is to provide assurance in relation to the following key Corporate Leadership Team (CLT) risks:

Health and Safety - *there is a risk of non-compliance with the Council's legislative obligations and associated suite of health and safety policies. Also, any failure to implement adequate controls or meet applicable legislation could risk an incident resulting in harm to staff, agency workers, contractors, service users or members of the public, together with liability claims, regulatory fines and associated reputational damage.*

The review will assess the design adequacy and operating effectiveness of the H&S framework established across waste and recycling and street cleansing to provide management with assurance that the Council's Health and Safety policy and associated controls are consistently applied, with all areas of non-compliance addressed and resolved in a timely manner.

The review will also incorporate a review of follow-up actions to ensure that recommendations raised by the Council's Health and Safety Team in their recent recycling and refuse collection reviews have been effectively implemented.

Limitations of Scope

- Compliance with applicable health and safety requirements for employees and agency workers who drive as part of their role are specifically excluded from the scope of this review, as this risk is covered by a separate audit that is due for completion by 31st March 2018.
- Property related H&S requirements for the relevant CEC sites (e.g. fire risk, legionella controls) are excluded from scope.

Approach

Our audit approach is as follows:

- Obtain and review health and safety policies and local procedures to check that they apply and appropriately control Health and Safety risks associated with waste and recycling and street cleansing;
- Obtain and review relevant H&S risk assessments to check that all significant risks have been identified and suitable controls have been identified and implemented
- Obtain an understanding of how management ensures that policies and local procedures are consistently applied to ensure ongoing compliance with applicable health and safety requirements;
- Confirm that key health and safety metrics have been established and are supported by management information and reporting;
- Obtain an understanding of the processes applied to establish the root cause of any significant or recurring health and safety incidents; and
- Obtain an understanding of what management arrangements are in place to ensure that health and safety controls are maintained where CEC employees (and agency workers) are working on 3rd party facilities such as waste disposal sites. The sub-processes and related control objectives included in the review are:

Sub-process	Control Objectives
Health and Safety Management	<ul style="list-style-type: none"> • Adequate health and safety governance measures, risk assessments; controls; assurance, and management oversight have been established to support waste and recycling and street cleansing operations; • Appropriate ownership of local H&S arrangements, including clarity on operational roles and responsibilities, has been established and is regularly reviewed and refreshed, with changes communicated to all employees; • Risk assessments and controls are regularly reviewed to reflect the outcomes of any recurring or significant incidents as well as to ensure compliance with Council H&S Policy, legal and regulatory requirements and relevant industry standards and best practice. • Adequate co-ordination for H&S arrangements at 3rd party sites. • Adequate H&S arrangements for agency staff. • Appropriate engagement and consultation with Trades unions. • Significant incident procedure is in place and has a good level of awareness.
Health and Safety Performance	<ul style="list-style-type: none"> • Appropriate assurance and governance arrangements have been established by management to confirm ongoing compliance with health and safety requirements; • These assurance arrangements are subject to ongoing review and revision to reflect any changes, any new health and safety legislative requirements / industry standards, and changes in the organisational structure • Metrics include incident statistics, breach reporting and details of any significant or recurring incidents and training attendance and completion;

	<ul style="list-style-type: none"> • Management information is prepared and provided to management at appropriate intervals to provide information on compliance; details of breaches and incidents; and ongoing training completion; • Select a sample of significant breaches and recurring incidents and confirm that appropriate and timely action is taken by management to identify and address the root causes; • Select a sample of employees who have not completed the necessary health and safety training and explore the root causes of these omissions. Understand how management proposes to rectify; and • Select a sample of significant and recurring incidents and breaches and confirm that appropriate action has been taken by management to address these and mitigate the risk of recurrence
Follow-up	<p>Select a sample of the actions from the three Health and Safety audit reports issued in December 2017 and confirm (by obtaining supporting evidence) that appropriate action has been implemented timeously to address the gaps identified.</p> <p>Select a sample of incident investigations and confirm (by obtaining supporting evidence) that appropriate action has been implemented timeously to address the areas for improvement identified.</p>

Internal Audit Team

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Timetable

Fieldwork Start	3 April 2018
Fieldwork Completed	6 April 2018
Submission of Draft Report	15 April 2018
Response from Auditee	29 April 2018
Final Report to Auditee	5 May 2018

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) 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:

- Copy of Council health and safety policy
- Copies of health and safety procedures for waste and recycling and street cleansing
- Details of health and safety key performance metrics
- Details of health and safety assurance arrangements (e.g. audits) (if any)
- Copies of the most recent health and safety management information
- Details of any recent health and safety incidents (reportable and near misses) and any policy breaches.

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

Appendix 3 – Sample of audit actions

Site/Audit Report	Action Reference	Action	Notes from discussion
Seafield Refuse Collection	13.15	Contact Corporate Property in relation to emergency lighting being installed.	Pending - Unsure about why emergency lighting is needed. Needs to check with the supervisors.
	15.4.1/15.4.2	Manager to contact Corporate Property to establish the presence/or not, of asbestos in the property.	Completed - No asbestos in buildings. Training being carried to help staff identify asbestos waste.
	13.5	Ensure fire drills are carried out.	Pending – Team not sure who is responsible for carrying out fire drills. Robert Brown (Area Manager) thinks this action should sit within Facilities Management’s remit.
Craigmillar Depot	13.1	Fire risk assessment requires update/review.	Pending – This is being followed up with Facilities Management.
	15.3.7	Ensure test and inspections for mobile lifting equipment (JCB) are carried out.	Pending – further help required
	14.4	Ensure a risk notification procedure is put in place (see audit criteria box 14.4).	Pending - There is no set risk notification procedure throughout waste. Resilience team are working on a council wide process. N/A – Team has provided feedback to H&S that they are not clear on what a “risk notification procedure” is.
Sighthill HWRC	4.8.1	Ensure specific noise assessments are carried out to establish/confirm sound levels both inside and outside the cabs of the JCB-3CX and JCB 360.	Pending
	5.1	Ensure health and safety objectives have been set for the unit/ directorate (linked to identified risks, opportunities and performance criteria).	Pending – Actions sits at senior management level (rather than depot level)

	14.4	Ensure health and safety objectives have been set for the unit/ directorate (linked to identified risks, opportunities and performance criteria).	<p>Pending - There is no set risk notification procedure throughout waste. Resilience team are working on a council wide process.</p> <p>N/A – Team has provided feedback to H&S that they are not clear on what a “risk notification procedure” is.</p>
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Governance, Risk and Best Value Committee

10:00, Tuesday, 31 July 2018

Improving the implementation of Council decision making

Item number	7.3
Report number	
Executive/routine	
Wards	
Council Commitments	

Executive Summary

This report provides a follow up to the November 2017 report on the dissemination of council policies and sets out a strategic approach to how the council can improve the implementation of council decisions and how we can provide better assurance that successful implementation is taking place.

The proposed approach recommended for approval has five strands of work recognising the importance and long-term nature of the issue.

Improving the implementation of Council decision making

1. Recommendations

- 1.1 That the Committee agrees the approach set out at 3.2 and agrees to a follow up report providing an update on the activity proposed in the report in early 2019.

2. Background

- 2.1 The Governance, Risk and Best Value Committee (GRBV) had previously agreed a revised approach for the dissemination and implementation of committee decisions by directorates. It was agreed to introduce a spot-check on the dissemination of Council policies with a reporting going to GRBV in November 2017.
- 2.2 The 2017 report provided the fourth of these updates and included the results of a spot checking exercise that was undertaken in April 2017 which focussed on dissemination to Council officers of two Council policies by way of a questionnaire to randomly selected officers from two service areas.
- 2.3 This was emailed to officers by Senior Executive Officers using the Survey Monkey platform and utilised an expanded sample size. Questions were tailored to gain an understanding of officer's awareness of where to find policies. The expanded sample size of 240 for each survey was maintained, however, response rate was significantly lower than previously, with only 34 individuals responding to each survey. The selected policies were the Health and Safety Policy and the Managing Customer Contact in a Fair and Positive Way Policy.
- 2.4 At Committee it was agreed to provide a future report on more effective ways to monitor the dissemination and understanding of Council policies.

3. Main report

- 3.1 Whilst the approach set out in 2.1 is helpful and provided meaningful feedback it is felt that a refreshed and broader approach is required if longer term improvement and cultural change is to be successful. This revised approach brings together process improvement, digital innovation, and cultural change with the aim of bringing longer term improvement to the successful implementation of council decision making. Within this, the report sets out some improvement activity that has already taken place, some that is in active development and proposals to pilot

new approaches, the culmination of which it is hoped will support a comprehensive approach to the implementation of council decisions.

- 3.2 The five proposed strands of work are to:
- 3.2.1 Review and evolve the Council's existing Policy Register to improve the foundations of council policy implementation;
 - 3.2.2 Review the Council's current report template to better capture implementation actions and next steps for all council decisions;
 - 3.2.3 Introduce a new committee management solution to modernise and digitalise the process and recording of Council decision making;
 - 3.2.4 Further align the Council's Change Portfolio to ensure all major change is captured and monitored and successfully implemented; and
 - 3.2.5 Pilot a new learning and insight approach to improve our understanding of the practical delivery of council decisions and how managers can most effectively support their implementation.

Review of the Council's Policy Register

- 3.3 The council's policy register was established in April 2015 to ensure that all council policies were recorded and captured in a single place. This was introduced to ensure that the public could access council policy in an easy and transparent manner and to reinforce the importance of the role of elected members in setting policy. The register is managed by Strategy and Insight and is updated as new council policies are introduced or existing policy amended.
- 3.4 It is proposed that Strategy and Insight undertake a strategic review of the register to both ensure that it is fully up to date and includes all council policy but also that the register is evolved to provide greater nuance and distinction between different types of council policy, for example the separation between internal human resources policies and external facing strategic policy direction. It is hoped this will improve the impact of the register and the quality and accessibility of the information contained within the register.
- 3.5 This review would also consider how the policy register would align with the introduction of a new committee management solution at 3.7. The conclusions of this review would be brought back to Corporate Policy and Strategy Committee for any decision and as part of the follow up report to GRBV in early 2019 after consultation with members of GRBV as part of the process.

A review of the Council's Report Template

- 3.6 The Council's report template is scheduled for review and consideration by Strategy and Insight in conjunction with GRBV members. It is recognised there is opportunity to improve the template, alongside broader support for officers in improving the quality of council reports, to improve council decision making. As part of this work there is an opportunity for the report template to clarify the implementation approach for council decisions ensuring elected members see greater clarity on next steps and

ensuring the policy cycle is fully reflected from inception to conclusion. It is therefore proposed that the review of the template considers an overt implementation section to the template. Again, this will be brought back to GRBV for consideration as part of the follow up to this report in early 2019.

Introduction of a new Council decision making support management solution

- 3.7 Strategy and Insight are currently working with ICT to implement a new Council decision making digital solution. The solution will digitalise the management of committee business and follow up decision making, help to make the process more efficient, more transparent, and easier to track progress against.
- 3.8 Procurement and market testing is currently underway with implementation currently scheduled for April 2019. Alongside the other elements of this approach it is intended that this will have a very significant impact in the tracking and follow up of council decisions. It is proposed that an update of this work is brought back in the follow up of this report in early 2019.

Further align the Council's Change Portfolio

- 3.9 In February 2018 GRBV agreed a revised approach to the management of significant change across the council to ensure that all significant projects, both physical and broader change was captured and managed as part of a whole system approach. The first cycle of the new approach was presented to GRBV in May and included 52 different change projects across the council. This is a fundamental part of council implementation and it is proposed that as part of this broader approach to council implementation the alignment between the change portfolio and the policy register is considered to ensure alignment and join up. Any conclusions of this assessment would be again reported back to GRBV as part of the follow up report on this issue.

Pilot a new learning and insight approach to support council implementation

- 3.10 Previous approaches to improve the dissemination of council decision making have centred around undertaking surveys to understand implementations and their implications. Building on this good work it is proposed we pilot a new approach to make the council's approach to following up on council decision making more holistic.
- 3.11 The proposal is that we would pilot an ethnographic approach. This approach would be to select a specific council policy, food waste implementation has been suggested as a good example, and to observe in setting the practical implementation of the policy and to then analyse that against the policy agreed by council. In the pilot phase this work would be undertaken by qualified researchers within Strategy and Insight but if shown to be successful could adopted more broadly.
- 3.12 Based on the field work we would then work with Communication colleagues, Learning and Development within HR and most of all managers within the service to look at any activity required to ensure implementation aligned with the agreed

policy. Practically, this could include additional training, work within teams and communications activity to ensure staff knew what was required of them and that we were working with them in a supportive way to ensure successful implementation.

- 3.13 This approach could also potentially improve council policy making by providing a feedback loop to committee on the practical challenge and consequences of any agreed policy which may result in council wishing to amend or potentially change decisions.
- 3.14 Clearly, resources are not available for this to be undertaken for all council policies but it is proposed that this is piloted with a single policy with the result brought back to GRBV for consideration and analysis before potentially widening out the methodology to further specific council policies. It is proposed that this work would be undertaken in the autumn of 2018 with the result brought back to Corporate Policy and Strategy Committee and GRBV in early 2019.

4. Measures of success

- 4.1 To have more transparent and effective arrangements in place to improve the process involving the decision and the implementation of that decision.

5. Financial impact

- 5.1 There are no financial impacts arising from this report.

6. Risk, policy, compliance and governance impact

- 6.1 The proposals in the report seek to improve the governance arrangements supporting decisions and the subsequent implementation throughout the Council. An improved monitoring process and the expected benefits this would bring to culture and operational effectiveness should lead to more effective governance arrangements and reduce the risk of non-compliance with Council policy or statute.

7. Equalities impact

- 7.1 There are no equality impacts arising from this report.

8. Sustainability impact

- 8.1 There are no sustainability impacts as a result of this report.

9. Consultation and engagement

- 9.1 Engagement with elected members and officers would take place if the proposals are agreed.

10. Background reading/external references

10.1

Andrew Kerr

Chief Executive

Contact: Gavin King, Senior Manager Democracy, Governance and Resilience

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11. Appendices

Governance, Risk and Best Value Committee

10.00am, Tuesday, 31 July 2018

Licensing Forum: Update on Review of Constitution and Membership

Item number	7.4
Report number	
Executive/routine	
Wards	All
Council Commitments	

Executive Summary

The Local Licensing Forum ('the Forum') is a lay advisory body set up by the Council as required by the Licensing (Scotland) Act 2005. The Forum is a separate legal entity from the Council and is not a Council committee. The Council has a legal duty to establish a Forum, to appoint the membership of the Forum, and to provide support and assistance as required.

This report updates the committee on steps taken to move forward with this work.

Licensing Forum: Update on Review of Constitution and Membership

1. Recommendations

- 1.1 The Governance, Risk and Best Value Committee is asked to note:
 - 1.1.1 the appointment of three temporary Licensing Forum members representing the community which returns the Licensing Forum to a membership of 21; and
 - 1.1.2 notes the progress made on reviewing the appointment process and constitution, with a revised process and constitution to be submitted to the City of Edinburgh Council for approval in September 2018.

2. Background

- 2.1 The Licensing (Scotland) Act 2005 ('the Act') requires local authorities to establish a 'Local Licensing Forum'. Whilst Licensing Boards have been in place as separate legal entities for many years, Licensing Forums were created by the Act. However, both are independent of the Council and its structures. The Act does not provide any mechanism by which the Council could exercise governance over the Forum.
- 2.2 The Act sets out the functions of the Forum, specifically:
 - 2.2.1 keeping under review the operation of the Act in the Forum's area, and the exercise by the local Licensing Board of its functions; and
 - 2.2.2 giving advice and making recommendations to the Board in relation to those matters as the Forum considers appropriate.
- 2.3 The Act makes it clear that the Forum's role is not to review, give advice or make recommendations to the Board in relation to the exercise of their functions in relation to particular cases.
- 2.4 The operation, membership and constitution of the Forum was reviewed in 2012, shortly after the local government elections. All reports relating to the Forum have been dealt with by full Council, as none of the existing executive committees have the Licensing Forum within their remit.
- 2.5 The constitution of the Forum was reviewed in 2017 and Council agreed those changes in [November 2017](#). Following meetings of the Governance Risk and Best Value Committee earlier this year a further review of the constitution commenced in March 2018.

3. Main report

Review of Forum Membership Appointment Process and Constitution

- 3.1 As requested by the Committee, a review the current appointment process is to be progressed to ensure that it is transparent, fair and fully understood. A written process has been drafted, setting out how the Council will recruit, select and appoint members of the Forum, together with minor recommended changes to the Constitution.
- 3.2 Additionally, using the approach used to recruit lay members of similar public bodies, an outline description of a person specification has been drafted, to allow volunteers interested in applying to better understand what might be expected of them. These documents are currently out for consultation but the current drafts are attached at Appendices 2 - 5 for the committee's information.
- 3.3 These were to be discussed at a Licensing Forum meeting on 30 May 2018 however unfortunately this meeting was not quorate. Officers informally briefed those Forum members who were there and all Forum members were then provided with a copy of the documents by email, and asked to provide comments and suggestions on the draft documents.
- 3.4 The feedback from this consultation is currently being considered. It is planned to make any amendments necessary to the documents following this informal consultation, with a report being prepared and reported to Council for approval. It is expected that this work will be reported in September 2018.
- 3.5 Thereafter, as previously reported, the current Forum will be disbanded and a full selection and appointment process will be undertaken later in the year.

Current Licensing Forum

- 3.6 The current Forum will continue in the meantime, to ensure that the work of the Licensing Board is able to proceed timeously in reviewing its Statement of Licensing Policy including the required statutory consultation process with the Forum.
- 3.7 As at the beginning of 2018 there were three vacancies for Licensing Forum members representing the community. At the request of the committee a short recruitment exercise has been undertaken to identify interested volunteers to fill these vacancies. All councillors were invited to ensure that any person whom they thought might wish to volunteer to be a community representative was aware that these temporary vacancies were being recruited to, and to invite such persons to reply. It has been made clear to all interested parties that these vacancies will be filled on a temporary basis, and that the Forum will be disbanded prior to a full recruitment process being undertaken for appointment to the new Forum later this year.
- 3.8 As at 27 June 2018 three volunteers had applied and a short interview was undertaken by three Councillors from the Committee. These members have since

been appointed on the recommendation of that recruitment panel using delegated powers.

4. Measures of success

- 4.1 The Council supports and encourages an active local Licensing Forum, which reflects the proposed membership set out within the Licensing (Scotland) Act 2005.

5. Financial impact

- 5.1 The costs of supporting the Forum are minimal and are contained within the Place revenue budget.

6. Risk, policy, compliance and governance impact

- 6.1 The Local Licensing Forum is independent of the Council and governance arrangements therein.

7. Equalities impact

- 7.1 Guidance will be sought from the Equalities Commission to ensure that best practice for appointing members of a public body is incorporated as appropriate within the revised selection and appointment process.

8. Sustainability impact

- 8.1 There are no sustainability issues arising out of the contents of this report.

9. Consultation and engagement

- 9.1 Consultation on changes to the Forum constitution and membership is detailed in paragraphs 3.1 to 3.5 above.

10. Background reading/external references

- 10.1 [Report to Full Council November 2017](#)
10.2 [Report to Full Council September 2012](#)
10.3 [Licensing \(Scotland\) Act 2005](#)

Paul Lawrence

Executive Director of Place

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E-mail: andrew.mitchell@edinburgh.gov.uk | Tel: 0131 469 5822

11. Appendices

- 11.1 Appendix 1 – Forum Members as at 7 December 2017
- 11.2 Appendix 2 – Current Licensing Forum Constitution
- 11.3 Appendix 3 - Draft Licensing Forum Constitution
- 11.4 Appendix 4 - Draft recruitment procedure
- 11.5 Appendix 5 - Draft person specification for lay member of Licensing Forum

APPENDIX 1: FORUM MEMBERS AS AT 7 DECEMBER 2017

1. Licensing Standards Officer
 - Ken Fairgrieve

2. Licence Holders and Persons with Relevant Interests
 - Graeme Arnott
 - Marshall Bain
 - Rosaleen Harley (Convener)
 - Paul Togneri (Scottish Beer and Pub Association)
 - Dennis Williams
 - John Lee
 - Peter Swanson
 - James Nicholson

3. Police Scotland
 - Sgt John Young

4. Health, Education & Social Work
 - Jim Sherval

5. Young Persons
 - Jenna Kelly

6. Community/residents:
 - Penny Richardson (North rep.)
 - Vacant (East rep.)
 - Vacant (West rep.)
 - Norman Tinlin (South West rep.)
 - Bridget Stevens (additional)
 - Samuel Piacentini (City Centre/Leith rep.)
 - Robin Morris (South rep.)
 - Chris Wigglesworth (Friends of the Meadows (additional))

The City of Edinburgh Licensing Forum

Constitution and Remit

City of Edinburgh Licensing Forum Constitution

1 Title

2 Introduction

3 Definitions

4 Terms of Reference

5 Functions

6 Membership

7 Convener

8 Meetings

9 Method of Voting

10 Special Meetings

11 Conduct of Members

12 Attendance at Meetings

13 Resignation etc

14 Alterations to Constitution and powers to make or amend rules 1 Title

1.1 The Forum shall be known as the City of Edinburgh Licensing Forum.

2 Introduction

2.1 The City of Edinburgh Licensing Forum has been established to represent the views of people concerned with the operation of the licensing system in the geographical boundaries of the City of Edinburgh Council. The Forum has been established in accordance with

Sections 10 and 11 and Schedule 2 of the Licensing (Scotland) Act 2005. It is the role of the Forum to keep the operation of the licensing regime, and the use of licensing powers, under review in the Edinburgh area. The Forum is also responsible for giving advice and recommendations to the City of Edinburgh Licensing Board.

2.2 This document sets out the Forum's constitution.

3 Definitions

3.1 'Act' in this constitution means the Licensing (Scotland) Act 2005 as amended from time to time.

3.2 'The City of Edinburgh Licensing Forum' or 'the Forum' means that body established by the City of Edinburgh Council ('the Council') in accordance with Section 10 of the Act.

3.3 'Licensing Board' or 'the Board' means the City of Edinburgh Licensing Board.

3.4 'Licensing Standards Officer' or 'LSO' means a person employed by the Council and qualified as required by the provisions of the Act.

3.5 'Edinburgh' means that area administered by the Council incorporated under the Local Government etc (Scotland) Act 1994.

4 Terms of Reference of the Forum

4.1 To keep the liquor licensing system in the Council area under regular review and to seek to stimulate debate on matters relevant to the system.

4.2 To respond to consultation exercises undertaken by the Board and the Scottish Government.

4.3 To consider the implications of relevant local data and statistics for the liquor licensing system in the Council area;

4.4 To meet the Board at least once per year.

4.5 To give advice and make recommendations to the Board on relevant matters, except individual licensing applications.

5 Functions

5.1 The Forum will review the operation of the liquor licensing regime and the exercise of licensing powers in Edinburgh, and give advice and make recommendations to the Board.

5.2 The Forum will give advice and make recommendations to the Board in relation to policy and other appropriate areas of concern.

5.3 The Forum will have no involvement in the exercise of the Board's powers in any particular case or application.

5.4 Forum members will take all reasonable steps to encourage all relevant people to make their views known to the Forum, and to represent their views. This may include any relevant organisations and residents within the Edinburgh Council area.

5.5 It is inappropriate for any member to use the Forum to pursue their own interests or resolve personal issues. Unless he or she has been specifically appointed to represent that organisation, a member of the Forum must not express or promote the views of any organisation of which he or she is also a member.

5.6 The Forum is entitled, on request, to be provided with copies of any statistical information provided to the Board, for the purpose of preparing a licensing policy statement or supplementary statement.

6 Membership

6.1 Membership of the Forum must always be between five and 21 people. This number will be subject to review by the Council, from time to time, on request by the Forum, the Board or the Council's Executive Director of Place ('the Director').

6.2 In order to be eligible for membership of the Forum, a person must be:

- Aged 18 years or above (with the exception of a member who is a 'young person')
- Able to show that he or she has an interest in the licensing system

6.3 Residents' representatives will be appointed to represent each of the four Community Planning Areas (one for each area). In addition one representative shall be appointed to represent Ward 11 (City Centre), and one to represent Edinburgh Association of Community Councils.

- South East
- South West
- North West
- North East
- Ward 11 (City Centre)

6.4 Membership will be representative of the five key interest areas including holders of premises and individual licences and young people.

6.5 A Licensing Standards Officer, a person nominated by the Health Board, a representative nominated by the Chief Constable and a person nominated by the Chief Social Worker will be appointed as members of the Forum.

6.6 A nominee of the City of Edinburgh Council's Executive Director of Communities and Families will be appointed to represent Education.

6.7 Once the Council has appointed Forum members, it shall delegate power to the Director to reappoint members in consultation with the convener of the Forum ('the Convenor').

6.8 Members will be appointed initially for a period of three years. On a rolling basis, one third of members will be reappointed every three years.

6.9 Members are expected to make every effort to attend meetings. Should a member be unable to attend, he or she should contact the Convenor before

the meeting. The member may formally nominate a substitute, to express views on his or her behalf. The substitute must be eligible for the same category of membership as the non-attending member.

6.10 Ex officio members: The Forum may invite other persons to attend and participate in meetings, should this be required. Any such invitation is at the discretion of the Convener. Any such person shall not be entitled to vote in any decision made by the Forum. Neither shall such a person be entitled to vote in choosing a Convener.

6.11 The Council will provide facilities and reasonable expenses to assist the Forum. This may involve access to administrative support and the use of Council premises for meetings. Such facilities must only be used in carrying out Forum duties.

7 Convener

7.1 At its first meeting and at the first meeting in each Council year the Forum will elect a Convener from its members. Any member of the Forum may stand for election as Convener. The Convener will hold office until the first meeting in the following year unless he or she resigns or is dismissed.

7.2 If the Convener is unable to attend a meeting of the Forum, he or she must send his or her apologies to the Community Safety Senior Manager. The Convener may nominate a substitute to express views on his or her behalf. The Forum should nominate another one of the usual members to chair that meeting.

If the Convener is not present at any meeting, or is unable to act for any reason, the meeting may be chaired by any other member present.

7.3 The Convener is responsible for ensuring that meetings are conducted in an orderly fashion. The Convener should also manage the discussion so that everyone has a chance to speak, while ensuring that all agenda items are discussed in the available time. All Forum members will have a responsibility to promote participation.

8 Meetings

8.1 The Forum will have at least four meetings in each Council year.

8.2 The Forum will meet with the Board at least once in each Council year.

8.3 All Forum meetings will be held in public and will be open to the media.

8.4 Meetings will be arranged by the Forum, in consultation with the Council, to ensure that appropriate facilities are available.

8.5 Dates and times of meetings, the agenda, and any connected papers will normally be issued by email or by post (if a member so requests) to the Forum members in advance of the meeting.

8.6 Forum papers will be posted on the Council website. This will include agenda, minutes of previous meetings, and other materials relevant to the Forum's operation.

8.7 The minimum number of members present for any meeting of the Forum is eight. If this minimum does not attend, the meeting will be adjourned to a later date.

8.8 All members may put forward suggestions for agenda items. The Convener is responsible for arranging this.

8.9 The Director will arrange for a note to be kept of every meeting of the Forum. This note will include:

- The names of members in attendance
- A brief note of topics dealt with
- A record of all decisions taken by the Forum

8.10 A note of each meeting will be submitted for approval at the next meeting.

9 Method of Voting

9.1 All members have an equal vote, with the convener having a casting vote in the event of a tie.

9.2 Ex officio members have no voting rights.

9.3 Where the Forum agrees to make a recommendation to the Board, the wording of the recommendation shall be recorded in the action note. The Convener shall thereafter ensure that it is communicated to the Clerk of the Licensing Board.

10 Special Meetings

10.1 A Special Meeting of the Forum can be called at any time by the convener, or if at least eight Forum members request it in writing. The convener will decide on the date and place of the Special Meeting.

11 Conduct of members

11.1 Members must behave in a respectful and courteous manner towards others at all times while exercising Forum functions. With respect to the manner in which the Forum's business is carried out, the convener's decision is final.

11.2 Members should be open about their decisions and the reasons behind them.

11.3 All members are accountable for the Forum's decisions and actions. Each member must ensure that advice given, or recommendations made, reflects the views of the whole Forum.

11.4 The Forum is encouraged to produce an annual action plan setting out regular and short term pieces of work that it will undertake to monitor the licensing system. Any action plan will be discussed with the Board at its annual joint meeting.

12 Attendance at Meetings – Forum members

12.1 If a member does not attend a meeting of the Forum for 2 consecutive meetings, without reasonable explanation. The Forum may consider the circumstances and if not satisfied that the member had a reasonable explanation for failing to attend, members from the Forum may vote to remove that member from the Forum.

13 Attendance at Meetings – members of the public

13.1 Members of the public are welcome to attend Forum meetings, but are expected to sit at the side rather than in the body of Forum Members.

13.2 Should members of the public wish to speak at a Forum meeting then they should indicate notice of attendance to the Convener a week before the meeting; and will be given a maximum of five minutes to address the Forum, or otherwise at the discretion of the Convener.

14 Resignation

14.1 Members wishing to resign may do so, in writing, to the Executive Director.

15 Alterations to Constitution and Powers to Make or Amend Rules

15.1 The Forum at any time may submit a report to the Council asking it to amend the constitution of the Forum, or to make or amend rules relating to the Forum.

The City of Edinburgh Licensing Forum Constitution and Remit

City of Edinburgh Licensing Forum Constitution

15 Title

16 Introduction

17 Definitions

18 Terms of Reference

19 Functions

20 Membership

21 Convener

22 Meetings

23 Method of Voting

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25 Conduct of Members

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27 Resignation etc

28 Alterations to Constitution and powers to make or amend rules

1.1

2.1

1 Title

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2 Introduction

2.1 The City of Edinburgh Licensing Forum has been established to represent the views of people concerned with the operation of the licensing system in the geographical boundaries of the City of Edinburgh Council. The Forum has been established in accordance with Sections 10 and 11 and Schedule 2 of the Licensing (Scotland) Act 2005. It is the role of the Forum to keep the operation of the licensing regime, and the use of licensing powers, under review in the Edinburgh area. The Forum is also responsible for giving advice and recommendations to the City of Edinburgh Licensing Board.

2.2 This document sets out the Forum's constitution.

3 Definitions

3.1 'Act' in this constitution means the Licensing (Scotland) Act 2005 as amended from time to time.

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3.3 'Council year' means from May to May each year.

3.4 'Licensing Board' or 'the Board' means the City of Edinburgh Licensing Board.

3.5 'Licensing Standards Officer' or 'LSO' means a person employed by the Council and qualified as required by the provisions of the Act.

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4 Terms of Reference of the Forum

4.1 To keep the liquor licensing system in the Council area under regular review and to seek to stimulate debate on matters relevant to the system.

4.2 To respond to consultation exercises undertaken by the Board and the Scottish Government.

4.3 To consider the implications of relevant local data and statistics for the liquor licensing system in the Council area;

4.4 To meet the Board at least once per year.

4.5 To give advice and make recommendations to the Board on relevant matters, except individual licensing applications.

5 Functions

5.1 The Forum will review the operation of the liquor licensing regime and the exercise of licensing powers in Edinburgh, and give advice and make recommendations to the Board.

5.2 The Forum will give advice and make recommendations to the Board in relation to policy and other appropriate areas of concern.

5.3 The Forum will have no involvement in the exercise of the Board's powers in any particular case or application.

5.4 Forum members will take all reasonable steps to encourage all relevant people to make their views known to the Forum, and to represent their views. This may include any relevant organisations and residents within the Edinburgh Council area.

5.5 It is inappropriate for any member to use the Forum to pursue their own interests or resolve personal issues. Unless he or she has been specifically appointed to represent that organisation, a member of the Forum must not express or promote the views of any organisation of which he or she is also a member.

5.6 The Forum is entitled, on request, to be provided with copies of any statistical information provided to the Board, for the purpose of preparing a licensing policy statement or supplementary statement.

6 Membership

6.1 Membership of the Forum must always be between five and 21 people. This number will be subject to review by the Council, from time to time, on request by the Forum, the Board or the Council's Executive Director of Place ('the Director').

6.2 In order to be eligible for membership of the Forum, a person must be:

- Aged 18 years or above (with the exception of a member who is a 'young person')
- Able to show that he or she has an interest in the licensing system

6.3 The forum membership shall include members required as set out in Paragraph 2 (2) of Schedule 2 of the Act specifically;

- A Licensing Standards Officer,
- A representative of the Health Board.

6.4 The forum membership shall thereafter be appointed to reflect Paragraph 2 (5) of Schedule 2 of the Act and these are as follows:

- a) Not less than six residents' representatives will be appointed to specifically
 - a. four representatives, one for each Community Planning Areas within the City
 - b. one additional seat to represent Ward 11 (City Centre), and
 - c. one additional seat to represent Edinburgh Association of Community Councils.
- b) A minimum of six places shall be reserved for holders of premises or personal licences.
- c) A representative of the City of Edinburgh Council's Executive Director of Communities and Families to represent young people.
- d) A representative of the Chief Social Worker
- e) A representative of the Chief Constable
- f) The remaining four seats from any other interested person up to a statutory maximum of 21 members whilst maintaining a balance wherever possible between community and trade representatives.

{The consultation welcomes views on how the Council should allocate the six seats available for community representatives to ensure that the all areas of the city are appropriately represented}

Establishing the forum and reappointments

- 6.5 Once the Council has established and appointed Forum members, it shall delegate power to the Director to reappoint members in consultation with the convener of the Forum ('the Convenor').
- 6.6 Members will be appointed initially up to three years. On a rolling basis, one third of members will be reappointed every three years. When the forum is established each community and trade representative will be allocated randomly a number 1, 2 or 3. Members with a number (1) shall require to be reappointed 1 years after initial appointment, members with a number (2) shall require to be reappointed 2 years after initial appointment, members with a number (3) shall require to be reappointed 3 years after initial appointment. Thereafter the process will continue until such time as the Council may direct.
- 3.1
- 4.1 Method of Selection and Appointment.
- 5.1
- 6.7 Where a representative of an organisation is appointed to the forum it will be for that organisation to select the representative. E.g. NHS Lothian shall select a representative.
- 6.1
- 6.8 In relation to representatives of the community the Executive Director of Place shall prepare guidance a guidance on how the community representatives shall be nominated for appointment including a person specification.
- 7.1
- 8.1
- 6.9 In relation representatives of the trade the Executive Director of Place shall recruit volunteers from the trade by advertising the opportunity to serve on the forum and shall appoint suitably interested parties using an agreed person specification.
- 9.1
- 6.10 Where a vacancy occurs the Executive Director of Place shall recruit a replacement using the process as outlined in 6.8 and 6.9 above to fill said vacancy. Should a vacancy occur the forum shall continue to operate and a vacancy will not affect the validity of any proceedings.
- 6.11 Members are expected to make every effort to attend meetings. Should a member be unable to attend, he or she should contact the Convener before the

meeting. The member may formally nominate a substitute, to express views on his or her behalf. The substitute must be eligible for the same category of membership as the non-attending member.

6.12 Ex officio members: The Forum may invite other persons to attend and participate in meetings, should this be required. Any such invitation is at the discretion of the Convener. Any such person shall not be entitled to vote in any decision made by the Forum. Neither shall such a person be entitled to vote in choosing a Convener.

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7.2 If the Convener is unable to attend a meeting of the Forum, he or she must send his or her apologies to the Regulatory Services Manager. The Forum should nominate from those members in attendance a member to chair that meeting. The Convener may nominate a substitute to express views on his or her behalf

7.3 The Convener is responsible for ensuring that meetings are conducted in an orderly fashion. The Convener should also manage the discussion so that everyone has a chance to speak, while ensuring that all agenda items are discussed in the available time. All Forum members will have a responsibility to promote participation.

8 Meetings

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8.2 The Forum will meet with the Board at least once in each Council year.

8.3 All Forum meetings will be held in public and will be open to the media.

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8.9 The Director will arrange for a note to be kept of every meeting of the Forum. This note will include:

- The names of members in attendance
- A brief note of topics dealt with
- A record of all decisions taken by the Forum

8.10 A note of each meeting will be submitted for approval at the next meeting.

9 Method of Voting

9.1 All members have an equal vote, with the convener having a casting vote in the event of a tie.

9.2 Ex officio members have no voting rights.

9.3 Where the Forum agrees to make a recommendation to the Board, the wording of the recommendation shall be recorded in the action note. The Convener shall thereafter ensure that it is communicated to the Clerk of the Licensing Board.

10 Special Meetings

10.1 A Special Meeting of the Forum can be called at any time by the convener, or if at least eight Forum members request it in writing. The convener will decide on the date and place of the Special Meeting.

11 Conduct of members

11.1 Members must behave in a respectful and courteous manner towards others at all times while exercising Forum functions. With respect to the manner in which the Forum's business is carried out, the convener's decision is final.

11.2 Members should be open about their decisions and the reasons behind them.

11.3 All members are accountable for the Forum's decisions and actions. Each member must ensure that advice given, or recommendations made, reflects the views of the whole Forum.

11.4 The Forum is encouraged to produce an annual action plan setting out regular and short term pieces of work that it will undertake to monitor the licensing system. Any action plan will be discussed with the Board at its annual joint meeting.

12 Attendance at Meetings – Forum members

12.1 If a member does not attend a meeting of the Forum for 2 consecutive meetings, without reasonable explanation. The Forum may consider the circumstances and if not satisfied that the member had a reasonable explanation for failing to attend, members from the Forum may vote to remove that member from the Forum.

13 Attendance at Meetings – members of the public

13.1 Members of the public are welcome to attend Forum meetings, but are expected to sit at the side rather than in the body of Forum Members.

13.2 Should members of the public wish to speak at a Forum meeting then they should indicate notice of attendance to the Convener a week before the meeting; and will be given a maximum of five minutes to address the Forum, or otherwise at the discretion of the Convener.

14 Resignation

14.1 Members wishing to resign may do so, in writing, to the Executive Director.

15 Alterations to Constitution and Powers to Make or Amend Rules

15.1 The Forum at any time may submit a report to the Council asking it to amend the constitution of the Forum, or to make or amend rules relating to the Forum

Appendix 4- Draft recruitment procedure

PROCEDURE FOR RECRUITING MEMBERS OF THE LICENSING FORUM.

When establishing the membership of the Licensing Forum or appointing a further member in the event of a vacancy the following procedure will be undertaken. The Forum shall continue to operate notwithstanding any vacancy which occurs from time to time.

Community Representatives

1. The Executive Director of Place shall prepare recruitment plans which reflect the community planning arrangements in effect at that time and shall consult the Democratic, Resilience and Governance Senior Manager and the Convenor of the various Locality Committees on these plans.
2. Localities will be asked to form selection panels involving a broad of community groups in that area. These selection panel will be asked to nominate a representative for each locality or community planning area.
3. For the representative of the City Centre ward, the relevant locality shall form a selection panel involving a broad of community groups in the City Centre Ward.
4. Edinburgh Community Council Association shall nominate a member in accordance with its own governance arrangements.
5. Having established selection panels for each area the Council will advertise vacancies for community members of the forum and invite applications from interested parties. Applicants will be provided with a person specification and asked to fill in a short application form.
6. A selection panel shall be provided copies of the applications received for the relevant area and will shortlist and interview applicants. The selection panel will nominate a preferred candidate for the Executive Director of Place to appoint.
7. Should a vacancy occur in any of the posts filled by a community representative or when any such representative is required to be reappointed then the above process will be followed.

Trade Representatives

1. The Executive Director for Place will establish a selection panel to recruit and nominate trade representatives.
2. Having established selection panels for each area the Council will advertise vacancies for trade members of the forum and invite applications from interested parties. Applicants will be provided with a person specification and asked to fill in a short application form.
3. A selection panel shall be provided copies of the applications received for the relevant area and will shortlist and interview applicants. The selection panel will nominate 6 preferred candidates for the Executive Director of Place to appoint.
4. Should a vacancy occur in any of the posts filled by a community representative or when any such representative is required to be reappointed then the above process will be followed.

Additional Members

1. The forum constitution allows up to 21 members and in addition to the 6 community and trade representatives set out above there are up to 4 additional members who may be appointed to bring that number up to 21.
2. The Executive Director of Place must wherever possible ensure that the balance between Community and Trade representatives remains equal when appointing additional members.
3. Additional members will be identified as possible.
 - a. Community representatives: When the forum is established each selection panel can nominate any applicant(s) who meets the person specification as an additional member.
 - i. Where the number of nominees is less than or equal to the number of additional seat available they shall be appointed by the Executive Director for Place.
 - ii. Where the number of nominees is more than the number of additional seat available the executive director for place shall appoint additional members by drawing lots. Any remaining shall be on a reserve list.
 - iii. Where a vacancy occurs in an additional member these shall be filled from the reserve list, selected if necessary by drawing lots. If there is no one on the reserve list then city wide recruitment will take place.
 - b. Trade representatives: When the forum is established the selection panel can nominate an applicant(s) who meets the person specification as an additional member.
 - i. Where the number of nominees is less than or equal to the number of additional seat available they shall be appointed by the Executive Director for Place.
 - ii. Where the number of nominees is more than the number of additional seat available the executive director for place shall appoint additional members by drawing lots. Any remaining shall be on a reserve list.
 - iii. Where a vacancy occurs in an additional member these shall be filled from the reserve list, selected if necessary by drawing lots. If there is no one on the reserve list then city wide recruitment will take place.

Appendix 5- Draft person specification for lay member of Licensing Forum

Person Specification

Position Title	Lay member of the City of Edinburgh Licensing Forum
Service Area	Supported by the Place Directorate
Responsible To	n/a

Person Specification

**Qualifications,
training &
professional
membership**

Members of the forum are volunteers, the person specification is intended to set out the skills and attributes necessary to serve on the forum.

- Community members need not hold a formal qualification but should be able to demonstrate that they are active in their local community and have an interest in Liquor Licensing.
- Trade members should normally hold a premises licence or a personal licence. Alternatively they should be able to demonstrate an active interest in the licensed trade within the City or alternatively show that they represent a trade group with an active interest in the licensed trade within the City.
- Qualifications are not essential but where a person can show be a legal, licensing or health qualification or equivalent this will be desirable.
- Any relevant membership of a voluntary group or trade association/body.

Essential

Essential

Desirable

Desirable

- Experience of volunteering or membership of a lay body. Desirable

The successful candidate will demonstrate evidence of the following experience, knowledge, skills and understanding. Evidence will be sought for selection purposes.

REPRESENTATION

- Able to represent the interests of the organisation or group who the member is appointed to represent Essential
- Able to feedback to the organisation or group who the member is appointed to represent

Essential

ASSESSMENT OF INFORMATION

- Ability to consider evidence provided to the forum, submissions made and reach a considered view on how these relate to the functions of the licensing board. Essential
- Awareness of the Licensing (Scotland) Act 2005 and apply their understanding to the discussions and decisions of the forum Essential

WORKING EFFECTIVELY WITH OTHERS

- Can demonstrate the skills of working effectively with a range of forum members and other stakeholders to deliver effective discharge of the forum's functions Essential

- Supporting other forum members to contribute effectively Essential

COMMUNICATIONS

- Able to participate and speak at public meetings Essential
- Able to communicate views of groups or organisation who the member represents in a clear and balanced Essential
- Occasionally prepare a short written report or similar material Essential

Planning and Decision Making

- Able to contribute to the planning of future business of the forum Essential
 - Ability to participate in decision making processes in an open, transparent manner and which supports a wider range of contributions. Essential
-

Governance, Risk and Best Value Committee

10.00am, Tuesday 31 July 2018

Quarterly Status Update – ICT Programme

Item number	7.5
Report number	
Executive/routine	
Wards	All
Council commitments	

Executive Summary

The purpose of this report is to provide a quarterly progress update of the Council's ICT programme of work. The Council and our ICT partner, CGI, continue to work positively together to increase the pace of activity to deliver the core ICT and associated change which enable and enhance our citizen facing services and the internal business operations of the Council.

Since the last update to Committee, the Finance and Resources Committee and the CGI Board have approved the re-set of the agreement between the partners and this has led to a refreshed governance framework I being deployed, which continues to be enhanced. This revised framework will provide greater assurance across the quality, performance, cost and delivery of the whole ICT programme, which continues to evidence positive progress across a number of areas.

Quarterly Status Update – ICT Programme

1. Recommendations

- 1.1 It is recommended that the Committee reviews and scrutinises the quarterly update.

2. Background

ICT strategy

- 2.1 The City of Edinburgh Council's current strategy is to focus on understanding citizen and colleague needs to deliver the outcomes that matter to them. By defining the Council's approach around the benefit that citizens and colleagues will receive, through enablement by ICT and Digital, we will maximise the value that can be delivered from our reducing resource base. This will help us to deliver a 'One Council' focus to designing and sourcing our ICT and Digital provision whilst enabling citizen and colleague-centric delivery, i.e. what the Council needs to deliver the services where and how service users need them.

CGI – The Council's ICT partner

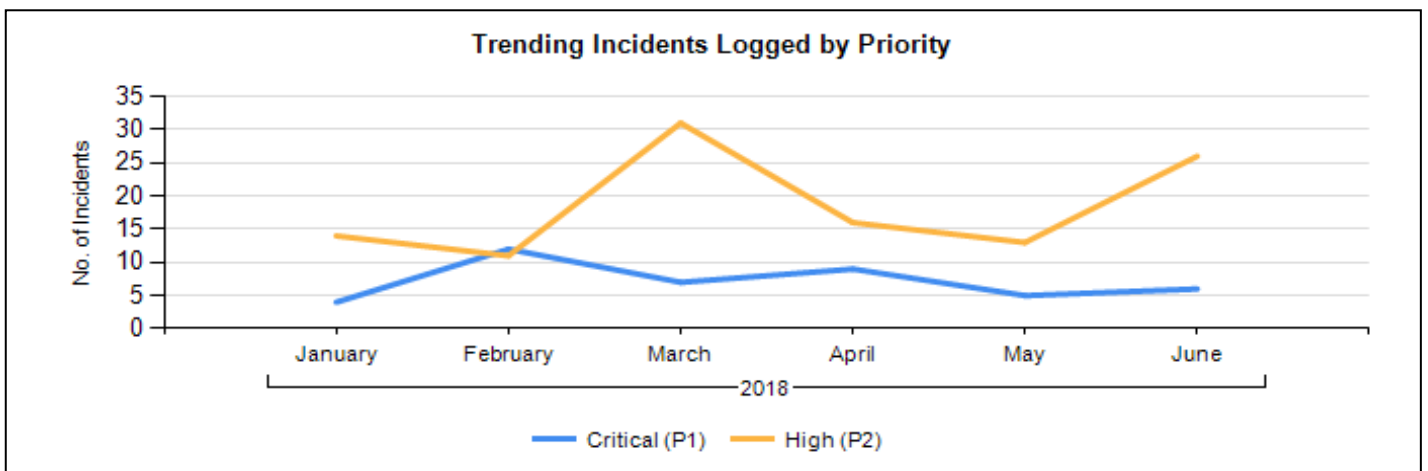
- 2.3 Our partnership with CGI will save the Council at least £6m per annum against the 2015/16 ICT baseline spend, totalling £45m over the first seven years, is on track to be achieved and is assumed as part of the Council's Medium Term Financial Framework and planning assumptions.
- 2.2 The term of the contract awarded was for "up to nineteen years" to CGI, with periods awarded as 7 years initially, with the option for the Council to extend by 5 years, a further 5 years, and a final 2 years. CGI are contractually responsible for providing to the Council: service transition, service transformation and operational ICT services delivery, initially comprised of a number of Output Based Specifications (OBS), these include base services, utility services, and business case development services.
- 2.3 As part of the re-set to the partnership agreement with CGI, we have agreed to alter some of the commercial elements and OBS requirements to ensure that further value for money can be achieved, during the initial phase of the contract, and to bring the content of relevant OBS up-to-date with current Council requirements and the technology now available from the market.

3. Main report

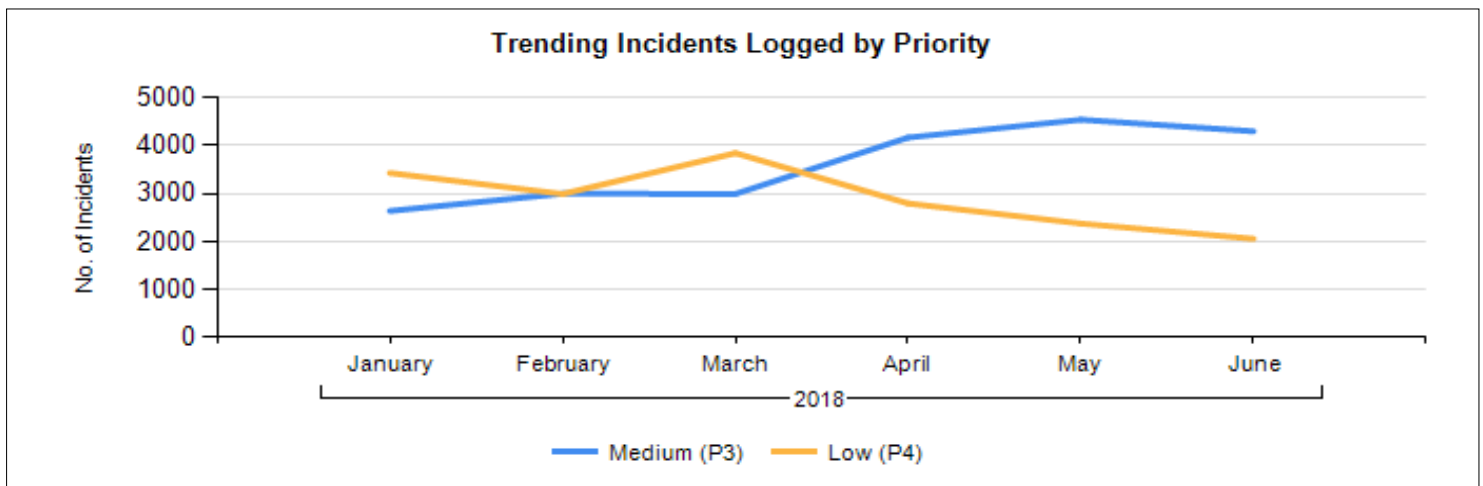
- 3.1 Since the last update to the Governance, Risk, and Best Value Committee (GRBV), there continues to be general improvement in both core service and ICT transformation deliverables.
- 3.2 During June, the partnership agreement was formally re-set, following the signing of the variation agreement providing both the Council and CGI with a stronger platform for future success.

Core Service Performance

- 3.3 Service performance is currently driven through a set of twenty-five key contractual measures which, in turn translate to a set of key performance indicators (KPIs). These KPIs are in the process of being revised as part of the re-set of the agreement, to ensure than a clearer scorecard covering service, change/transformation, commercial and, most significantly customer/user satisfaction and experience is implemented.
- 3.4 Since the last report to Committee, there has been continued improvement in core service provision with 91% percent of all existing service level agreements met or exceeded during the last quarter, compared to the previous quarter where 85% percent of service level agreements were achieved.
- 3.5 There has been a stabilisation and slight reduction in the number of Priority 1 incidents experienced since March and, until June, a reduction in Priority 2 (P2) incidents. Unfortunately, during June, there was a slight increase in 2 P2 incidents. Importantly, all of the incidents concerned were resolved within service level agreement time frames.
- 3.6 External benchmarking of these highest severity incidents indicates that our incident rate is below the industry average. Work, as part of the business as usual operational approach, to review the root cause analysis for each incident to mitigate and reduce incidents further.



3.7 As part of the last report to Committee, the GRBV members were advised that trends for both Priority 3 (P3) and Priority 4 (P4) incidents remained high and that the Council needed to see continued improvements in respect of the incident trends overall, but with a continued focus on P1 and P2 incidents due to their criticality. Since that report, there has been an improving trend over the last quarter, with sustained reductions in P4 reported incidents, which is welcomed. Concerns remains around the recorded increase in the volume of P3 incidents, following a period of improvement in the previous quarter. Work is now underway to continue to analyse root causes and to support learning and education on password management, self-service and reminding end users to shut down their machines overnight, rather than simply placing them into standby mode, in order for systems to apply security patches and install necessary system updates, which improve service performance.



ICT Programme – Change Portfolio

3.8 The portfolio of major change projects that the ICT programme is responsible for delivering includes a series of critical service developments and improvements. A selection of these major change programmes are outlined as follows:

3.8.1 Wide Area Network (WAN): To deliver a high bandwidth, fibre-based wide area network delivering improvements in operational efficiency, productivity, reliability, and scalability to enable the next generation of digital learning opportunities in city schools and to improve commercial and cultural opportunities for live event streaming, webcasting and conferencing in the city’s cultural venues.

3.8.2 LAN (LAN) and Voice: to reduce infrastructure costs and complexity, to implement flexible ‘find me/follow me’ call routing, allowing remote and mobile working and to create opportunities for further innovations and savings through agile working practices.

3.8.3 End User Compute (EUC): to allow anytime, anywhere access to e-mail, important documents, contacts, and electronic calendars across devices, to share large, hard-to-email files both inside and outside the Council. The

delivery of this programme has been mutually delayed due the Council increasing the scope of the original OBS, to encompass the full Learning and Teaching ICT estate, with the corresponding contractual change principles now agreed with CGI.

3.8.4 Enterprise Resource Planning (ERP): A single integrated platform supporting all financial and human resources transactions, including payroll. This programme has now been halted as part of the overall variation agreement.

3.8.5 Customer Digital Enablement ('Channel Shift'): to improve citizen engagement with real time, online transactions across Council services, to increase operating efficiencies and significantly reduce the cost of end-to-end transactions and to improve citizen insight and enabling agile and rapid development of future online services.

3.8.6 Libraries: to improve the user experience of the library system to better engage citizens and increase adoption through improved user interface, to reduce operating costs through lower cost software and increased device support, and to become a single library management system.

3.9 The current status of some of the major change projects, as assessed by the Council, is as follows:

Project	Current Status	Target completion date	Status update
Enterprise Resource Planning (ERP)	Planning	Planning	<p>This project is currently being re-set and scoped to ensure the solution meets the requirements of the Council's corporate and customer operations and is appropriately future proofed.</p> <p>Good progress has been made by the Council and CGI to close down the former project and secure the learning and intellectual property gained through that work. This project will move into formal delivery during August.</p>
Customer Digital Enablement (Channel Shift)		Initial Phase completion date 30/04/2018	<p>The initial phase rollout of the Customer Relationship Management (CRM) functionalities of Web Chat; Knowledge base, and E-mail Integration and Web Chat functionality has now been successfully completed.</p> <p>Whilst the delivery status remains red, at present, the trend has improved rather than remained static or worse. This project is benefitting from effective joint working between the Council and CGI and implementation of the most effective solution for both now and the long terms needs of the Council.</p>

End User Compute (EUC) or Device Refresh		Agreed completion date of 30/6/2019	Scoping and agreement to the revised commercial arrangements for this key project were achieved through the re-set process between the Council and CGI. The project is now in full delivery mode, with initial upgrades to hardware and operating systems being positively received by end users. A briefing note on the details and timeline for this project has been circulated separately to the members of the Governance, Risk and Best Value Committee. The completion date of 30 June 2019
Local Area Network (LAN)		03/11/2017	All sites have had the network upgraded and some outstanding remedial work is being finalised as business as usual activity.
Enterprise Content Management and Intranet		Under Review	This project is now being initiated and is being jointly reviewed by the Council and CGI, with a Senior Responsible Officer having been identified.
Wide Area Network (WAN)		Complete	Closed, but not delivered against original contractual milestones.
Libraries Phase I		Complete	Project closed
Room Bookings		Complete	Project closed
Parent Pay		Complete	Project closed
Cashless Catering		Complete	Project closed
BACS		Complete	Project closed
Bulk Printing		Complete	Project closed
Contact Centre		Complete	Project closed
Telephony (Voice)		Complete	Project closed
AIM / ACR		Complete	Project closed
iTrent – IE11		Complete	Project closed
iWorld		Complete	Project closed
Boroughmuir High School		Complete	Project closed
EBS		Complete	Project closed
Elections		Complete	Project closed
QMatic		Complete	Project closed
Portobello High School		Complete	Project closed
Intelligent Automation		Complete	Project closed

Customer Contact - Workforce Management		Complete	Project closed
James Gillespie High School		Complete	Project closed

3.10 In addition to the major projects detailed above, which is not an exhaustive list, there is also a large volume of small and complex changes.

Governance and Contract Management

3.11 The Council and CGI have a current governance model in working order and there are various boards and governance meetings used to manage the entire ICT programme.

3.12 An Internal Audit in respect of CGI Contract Management arrangements has now been completed, with PWC involvement, with no High findings having been identified. A total of 2 Medium rated findings were identified, which are being addressed as part of the Council and CGI's revisions to governance arrangements

Security Management

3.13 The Council and CGI continue to work positively to address a range of security improvements, with significant progress being made in respect of patching, vulnerability testing and scanning and the decommissioning of arcane Windows 2003 servers for some legacy applications.

3.14 The Council has now established a Cyber and Information Security Steering Group, chaired by the Executive Director of Resources, as the Council's nominated executive lead for cybersecurity. This group is proactively leading the work across all Council services to deliver the requirements of the Public-Sector Cybersecurity Action Plan as required by the Scottish Government. Additional work being led by this Group includes a review of the ICT Acceptable Use Policy and future training plan for all staff.

4. Measures of success

4.1 There are a series of detailed contractual success measures, including a suite of key performance indicators. However, the main measure of success is to deliver an effective and efficient ICT programme of works on time and within budget which improves citizen and user satisfaction and experience.

4.2 A wholly revised series of key performance indicators (KPIs) that take much more explicitly into account customer/end user satisfaction, as well as service performance and delivery issues, is being currently being developed by the Council and CGI.

5. Financial impact

- 5.1 Our partnership with CGI will save the Council at least £6m per annum against the 2015/16 ICT baseline spend, totalling £45m over the first seven years, is on track to be achieved and is assumed as part of the Council's Medium Term Financial Framework and planning assumptions.
- 5.2 The Council has realised further financial benefits arising from the re-set variation agreement which are not detailed in this report owing to their commercial confidentiality. These benefits are being profiled fully by the Customer Services and IT Division, supported by Finance, and will be reported to the Finance and Resources Committee.

6. Risk, policy, compliance, and governance impact

- 6.1 The Council's Corporate Leadership Team (CLT) risk register formally identifies the risks associated with the delayed delivery of the ICT Programme, ensuring that sufficient mitigations and active management of risks continue to be undertaken.
- 6.2 The Council's Change Board actively monitors and tracks progress on all council wide programmes ensuring that targeted action is taken should timelines, benefits or costings deviate from the original business case, this includes the ICT programme.

7. Equalities impact

- 7.1 There are no equalities implications arising from this report.

8. Sustainability impact

- 8.1 There are no sustainability implications arising from this report.

9. Consultation and engagement

- 9.1 There are no formal consultation and engagement implications arising from this report.

10. Background reading/external references

- 10.1 ICT and Digital Strategy: <http://ictanddigitalstrategy.org.uk/>
- 10.2 [Status of the ICT programme](#) – report to Governance, Risk, and Best Value Committee, 29 August 2017
- 10.3 [Status of the ICT programme](#) – report to Governance, Risk, and Best Value Committee – 16 January 2018

Stephen S. Moir

Executive Director of Resources

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11. Appendices

- 11.1 None.

Governance, Risk and Best Value Committee

10.00am, Tuesday, 31 July 2018

Expansion of Early Learning and Childcare from 600 – 1140 hours by 2020. Audit Scotland Report and Risks

Item number	7.6
Report number	
Executive/routine All	
Wards	
Council Commitments	

Executive Summary

This report provides a summary of the Audit Scotland Report published February 2018, on the expansion of Early Learning and Childcare.

Expansion of Early Learning and Childcare from 600 – 1140 hours by 2020

1. Recommendations

- 1.1 The Governance, Risk and Best Value Committee is asked to:
 - 1.1.1 note the contents of this report.

2. Background

- 2.1 The Scottish Government has committed to closing the poverty related attainment gap through intervention and prevention at an early stage.
- 2.2 The Children and Young People (Scotland) Act 2014 (the Act), made changes to how Early Learning and Childcare (ELC) is provided in Scotland.
- 2.3 From August 2014 the entitlement for funded ELC increased from 475 hours a year to 600 hours for all three and four year olds and eligible two year olds.
- 2.4 The Scottish Government is working with councils to further extend the entitlement to funded ELC to 1,140 hours per year by 2020. This is equivalent to around 30 hours a week in school term time provision.
- 2.5 The aims of the expansion to 1,140 hours focus on improving outcomes for children with an emphasis on high-quality ELC.
- 2.6 In Edinburgh, 11,000 children receive 600 hours of funded ELC in a range of services including, council run early years settings and private sector and voluntary sector providers in partnership with the local authority.
- 2.7 The Scottish Government requested that all Local Authorities submit an Expansion Plan for 2020 by the end of September 2017. This plan along with the finance template outlining our estimated revenue and capital cost for the expansion was reviewed throughout October and November 2017. Following this review the Scottish Government requested that all Local Authorities submit a revised finance template by 2 March 2018.
- 2.8 Edinburgh currently has a baseline revenue budget of £30 million to deliver 600 hours of Early Learning and Childcare. Revenue funding for 2018/19 has now be confirmed and Edinburgh has been allocated a total of £5,420,242 to meet the cost of delivering the expansion.
- 2.9 Following the agreement of the multi-year funding package, Edinburgh has been allocated a total revenue of **£48,025,000** by 2021-22. This will be issued as a

specific grant annually as follows 2019-20 **£26,019,000**, 2020-21 an additional **£17,035,000** and 2021-22 a further **£4,971,000**.

- 2.10 Edinburgh has been allocated a total capital funding of £39,480,000 to support the expansion. This is allocated as follows 2017-18 **£2,580,000**, 2018-19 **£12,400,000**, 2019-20 **£14,500,000**, and 2020-2021 **£10,000,000**

3. Main report

Summary of Key messages within the Audit Scotland Report.

- 3.1 The Scottish Government and Councils have worked well together to expand provision and parents are positive about the benefits of funded ELC.
- 3.2 The Scottish Government invested almost £650 million of additional funding since 2014 to expand funded ELC from 475 hours to 600 hour, but there is no evaluation of the impact of the additional hours on improving outcomes for children and their families.
- 3.3 Parents state funded ELC has a limited impact on their ability to work due to the hours available and the way in which those hours are provided.
- 3.4 There are significant risks that councils will not be able to expand funded ELC to 1,140 hours by 2020. In particular, it will be difficult to increase the infrastructure and workforce to the levels required, in the limited time available.
- 3.5 The Scottish Government expects the cost of delivering 1,140 hours will be about £840 million per year. Initial estimates from councils are significantly higher at around £1 billion per year to deliver the expansion to 1,140 hours.

The City of Edinburgh Council's position

- 3.6 All council run early years settings and private and voluntary sector providers in partnership with the council have delivered the increase of ELC from 475 hours to 600 hours from August 2018
- 3.7 Parental uptake of the increase to 600 hours was almost 100% from August 2018 and remains high. The increase provided parents with access to an additional 3 hours 50 minutes of ELC. As this was spread across five days in most cases, is difficult to measure the impact on improving outcomes for children and families.
- 3.8 Approximately 11,000 children are entitled to funded ELC in Edinburgh. From August 2017 the early years service began phasing in the expansion across twenty five local authority ELC settings, three forest kindergartens and in a pilot with seven childminders. By March 2018 approximately 1130 children have been able to access the increased hours.

- 3.9 An initial evaluation of the impact of the increased hours of ELC has shown that many children are benefitting from the longer day and learning from the routines which are part of this e.g. lunchtime experiences. There are also some reports of parents being able to start work as a result of having access to additional hours.
- 3.10 Recruitment for the first phase of the expansion in Edinburgh has been minimal as almost all settings were identified due to existing capacity. Where recruitment has been required, posts which are full time are easier to fill. The part-time posts required for the expansion e.g. to support lunches across the middle of the day have been a greater challenge to recruit.
- 3.11 **Phase 2** of the expansion will begin in August 2018 and planning for this is in progress. In addition to the Phase 1 settings a further twenty one local authority settings are being considered to provide additional hours from August. Our aim is that a further 1,000 children will be able to access the additional hours in these settings. Recruitment for this phase will be supported through Edinburgh's Early Learning and Childcare Academy (EELCA).
- 3.12 There are approximately 650 staff working in local authority ELC settings and we estimate another 700 may be required to enable us to deliver 1,140 hours of ELC to all eligible children by 2020. To support the increase in our workforce, we are building on our successful approach to 'growing our own' workforce through Edinburgh's Early Learning and Childcare Academy (EELCA). The next cohort of Modern Apprentice/Trainees will increase from 30 to 90 in August 2018.
- 3.13 Recruiting the number of staff we will require remains a significant challenge. We are liaising with external training providers and marketing and recruitment teams to highlight the opportunities for a career in ELC within Edinburgh. We have also enhanced our online communication to provide easier access to information about a career in ELC and links to qualification paths.
- 3.14 Demand for early years places (local authority and partner providers) across the city has been assessed on a cluster basis using non-denominational high school catchment areas. The projected demand for places is based on:
- Catchment birth data;
 - Uptake of early years places for three and four year olds in local authority and partner provider settings;
 - The estimated percentage of eligible two year olds in SIMD decile 1 and 2 in each cluster area;
 - Housing data from the Council's [Housing Land Audit and Delivery Programme 2017](#);
National Records of Scotland (NRS) 2014 based Population Projections for Scottish Areas.
- 3.15 The capacity of the city's existing Early Years establishments to meet the projected demand has been assessed based on current management arrangements and available infrastructure. Figure show that within City of Edinburgh Council area

there is a projected capacity shortfall of almost 3,000 places for 3-4 year olds and a shortfall of 360 places for 2 year olds.

- 3.16 In order to address these shortfalls an expansion strategy for Early Learning and Childcare in Edinburgh has been developed. The aim of this strategy is to provide all current and projected eligible children with a place in a City of Edinburgh Council or partner provider establishment in their own cluster area or an adjoining cluster area.
- 3.17 Much of this shortfall may be met by changing the opening hours and management arrangements at existing facilities. Some of the shortfall may also be met by adapting existing facilities. However, a significant programme of new build will also be required. A summary of the physical expansion opportunities identified is contained within Appendix 1. Should this expansion plan be implemented the number of places available for three and four year olds and eligible two year olds would be sufficient to meet projected demand.
- 3.18 Delivering new and refurbished facilities by 2020 will be a significant challenge requiring swift design, procurement and construction processes. Accordingly, early design work and site investigations have been progressed. The Council have also opened discussions with representatives from the Scottish Government and the construction industry to identify the most appropriate construction methodologies. As all local authorities face similar pressures to deliver 1140 hours by 2020 there is a risk that resources, particularly within the construction industry, become stretched.
- 3.19 Early engagement with affected school communities has also begun and, while the Scottish Government have removed the requirement for local authorities to undertake a statutory consultation process to establish a nursery, it is the intention to undertake informal consultation with all affected communities.

4. Measures of success

- 4.1 Overall progress measured using a suite of indicators within the Communities and Families Service Plan to ensure that our children have the best start in life, are able to sustain relationships and are ready to succeed.
- 4.2 Outcomes from Inspections from Education Scotland and the Care Inspectorate provide information on quality across the service.
- 4.3 We have achieved the Council's commitments 32 and 33.

5. Financial impact

- 5.1 All plans for Phase 1 and Phase 2 will be covered through the revenue funding of £5,420,242 allocated for 2018/19.

- 5.2 Following the agreement of the multi-year funding package, Edinburgh has been allocated a total recurring revenue of **£48,025,000** by 2021-22. This will be issued as a specific grant annually as follows 2019-20 **£26,019,000**, 2020-21 an additional **£17,035,000** and 2021-22 a further **£4,971,000**.
- 5.3 Edinburgh has been allocated a total capital funding of £39,480,000 to support the expansion. This is allocated as follows 2017-18 **£2,580,000**, 2018-19 **£12,400,000**, 2019-20 **£14,500,000**, and 2020-2021 **£10,000,000**.
- 5.4 Delivery plans will be reviewed to ensure affordability.

6. Risk, policy, compliance and governance impact

- 6.1 Approximately 40% of children entitled to funded early learning and childcare attend our partner provider provision. There is a level of uncertainty about future partner provision due to concern about the hourly rate they are paid to deliver an increase in funded early learning and childcare.
- 6.2 To enable us to address this and support the sustainability of our partner provider provision, we have included an increase in the hourly rate paid to partners within the finance template submitted to the Scottish Government. This will increase from £3.70 per hour to £3.80 per hour for 600 hour provision from August 2018.
- 6.3 We are proposing to increase the hourly rate to £5.31 per hour for 1140 hour provision. This will be piloted with a small number of partner providers in Phase 2 of the expansion during session 2018.
- 6.4 There is a risk that the guidance we received from Scottish Government delivery support team to devise our expansion plan estimates in our finance template may require us to provide models of delivery for the 1140 hours that will not provide parents with the level of choice that they want.
- 6.5 Delivering the required infrastructure and the ability to recruit the number of staff within the required timeframe continue to provide significant challenges in the Council's ability to deliver the expansion from 2020.
- 6.6 The timescales to allow the delivery of new infrastructure are extremely tight and represent a significant risk to the Council's ability to provide the statutory 1140 hours to all children. In addition, the requirement to construct and refurbish Early Years facilities on the scale proposed – both within Edinburgh and at a national level – will place significant pressure on the construction market. Accordingly, the availability of resources to undertake the work and supply the necessary services and products also represents a significant risk to the delivery of the Council's Early Learning Childcare expansion strategy.
- 6.7 The Scottish Government Early Learning and Childcare Service Model for 2020: Consultation Paper states *Families will be able to access funded ELC in the provider of their choice if that provider meets the criteria set out in the National Standard, is able to offer the entitlement in-line with local ELC delivery plans and*

has a place available. This presents a challenge to Best Value as parent expectations around choice of provision, flexibility and accessibility may not be operationally sustainable.

7. Equalities impact

- 7.1 All work within this area seems to address inequalities, both in terms of provision of resources and impact on outcomes for children and their families. There is no negative impact arising from these proposals.

8. Sustainability impact

- 8.1 There are no impacts on carbon, adaptation to climate or sustainable development arising from this report. These matters will be considered as part of planning, design development and in the implication of each phase of the expansion of the provision.

9. Consultation and engagement

- 9.1 Necessary consultation has been undertaken with key stakeholders in the development and delivery of the expansion. This includes an authority wide consultation with parents/carers, local authority and partner provider ELC settings and childminders. Consultation also took place in October 2017 with non-partner providers and sixteen have expressed an interest in coming into partnership; with the council.
- 9.2 A Blueprint for 2020: The Expansion of Early Learning and Childcare – Scottish Government Consultation.

10. Background reading/external references

- 10.1 [Children and Young People \(Scotland\) Act 2014](#)
- 10.2 [A Blueprint for 2020: The Expansion of Early Learning and Childcare in Scotland](#)
- 10.3 [2017 National Improvement Framework and Improvement Plan for Scottish Education: Achieving Excellence and Equity](#)
- 10.4 [Building the Ambition: National Practice Guidance on Early Learning and Childcare](#)
- 10.5 [My World Outdoors: Care Inspectorate](#)
- 10.6 [Report to Education, Children and Families Committee: Early Learning and Childcare Strategy Report August 2017](#)
- 10.7 [A Blueprint for 2020: The Expansion of Early Learning and Childcare in Scotland – Early Learning and Childcare Service Model for 2020: Consultation Paper.](#)

10.8 http://www.audit-scotland.gov.uk/uploads/docs/report/2018/nr_180215_early_learning.pdf

Alistair Gaw

Executive Director for Communities and Families

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11. Appendices

11.1 Early Learning Childcare (ELC) Expansion Strategy

APPENDIX 1

Early Learning Childcare (ELC) Expansion Strategy

Estimated additional incremental revenue costs of Early Years expansion

	2017/18 £000	2018/19 £000	2019/20 £000	2020/21 £000	2021/22 £000	Total £000
Staff costs - local authority settings	2.752	4.209	2.120	8.035	4.251	21.367
Staff costs - policy development, management and support	0.000	0.513	0.236	0.000	0.000	0.749
Other staffing costs	0.034	0.119	0.150	0.110	0.049	0.462
Funded partner provision	1.084	1.032	2.992	8.271	0.445	13.824
Lunches - cost of provision	0.570	0.713	1.567	3.353	-0.592	5.611
Other running costs, including educational resources and property expenditure	0.205	0.897	1.080	1.497	0.667	4.346
Total	4.645	7.483	8.145	21.266	4.820	46.359

Estimated capital costs of Early Years expansion

	2018/19 £000	2019/20 £000	2020/21 £000	2021/22 £000	Total £000
Refurbishment projects	0.949	0.725	0.000	0.000	1.674
Extension projects	0.000	10.045	13.759	0.000	23.804
New-build projects	0.000	0.000	12.949	0.000	12.949
Outdoor spaces	0.150	0.200	0.000	0.000	0.350
Other	0.000	0.203	0.203	0.203	0.609
Total	1.099	11.173	26.911	0.203	39.386

Governance, Risk and Best Value Committee

10.00am, Tuesday 31 July 2018

Annual Workforce Controls Report – referral from the Finance and Resources Committee

Item number	7.7
Report number	
Wards	All
Council Commitments	

Executive summary

On 12 June 2018 the Finance and Resources Committee considered a report which provided insight into Council workforce metrics and trends for workforce Full Time Equivalent (FTE), new starts and leavers, basic salary, overtime costs, agency costs and sickness absence rates and reasons, for the period January to December 2017. The report has been referred to the Governance, Risk and Best Value Committee for consideration as part of its work plan.

Terms of Referral

Annual Workforce Controls – referral from the Finance and Resources Committee

Terms of referral

- 1.1 Workforce costs form the largest single element of the Council's revenue budget. The application of robust and effective workforce controls was critical to achieving the savings set out in the Council's Business Plan and associated budget.
- 1.2 A report on the development of a workforce control framework was first reported to the Finance and Resources Committee on 19 March 2015 with subsequent annual reporting provided on 14 January 2016, and 23 February 2017.
- 1.3 The Council had implemented a single workforce dashboard and management information (MI) process to provide the organisation with consistent, regular, and accurate workforce MI/data to facilitate workforce control, strategic workforce planning, and to measure performance. Reporting had now been implemented at the Council, Directorate, and Division/Service level (for certain measures) to provide reliable insight into a range of workforce controls. The recent implementation of workforce dashboards at Directorate level provided regular MI on the monthly variation in Full Time Equivalent (FTE)/costs (by contract type – permanent, Fixed Term Contract (FTC), acting up/ secondment and apprentice), and trend analysis to support workforce management controls. Due to the organisational structure changes and their subsequent impact on our HR Management information system, some of the Directorate level dashboards only provided data from June 2017 rather than January 2017.

For Decision/Action

- 2.1 The Governance, Risk and Best Value Committee is asked to consider this report as part of its work programme.

Background reading / external references

Finance and Resources Committee 12 June 2018.

Laurence Rockey

Head of Strategy and Insight

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Links

Appendices

Appendix 1 - report by the Executive Director of Resources

Finance and Resources Committee

10.00am, Tuesday, 12 June 2018

Annual Workforce Controls Report

Item number	7.10
Report number	
Executive/routine	
Wards	
Council Commitments	

Executive Summary

This report provides insight into Council workforce metrics and trends for workforce Full Time Equivalent (FTE), new starts and leavers, basic salary, overtime costs, agency costs and sickness absence rates and reasons, for the period January to December 2017.

Annual Workforce Controls Report

1. Recommendations

- 1.1 The Committee is recommended to:
 - 1.1.1 To scrutinise the progress made to date and note the workforce trends over the period January to December 2017; and
 - 1.1.2 To refer this report to Governance, Risk and Best Value Committee as part of its work programme.

2. Background

- 2.1 Workforce costs form the largest single element of the Council's revenue budget. The application of robust and effective workforce controls is critical to achieving the savings set out in the Council's Business Plan and associated budget.
- 2.2 A report on the development of a workforce control framework was first reported to the Finance and Resources Committee on 19 March 2015, with subsequent annual reporting provided on 14 January 2016, and 23 February 2017.
- 2.3 Since the last report update to committee, the Council has implemented a single workforce dashboard and management information (MI) process to provide the organisation with consistent, regular, and accurate workforce MI/data to facilitate workforce controls, strategic workforce planning, and to measure performance. Reporting has now been implemented at the Council, Directorate, and Division/Service level (for certain measures) to provide reliable insight into a range of workforce controls. The recent implementation of workforce dashboards at Directorate level provides regular MI on the monthly variation in Full Time Equivalent (FTE)/costs (by contract type – permanent, Fixed Term Contract (FTC), acting up/secondment and apprentice), and trend analysis to support workforce management controls. Due to the organisational structure changes and their subsequent impact on our HR management information system, some of the Directorate level dashboards only provide data from June 2017 rather than January 2017.

3. Main report

- 3.1 This report provides MI and analysis to show the current position and trends across five core areas of workforce controls. The reporting provides analysis at both the organisation and directorate level. The analysis provides insight into:
- Full Time Equivalent employee population (FTE) and trends;
 - Basic salary costs for the FTE employee population and trends;
 - FTE and basic salary costs of new starts and leavers;
 - Overtime costs and trends;
 - Agency costs for primary, other, and off-contract suppliers and trends; and
 - Sickness absence rates, the reasons and costs of absence, and the impact of open ended long-term absence cases on organisation FTE.
- 3.2 For each of these measures, the reporting shows the position at December 2017, and month on month variation and trends observed since January 2017. The reporting also considers the current position and trends in the context of the earlier position at 2016.
- 3.3 A significant amount of structural change was implemented in the Council's HR management information system in 2017, and a new centralised data and MI reporting process was introduced by HR in June 2017 which allows for consistent and accurate reporting of workforce data for all new Council Directorates. Directorate level MI has been made available in this report, where data reconciliation between old and new structures has been possible, to give insight into the workforce control data below the organisation level and help understand the main reasons for organisation trends.
- 3.4 We also continue to see legislative changes which we are required to adopt. This includes factors such as travel expenses, shared parental leave and casual worker entitlement. Typically, such changes have cost implications. Whilst workforce planning can mitigate some of this, there will invariably be some unquantifiable additional costs.

Summary

- 3.5 The reporting period saw a consistent rising trend in FTEs amounting to an increase of 414 FTE. New starters account for around 21% of the total increase, with the balance being in part due to the adjusted reporting in 2016 of 250¹ FTE and contractual changes in our existing workforce (e.g. additional contracts or additional contractual hours).
- 3.6 Basic salary costs have also shown an upward trend, increasing by £18.8M in the period. Whilst much of this increase will be due to the increase in FTE, around £8.5M is due to the application of the 2017/18 annual pay award (c5.3 M) and pay steps (contribution based pay (CBP) and pay progression).

¹ Reported at F&R Committee June 2017

- 3.7 The basic salary cost for new joiners to the organisation was £2.1M lower than the cost of employees leaving the organisation as new starters tend to be appointed at the bottom of the grade, however this saving was offset by additional costs from additional FTE increases (existing population), the pay award and pay steps.
- 3.8 Fewer employees left the organisation under Voluntary Early Release Arrangement (VERA)/Voluntary Redundancy (VR) in the 2017 period than in 2016; there were 201 (177 FTE) VERA/VR leavers between January and December 2017, with a basic salary cost of £6.1M. This is due to the majority of reviews under Transformation completing in 2016, with the final stages completing in 2017/18. The Council pledge of no compulsory redundancy remains in place with the current administration. The enhanced voluntary redundancy payments agreed by the previous administration remain in place to incentivise early release.
- 3.9 A slight downward trend was observed for agency spend over the 12-month period. The total agency spend for the year was £18.8M, with an average monthly cost of approx. £1.6M.² It is noted that 93% of all agency spend was linked to the primary and other contracted suppliers. Approximately 40% (£7.6m) was paid through the social care agency workers framework, 29% (£5.5m) was spent in Waste and Cleansing, Health and Social Care and Customer/Business Support via the Pertemps contract and 11% (£2M) was paid to the previous supplier Addeco. The remaining 3.7M agency spend was spread across the Council. At its meeting on 1 December 2016 the Committee approved a change of agency supplier to Pertemps Recruitment Partnership Limited (“Pertemps”) and this contract came in effect on 12 June 2017. The new contract provides the Council greater value for money and based upon indicative historical spend for temporary agency staff there is a project cost saving of £713,036 over the contract period (including extension) compared with the previous negotiated rates. A second procurement exercise is currently underway for the provision of social care agency workers as the current framework agreement is due to end on 31 July 2018.
- 3.10 A slight downward trend was observed for overtime spend (down £40K) over the 12-month period despite the impact of the pay award and pay steps (post April 2017) on hourly rates.
- 3.11 Lost working time due to ill-health, or sickness absence, continued to rise, increasing from 5.21% to 5.41% over the period, with an estimated annual cost in the region of £23M in lost productivity. There were 172,000 days lost to absence in 2017; 32.1% of this absence was short term, and 67.9% was long term (more than 4 weeks). All directorates showed an increase in absence, except Place. The primary causes of long-term absence were stress, both work and non-work related, and mental health related illness.

² Figures quoted are based on invoices paid in each month and may change slightly once Commercial and Procurement Services complete April invoice reconciliation to work completed within 2017/8.

3.12 The 2016 period saw a significant reduction in FTE from January to December as part of the Transformation change programme. Over the same period, absence levels in the organisation increased and have continued to increase throughout 2017. It is recognised that the increase in sickness absence levels has been caused, in part by the impact of reduced FTE and a number of initiatives have been introduced during 2017 to better support employees and managers. It is anticipated that the effects of these initiatives will begin to be felt during 2018.

Workforce FTE

3.13 Following large scale workforce FTE reduction in 2016 where our population reduced by 952 FTE over the 12-month period (see Figure 1), 2017 saw a general upward trend in our FTE (see Figure 2) with an overall FTE increased by 414 FTE between January and December 2017.

Figure 1: Organisation FTE Trend 2016

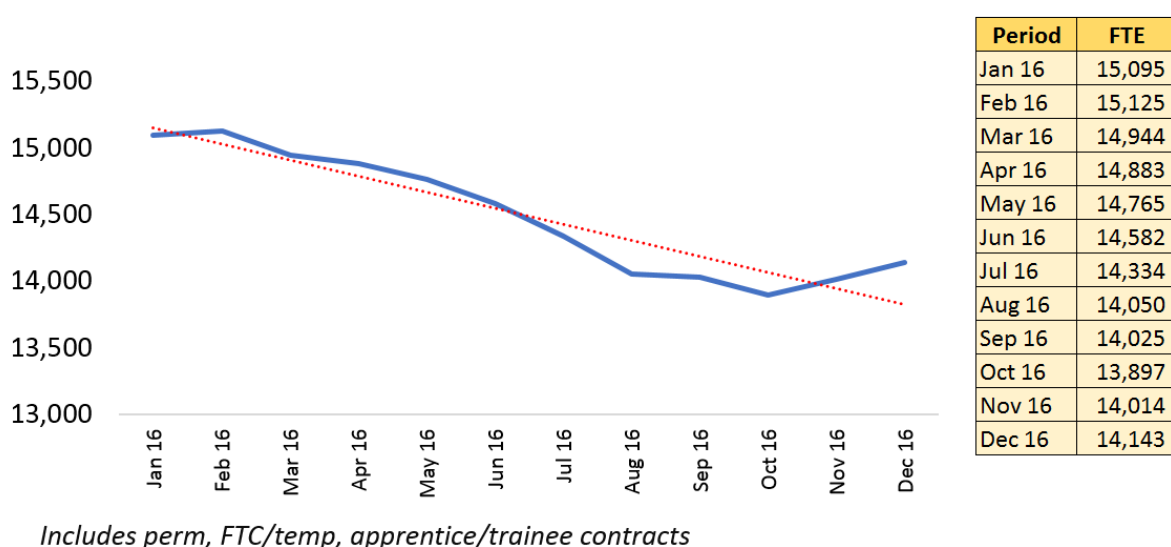
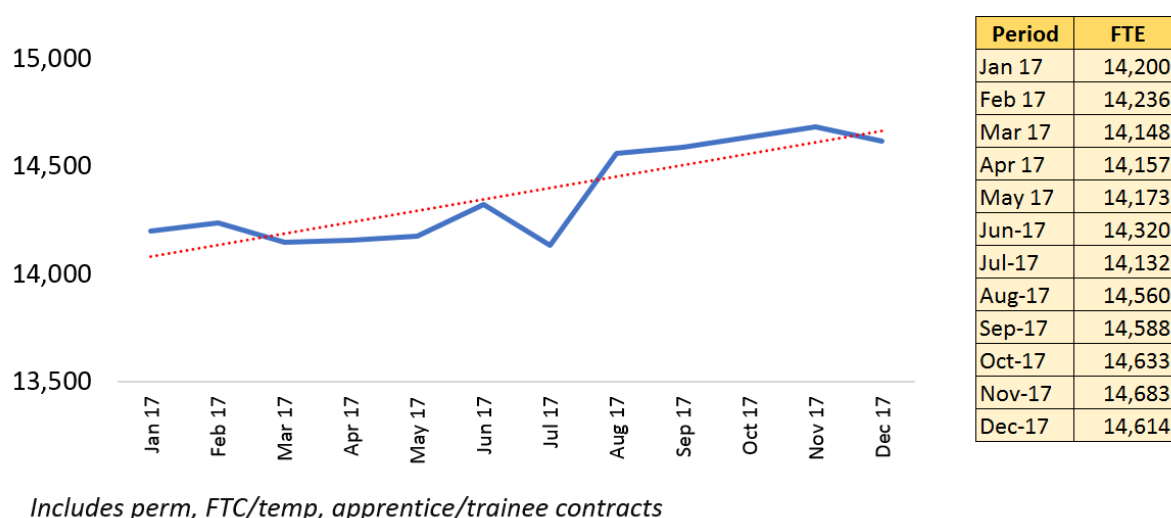


Figure 2: Organisation FTE Trend 2017

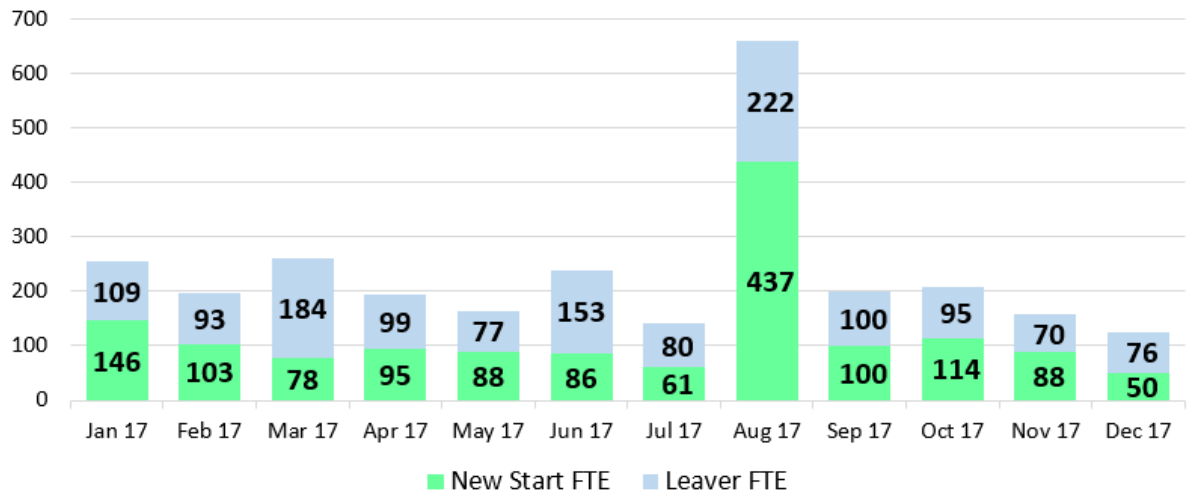


3.14 The greatest overall increase in FTE was observed in August and this was attributable to the appointment of additional teaching and school support resource

in Communities and Families, linked to greater Pupil Equity Funding being made available to the local authority. The total PEF funding allocated to Edinburgh for 2017/18 was £7.472m. PEF funding is targeted at closing the poverty related attainment gap to enable schools to deliver activities, interventions or resources which are additional to those already in plan. The primary focus is on activities and interventions that will lead to improvements in literacy, numeracy and health and well-being. As a result, any teachers recruited through PEF are excluded from the authority's contribution to any national teacher numbers and/or ratio commitment. FTE increased by 428 in August, 389 FTE of this was in Communities and Families, with 343 FTE in the primary and secondary schools structure. The August period figures also include the increase to basic salaries/linked payments resulting from application of the national pay award (£350/1%).

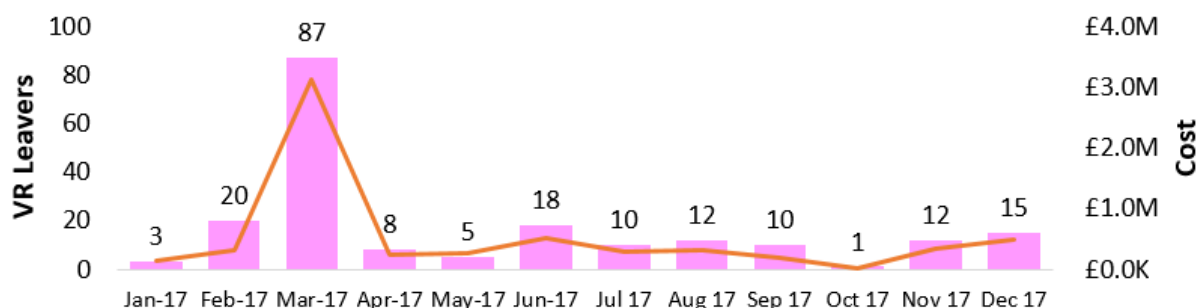
- 3.15 The usual seasonal FTE fluctuation was observed in the July 17 period, due to the end of the school year and associated contractual changes (e.g. ending of fixed term contracts); this is not visible in the 2016 trend due to employee reductions from transformation organisational reviews.
- 3.16 Over the year, there were 1446 new starts to the organisation and 1358 leavers, giving a net increase of 88 FTE from new starts. A breakdown of new starts and leavers in each month is shown in Figure 3. The main increase in total FTE increase across the Council in the year was attributable to contractual changes in the existing workforce (e.g. additional contracts or additional contractual hours).

Figure 3: FTE: Organisation New Starts and Leavers, January – December 2017



- 3.17 In 2017, 201 employees (177 FTE) left the Council (with total basic salary cost of £6.1M), as a result of VERA/VR arrangements linked to organisational reviews, with a peak in leavers at March 2017. This group of 177 FTE represents 13% of organisation leavers in the 2017 12-month period. These leavers are included in the organisation leaver data referred to in this report (FTE and costs). Figure 4 shows the total VERA/VR leavers over the year and the associated salary costs.

Figure 4: Organisation VERA/VR Leavers and Basic Salary Cost, January – December 2017

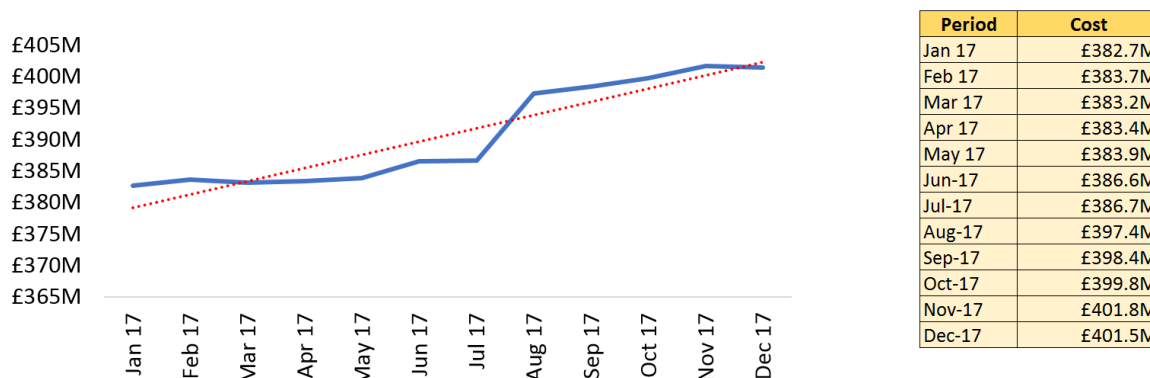


- 3.18 By comparison, in 2016 there were 700 VR/VERA leavers (FTE 651) with a total salary cost of £28.3M. This group of 651 FTE represented 32% of all organisation leavers in 2016.
- 3.19 The Council implemented a suite of workforce MI dashboards in June 2017 which provide additional insight into how the increase in overall FTE is comprised. Appendix 1 provides information on the FTE trend at the directorate level between June and December 2017. This data shows that the upward trend in FTE was not consistent across all directorates. Ongoing organisational reviews in Edinburgh Health and Social Care Partnership, Resources and the Chief Executive’s Service led to overall FTE reductions for these directorates between June and Dec 2017.
- 3.20 Organisation FTE increases are predominantly linked to Communities and Families, which saw the largest FTE increase of 330, from 6579 (June) to 6909 (Dec). Place and Chief Executive: Safer and Stronger Communities also saw increases, but on a smaller scale, increasing by 86 FTE and 18 FTE respectively.

Workforce Basic Salary Cost

- 3.21 In 2017 our basic salary costs increased by £18.8M, from £382.7M to £401.5M:

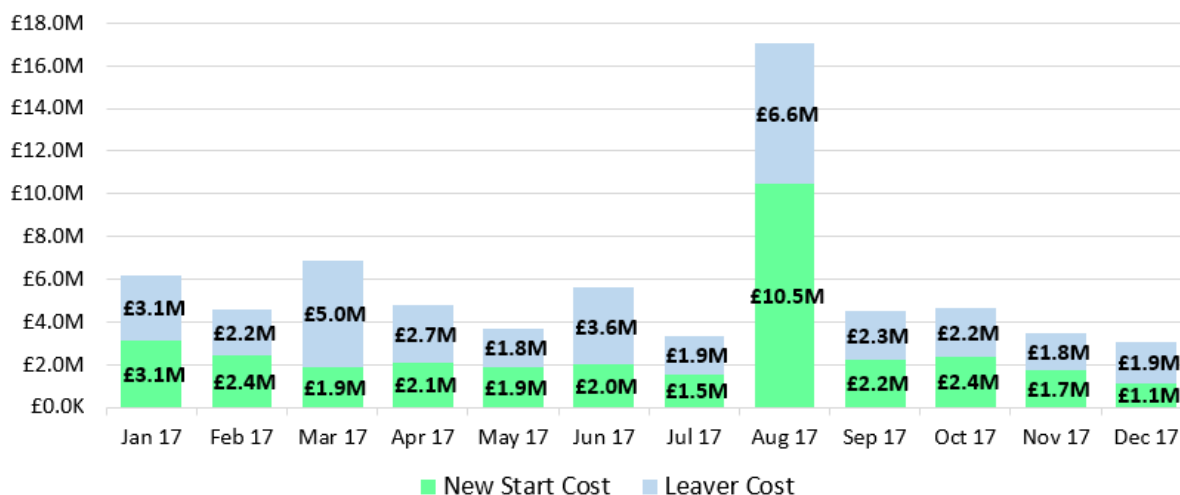
Figure 5: Organisation Basic Salary Cost Trend, January – December 2017



Includes perm, FTC/temp, apprentice/trainee contracts

3.22 Over the 12 months the total cost of new starters was £32.9M and leavers was £35M, giving a net saving of £2.1M in this area, see Figure 6. This means that the cost of new employees joining the organisation was lower than the cost of those employees that left in 2017.

Figure 6: Basic Salary Cost: Organisation New Starts and Leavers, January – December 2017



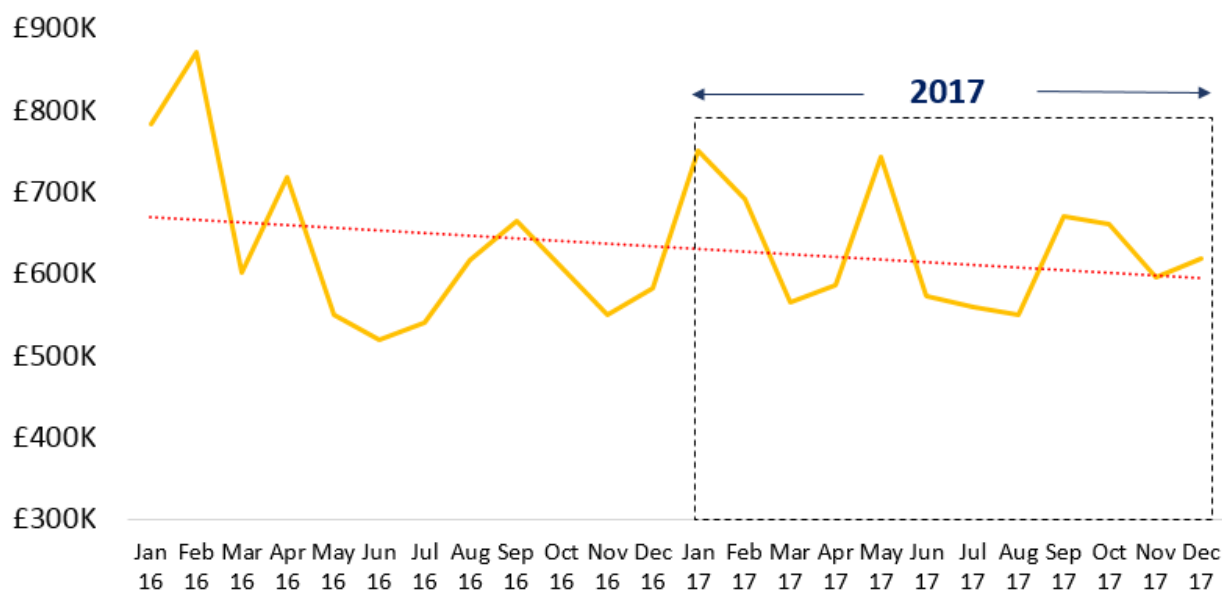
3.23 In addition to the pay award and CBP/pay progression, the additional increase in to basic salary costs observed in 2017 can be attributed to our rising FTE; where an overall increased FTE of 414 with an average salary cost of £20K yields a total approx. cost of £8M). The total extra cost of this FTE has been offset by the savings made from new starts/leavers (£2.1M).

3.24 Appendix 2 highlights the difference in basic salary cost trend between June and Dec 2017 across our Directorates. Basic salary cost trends are generally in line with the FTE changes observed in directorates over the same period – cost increases took place in Communities and Families, Place, and Safer and Stronger Communities. The slight cost increase in Resources, despite headcount reduction, is due to a small number of grade changes, a limited number of additional senior roles (G8-10) and the appointment of the Executive Director post, as this was previously covered through acting up arrangements without backfill.

Workforce Overtime Costs

3.25 Our total overtime expenditure in 2017 was £7.57M compared with £7.61M in 2016, a reduction of approx. £40K. Figure 7 shows the slight downward trend in overtime costs between Jan 2016 and Dec 2017.

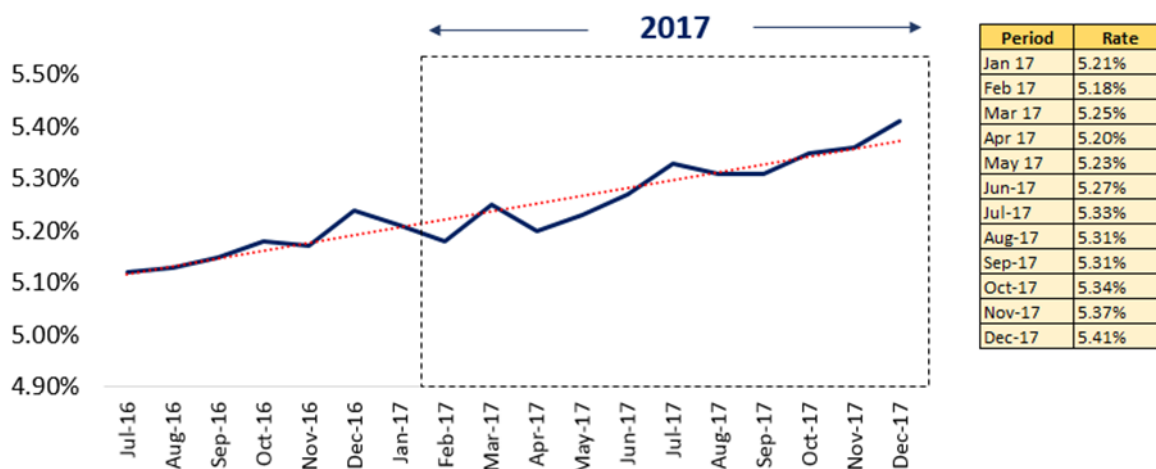
Figure 7: Organisation Overtime Cost, January 2016 – December 2018



Workforce Absence

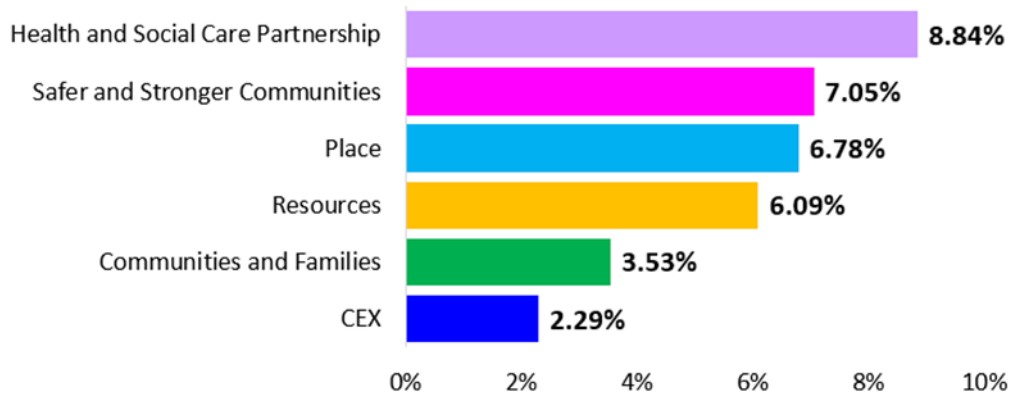
- 3.26 Our 12-month rolling absence rate steadily increased from 5.21% in Jan 2017 to 5.41% in December 2017. At December 2017 our total absence rate was 5.41%, with a short-term rate of 1.74% and a long-term rate of 3.67%.
- 3.27 The organisation absence trend is shown in Figure 8 for the period July 2016 to December 2017. The graph provides data from July 2016 and shows the upward trend has continued over the 18-month period. Over the 12 months January to December 2017, the Council lost 172,000 days to sickness absence – 32.1% of the days were lost to short term absence and 67.9% were lost to long term absence. The estimated cost to the organisation of all absence in 2017 was in the region of £23M.

Figure 8: Organisation Absence Trend (July 2016 – December 2017) 12 month rolling



- 3.28 Detail on the rolling absence rate by directorate is shown in Figure 9, with the highest absence figures showing in Edinburgh Health and Social Care Partnership.

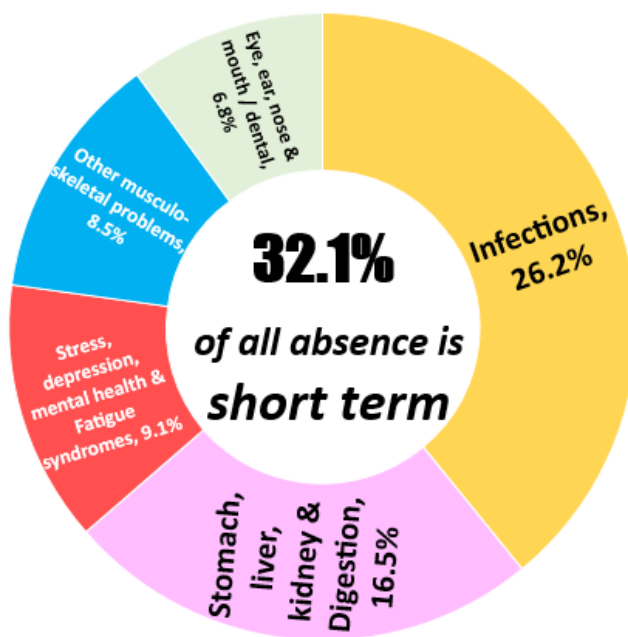
Figure 9: Rolling Absence Rates by Directorate, January – December 2017



3.29 Absence trends by Directorate are available for the period June – December 2017, and are captured in Appendix 2. The trend analysis shows upward absence trends in all directorates, except Place which has experienced a reduction in absence, understood to be linked to targeted absence management across hotspot services during 2017.

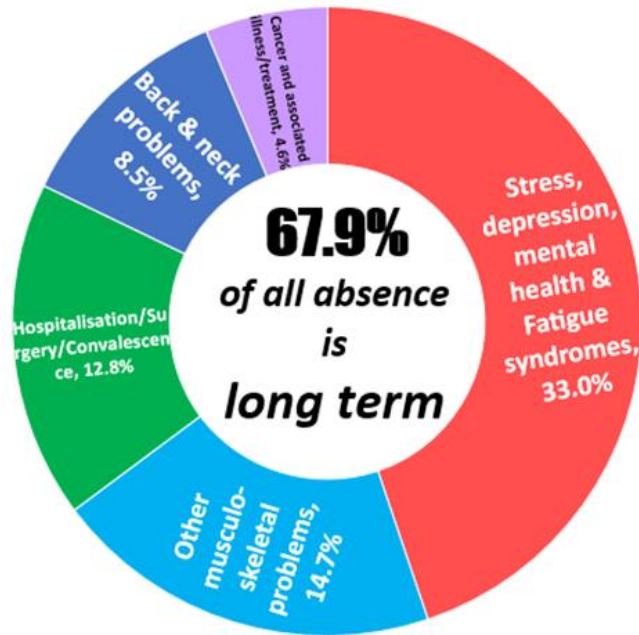
3.30 Figure 10 and Figure 11 report on the top 5 reasons for both short and long-term absence at the organisation level from January to December 2017.

Figure 10: Top 5 Reasons for Short Term Absence



Infections were the top reason for short term absences (26.2%); followed by stomach, liver, kidney, and digestion issues (16.5%); stress, depression, mental health, fatigue, and associated conditions (9.1%); musculoskeletal problems (8.5%); and then eye/ear/nose/mouth and dental issues (6.8%).

Figure 11: Top 5 Reasons for Long Term Absence

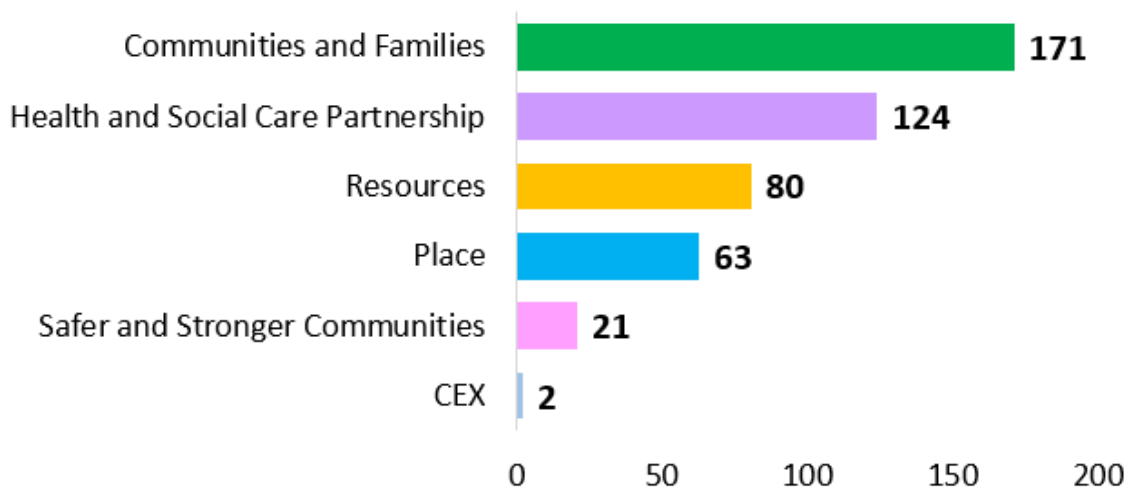


Stress, depression, mental health, fatigue, and associated conditions account were the top reason for long term absence (33% of all long-term absence); followed by musculo-skeletal problems (14.7%); hospitalisation/convalescence (12.8%; back and neck problems (8.5%); and cancer/associated illness and treatment (4.6%).

3.31 At December 2017 there were 556 open ended long-term absences (equivalent FTE of 461) with the majority of cases ongoing for less than 3 months. Of the longer-term cases, 46 employees had been absent for longer than 12 months at December 2017 with the most frequent cause being stress, depression, mental health, fatigue, and associated conditions - a third of all cases falling into this category.

3.32 Long term absence rates during 2017 showed a correlation with use of agency, and fixed term contracts during the same period. Figure 12 shows a snapshot the FTE lost across directorates to open ended long-term absence cases at December 2017.

Fig 12: FTE Lost to Open Ended Long-Term Absence Cases, by Directorate, December 2017



3.33 Best practice from Place has been shared across all Directorates. Regular absence dashboards and detailed data reporting have been provided at Directorate level to enable senior managers to identify hotspots and trends and to begin to measure the effectiveness of interventions. Support and Challenge Panels, line management training and consistent application of absence management processes across all directorates were rigorously followed during 2017. The first quarter of 2018 has seen some reduction in total open ended long-term absence cases. However, it is expected to take some time before the impact of interventive actions sees a reduction in the overall absence rolling rates.

Agency Costs

3.34 Figure 13 shows monthly agency billing in 2017 for the primary supplier (Pertemps since June 2017), our other contracted suppliers, and off-contract suppliers for agency staffing. Due to the nature of the billing process for agency staffing, we see some significant month on month fluctuations in the cost data, however the trend analysis (Figure 14) shows that between April 2016 and December 2017 the organisation has experienced a slight downward trend in agency spend.

3.35 Our total agency spend for the year was £18.8M, with an average monthly cost of approx. £1.6M. The primary and other contracted suppliers (£17.5M) accounted for 93% of all agency spend, with 7% (£1.3M) of the total spend attributable to off-contract suppliers.

3.36 Development of a workforce resourcing dashboard is in progress to provide further insight into agency resource utilisation.

Figure 13: Organisation Agency Costs, January – December 2017

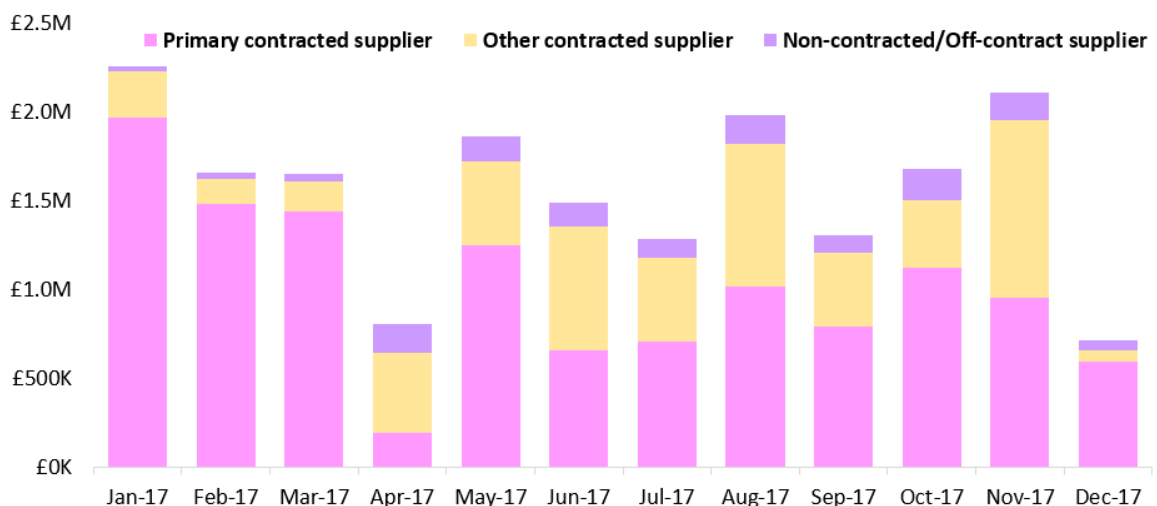
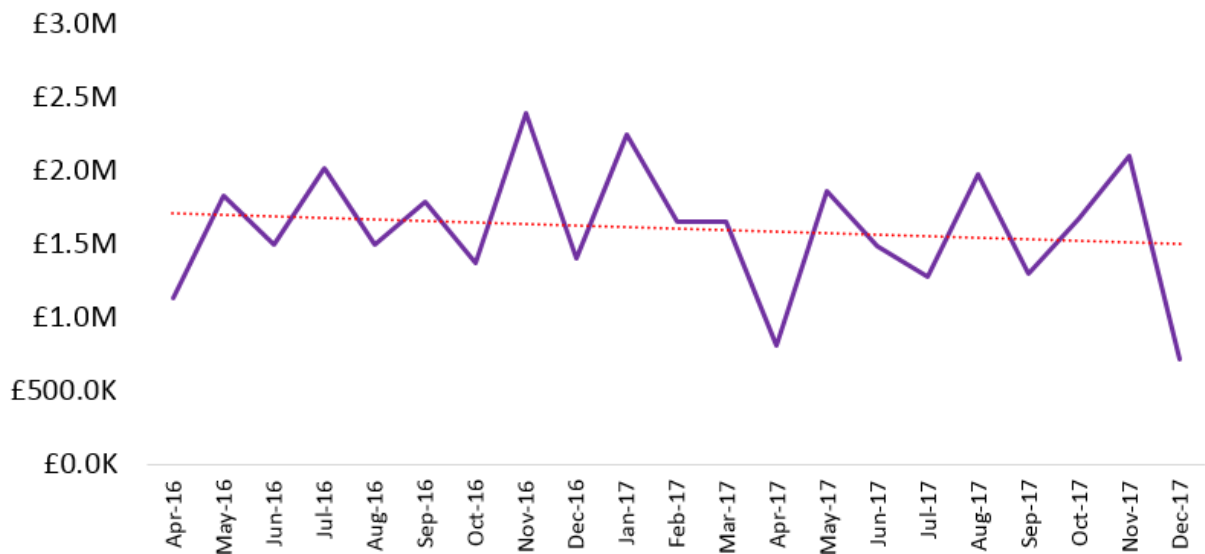


Figure 14: Organisation Agency Cost Trend, April 2016 – December 2017



4. Measures of success

- 4.1 Organisational workforce controls are aligned to the aims of our People Strategy, where our workforce reflects the city in which we operate, our organisation is the right size and shape to deal with challenges and deliver the change and services needed to deliver our strategic aims and outcomes. A Diversity and Inclusion dashboard is being developed which will be available shortly and will include comparative data on our workforce profile with our Edinburgh Community.

5. Financial impact

- 5.1 In the 2017 period the basic salary bill increased by £18.8M due to the increased size of the workforce, the annual pay award and pay steps. The total working days lost to sickness absence had an estimated financial impact of approx. £23M over the 12 months to December 2017. It should however be noted that the majority of these costs are opportunity costs relating to lost productive working time, because broadly similar salary costs would have been incurred had individuals been in work.

6. Risk, policy, compliance, and governance impact

- 6.1 Effective workforce management and reporting arrangements are essential to ensure that the Council can manage and control workforce costs, strategically plan for future change and measure performance.

7. Equalities impact

- 7.1 There are no significant equalities impacts arising from this report, although the Committee is advised that a Diversity and Inclusion workforce dashboard is currently under development which will complement existing reporting further.

8. Sustainability impact

- 8.1 There is no sustainability impact from this report.

9. Consultation and engagement

- 9.1 Consultation and engagement with key stakeholders, including leadership teams, Trades Unions and elected members is ongoing.

10. Background reading/external references

- 10.1 [Annual Workforce Controls Report](#) – report to Finance and Resources Committee 23 February 2017.

Stephen S. Moir

Executive Director of Resources

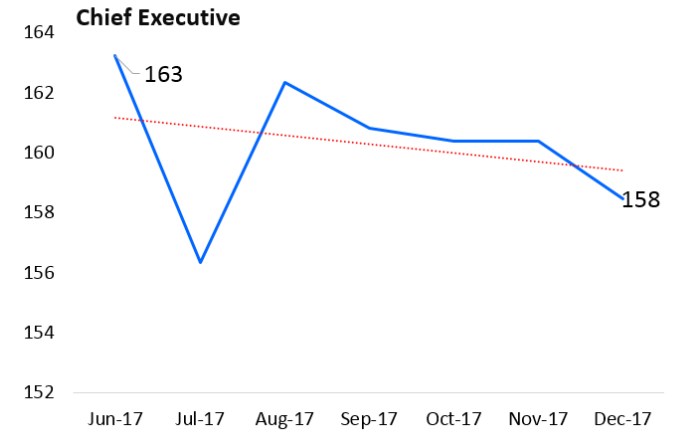
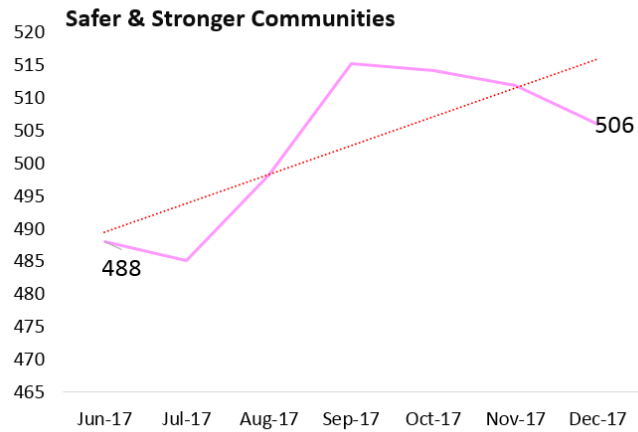
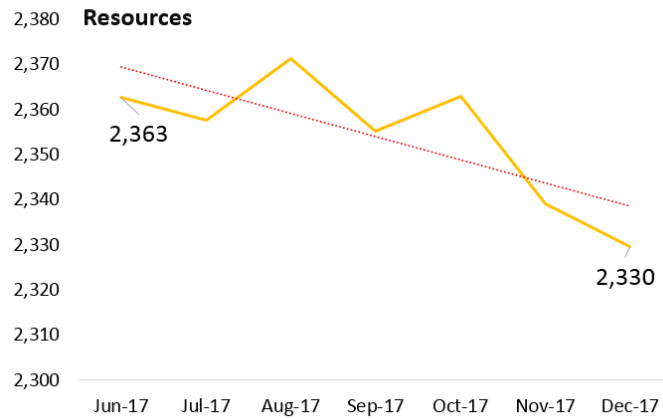
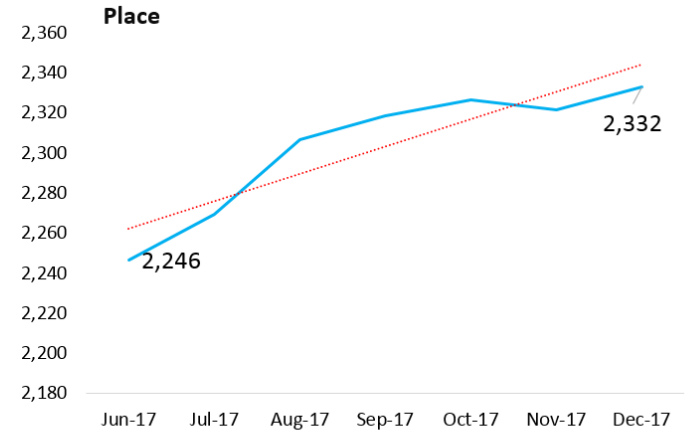
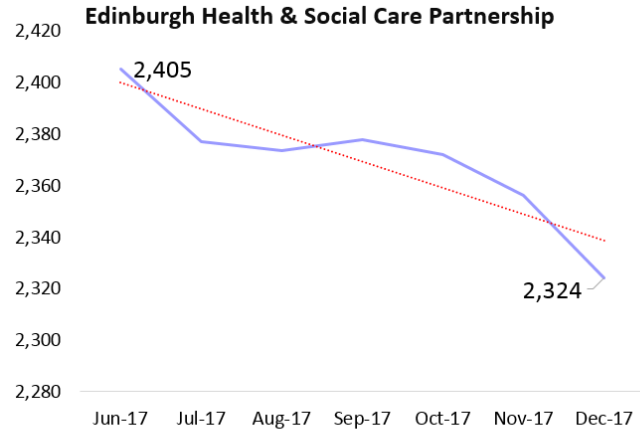
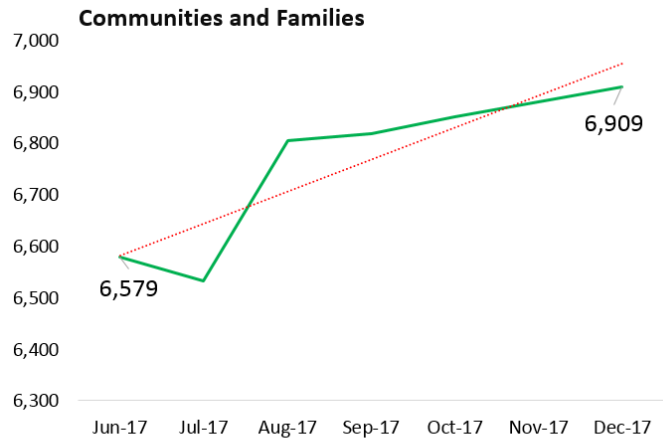
Contact: Katy Miller, Head of Human Resources

E-mail: katy.miller@edinburgh.gov.uk | Tel: 0131 469 5522

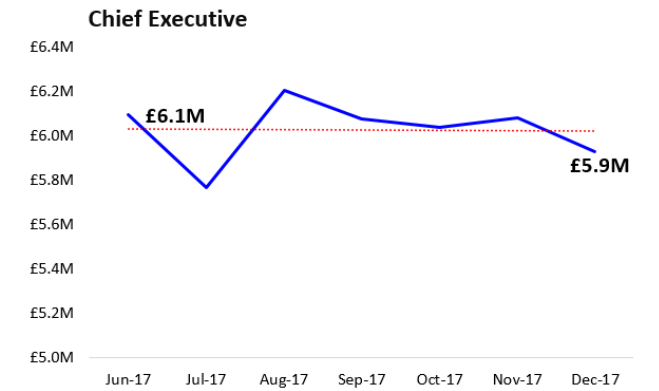
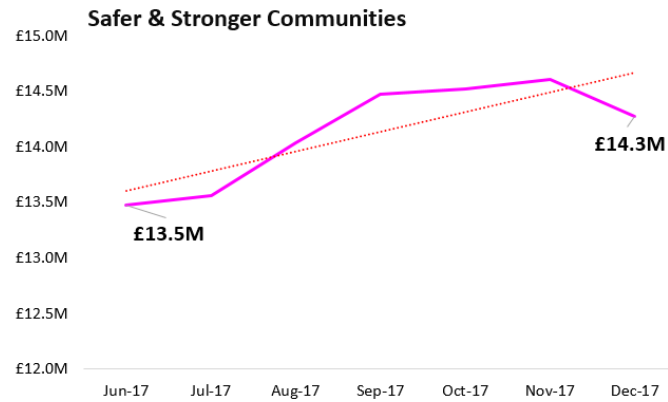
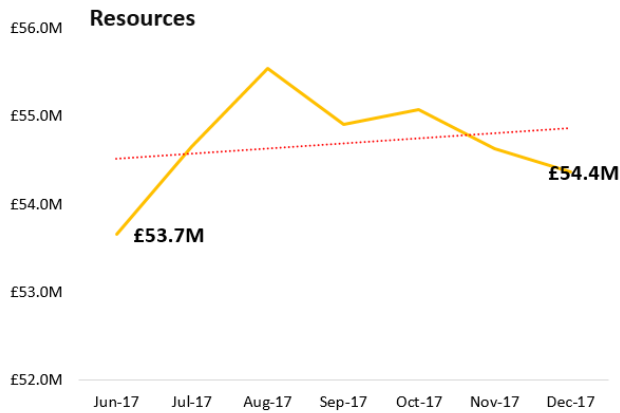
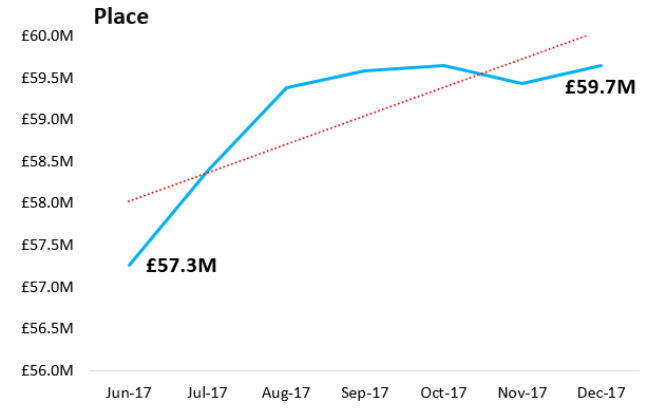
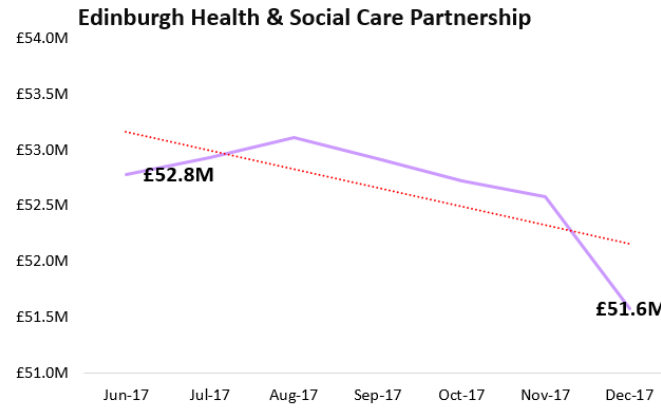
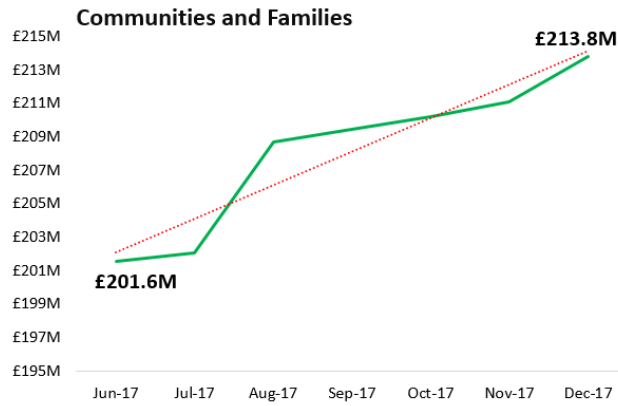
11. Appendices

Appendix 1	Directorate FTE Trends, January – December 2017
Appendix 2	Directorate Basic Salary Cost Trend, January – December 2017
Appendix 3	Annual Workforce Controls

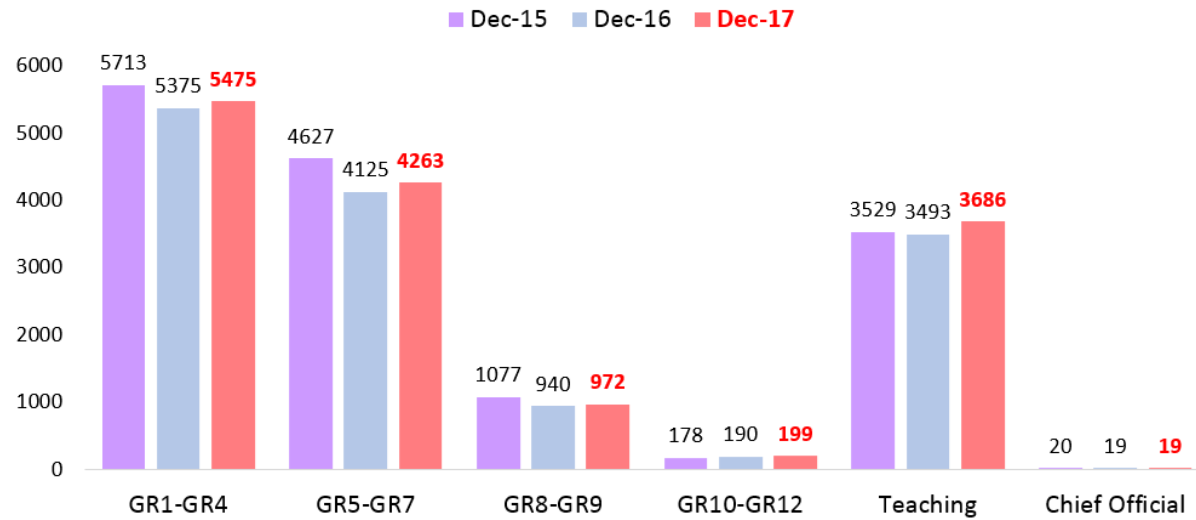
APPENDIX 1: Directorate FTE Trends, January – December 2017



APPENDIX 2: Directorate Basic Salary Cost Trend, January – December 2017



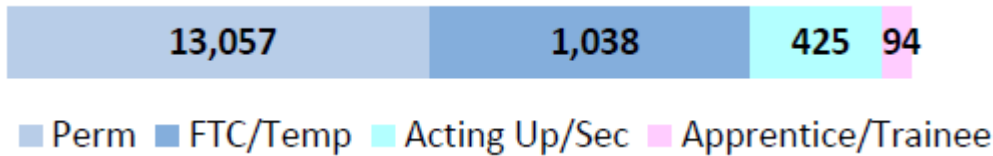
Workforce FTE by Grade (December 2015, 2016 and 2017)



Workforce FTE Variation by Grade (Dec 16 and Dec 17)

	Dec-16	Dec-17	Variation
GR1-GR4	5375	5475	+ 1.86%
GR5-GR7	4125	4263	+ 3.34%
GR8-GR9	940	972	+ 3.43%
GR10-GR12	190	199	+ 4.57%
Teaching	3493	3686	+ 5.53%
Chief Official	19	19	0.00%

Workforce FTE by Contract Type – December 2017



Projected Annual Basic Salary Cost by Directorate at December 2017

Directorate	Cost by Contract Type				Total Cost
	Perm	FTC/Temp	Acting Up/ Secondment	Apprentice/ Trainee	
Communities and Families	£191.3M	£20.8M	£1.3M	£349K	£213.8M
Health and Social Care Partnership	£51.0M	£345K	£270K	£0K	£51.6M
Place	£58.4M	£667K	£20K	£572K	£59.7M
Resources	£51.6M	£2.0M	£209K	£596K	£54.4M
Safer and Stronger Communities	£13.6M	£602K	£102K	£0K	£14.3M
Chief Executive	£5.5M	£316K	£61K	£68K	£5.9M
Surplus/Redeployment Group	£1.8M	£47K	£17K	£0K	£1.8M
Grand Total	£373.1M	£24.8M	£2.0M	£1.6M	£401.5M

Projected Annual Basic Salary Cost by Contract Type at December 2017

