# 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.

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# Report

# 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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Chief Internal Auditor

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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 | | | | |
|---|---|---|---|---|---|---|
| | **Audit Review** | **High** | **Medium** | **Low** | **Totals** | **Refer to EIJB** |
| | **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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Contents



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

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

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

# 1. Background and Scope

## Background

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.<br><br>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:<br><br>• One Corporate Leadership Team member;<br>• One Head of Service and one Locality Manager;<br>• One Senior Executive Assistant and one Executive Assistant; and<br>• One Modern Apprentice<br><br>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.<br><br>Additionally, there is currently no mandatory phishing and cyber security training in place for all Council employees who have e mail accounts. |

| Business Implication | Finding Rating |
|---|---|
| • Risk that the Council is exposed to malware or ransomware attacks that could infect technology networks; and<br>• Risk that commercial or employee sensitive information is disclosed to cyber criminals by Senior Management. | High |

| Action plans | |
|---|---|
| **Recommendation** | **Responsible Officer** |
| 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<br>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;<br>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 | 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.<br>b) Targeted training in Cyber-Security for a wide range of staff roles is a Public Sector Action Plan for Cyber Resiliency (PScAP) requirement.<br>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 then and they would like us to create guidance for Cyber Catalysts.<br>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.<br>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:<br>• All staff<br>• Targeted version to senior leaders<br>• Targeted version to ICT.<br>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.<br>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.<br>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.<br>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.<br>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 | 1. Completed<br>31 August 2018 for IA validation and closure<br>2. a) Completed<br>31 August 2018 for IA validation and closure<br>2b and c) 28 September 2019<br>2d) 28 September 2018<br>3. 28 September 2019<br>4. 31 October 2018 |

| | |
|---|---|
| to deliver this commitment before 28th September so no extension is requested.<br><br>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.<br><br>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.<br><br>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 |
|---|---|
| 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 |
|---|---|
| 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;<br>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;<br>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<br>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** |
| 1. and 2 - Accepted – these recommendations will both be fully implemented<br>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.<br>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<br>31 August 2018 for IA validation and closure<br>3. a and b) 31 March 2019<br>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.<br>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).<br><br>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).<br><br>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.<br><br>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).<br><br>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** | **Finding Rating** |
| It may not be possible to meet the requirements of the Scottish Government's Public Sector Action Plan for Cyber Resiliency. | **Medium** |
| **Action plans** | |
| **Recommendation** | **Responsible Officer** |
| 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;<br>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; | 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<br>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.<br>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;<br>2. Appropriate reconciliations and checks will be performed to ensure that the data has transferred completely and accurately;<br>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<br>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.<br>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).<br>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. | 29 March 2019 |

# Appendix 1 - Basis of our classifications

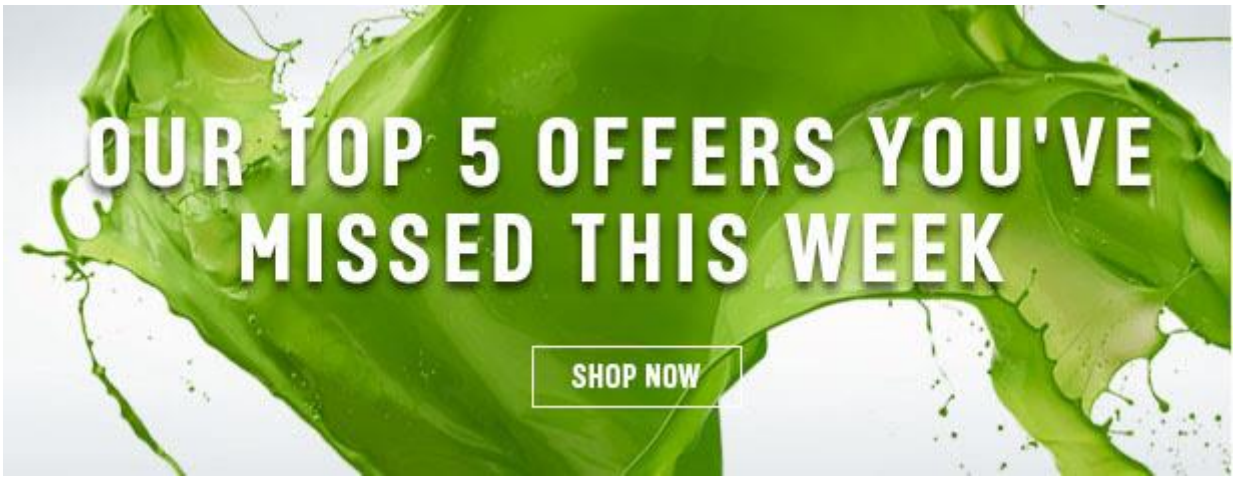
| Finding rating | Assessment rationale |
|---|---|
| **Critical** | A finding that could have a:<br>• ***Critical*** impact on operational performance; or<br>• ***Critical*** monetary or financial statement impact; or<br>• ***Critical*** breach in laws and regulations that could result in material fines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

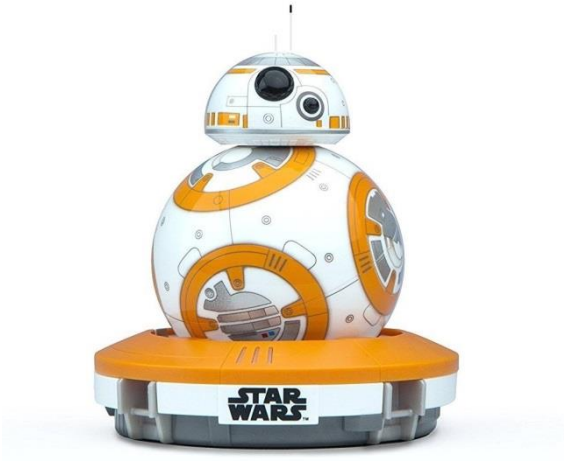
# Appendix 2 – Simulated Phishing e mails

## 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!

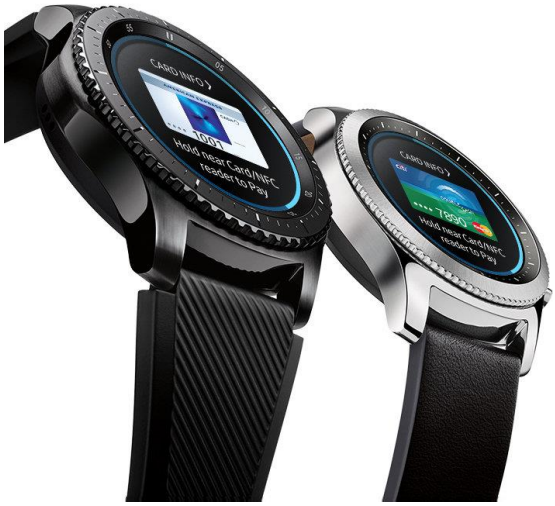
G-VOUCHERS



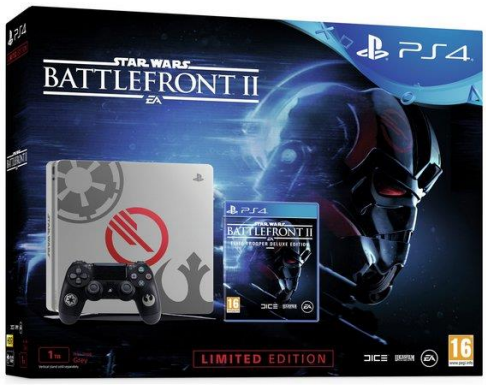

Sphero Star Wars BB-8 with Droid Trainer

~~£130~~ £78 View Deal



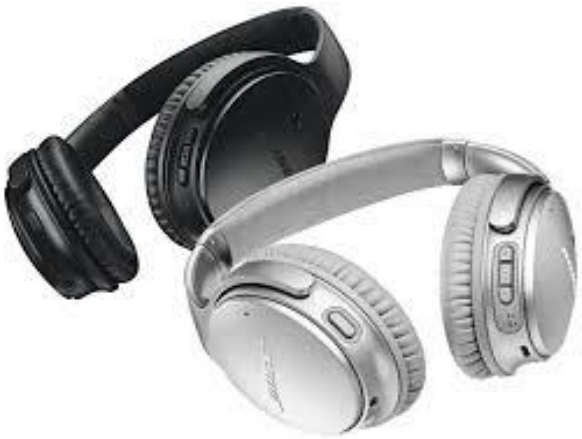
Samsung Gear S2 Classic Smartwatch

~~£349~~ £140 View Deal



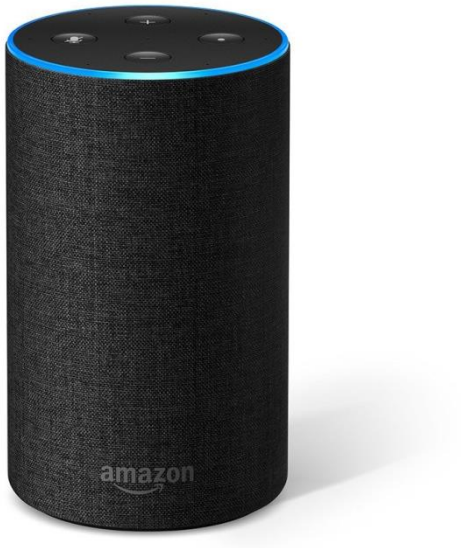

PS4 1TB Star Wars Battlefront 2 Deluxe Bundle

~~£280~~ £120 View Deal



Bose QuietComfort 35 Wireless Headphones 2

~~£330~~ £148 View Deal




Amazon Echo 2nd Generation

~~£70~~ £40 View Deal

## 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.

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# 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.<br>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

EDINBVRGH
THE CITY OF EDINBURGH COUNCIL

# Contents



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

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

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

# 1. Background and Scope

## Background

The City of Edinburgh Council (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 |
|---|
| 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.<br><br>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.<br><br>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. |

| Business Implication | Finding Rating |
|---|---|
| • Failure to operate consistently and effectively, and risk of potential legislative breaches.<br>• Reputational risk associated with major failure in CCTV infrastructure resulting in inability to provide the Service<br>• Potential financial loss associated with failure to recharge costs.<br>• Potential non-compliance with new GDPR regulations. | **High** |

| Action plans | |
|---|---|
| **Recommendation** | **Responsible Officer** |
| 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).<br>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:<br>• Approval and requisition of new CCTV equipment,<br>• Prioritisation of requests for cameras in new locations and their allocation across geographical sites,<br>• Identification and repair of damaged equipment,<br>• Retention, archiving and destruction of footage that are aligned with the Council's Records Management policy and Data Protection Act requirements, and<br>• Approval of requests for footage and the process for sharing footage in a secure manner. | Senior Manager, Community Justice |

| | |
|---|---|
| 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.<br>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.<br>5. A consolidated asset register should be prepared and maintained to record all CCTV equipment owned by the Council, its condition and location.<br>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.<br>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. | 27th September 2019 |
| 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. | 28th September 2018 |
| 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. | 27th September 2019 |
| 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 |

| | |
|---|---|
| fully document all security systems (including CCTV) in detailed Asset Registers<br>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.<br><br>The following control gaps were identified consistently across all three Service Areas, and have been discussed separately with each:<br><br>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.<br><br>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.<br><br>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.<br><br>4. Risks associated with the operation of CCTV services have not been identified and recorded on Service Area risk registers.<br><br>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 | Finding Rating |
|---|---|
| • Financial penalty and reputational damage associated with breach of Data Protection legislation and Council Records Management policies.<br>• Failure to operate consistently and effectively, and risk of potential legislative and National Strategy breaches.<br>• Employees may unknowingly breach applicable legislation or Council policies. | **High** |

| Action plans | |
|---|---|
| **Recommendation** | **Responsible Officer** |

| | |
|---|---|
| 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.<br>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<br>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.<br>4. Risks associated with delivery of CCTV services should be identified and recorded on the relevant Service Area risk registers.<br>5. Induction and ongoing training should be delivered to all CCTV staff and appropriate records maintained of completion. | 1. Security Manager, Property and Facilities Management<br>2. to 5 - Senior Manager, Community Justice |
| **Agreed Management Action** | **Estimated Implementation Date** |
| 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.<br>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<br>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.<br>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.<br>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. | 27th April 2018<br>28th September 2018<br>28th 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).<br>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. | 30th November 2018 |

# 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.<br>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 CCVTV 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. | • An ad hoc storage process is applied.<br>• Access restrictions are documented and communicated.<br>• There is independent review of activity in place but this is not documented or formalised. | • 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.<br>• This is where the footage downloaded for Court packages is also kept in drawer cabinets which are not locked. | • Footage is generated onsite in the concierge office.<br>• Any images removed are stored in a locked cupboard.<br>• 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. | • There is a very robust process in place for the receipt and response to third party requests for access to footage.<br>• 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. | • There is a written procedure included within the request forms showing the official process in place for Concierge staff and Police to follow.<br>• Requests are made in writing but there is no formal approval from the officer requesting the footage or for the Concierge making the copy.<br>• The process is not governed by a policy or aligned regularly with legislation.<br>• 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. | • There is a good procedure in place but it has not been formally documented.<br>• There is a gap around the destruction of CCTV footage, there is confusion | • There are no documented processes and procedures in place.<br>• All training is based on verbal update and 'on the job' experience. | • Footage downloaded and retained for evidence by the Police is subject to review and destruction.<br>• 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 lie 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.<br><br>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** | A finding that could have a:<br>• ***Critical*** impact on operational performance; or<br>• ***Critical*** monetary or financial statement impact; or<br>• ***Critical*** breach in laws and regulations that could result in material fines or consequences***; or***<br>• ***Critical*** impact on the reputation or brand of the organisation which could threaten its future viability. |
| **High** | A finding that could have a:<br>• ***Significant*** impact on operational performance; or<br>• ***Significant*** monetary or financial statement impact; or<br>• ***Significant*** breach in laws and regulations resulting in significant fines and consequences***; or***<br>• ***Significant*** impact on the reputation or brand of the organisation. |
| **Medium** | A finding that could have a:<br>• ***Moderate*** impact on operational performance; or<br>• ***Moderate*** monetary or financial statement impact; or<br>• ***Moderate*** breach in laws and regulations resulting in fines and consequences; or<br>• ***Moderate*** impact on the reputation or brand of the organisation. |
| **Low** | A finding that could have a:<br>• ***Minor*** impact on the organisation's operational performance ; or<br>• ***Minor*** monetary or financial statement impact; or<br>• ***Minor*** breach in laws and regulations with limited consequences; or<br>• ***Minor*** impact on the reputation of the organisation. |
| **Advisory** | A finding that does not have a risk impact but has been raised to highlight areas of inefficiencies or good practice. |

# Appendix 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

- 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 | • 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.<br>• Risk registers for all service areas include relevant CCTV related risks. |
| Estate allocation and maintenance | • An asset register has been established and regularly updated to reflect additions and disposals, and record the location of all CCTV cameras and infrastructure.<br>• Supporting rationale is provided for all requests for installation of cameras.<br>• A clear prioritisation process has been established to support allocation of the estate across public spaces.<br>• 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 | • CCTV footage is generated and stored in a secure environment with access restricted to only authorised personnel.<br>• 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 | • There are documented processes and procedures in place supporting retention, archiving and destruction of CCTV footage.<br>• There are documented procedures in place to ensure that CCTV footage is only provided to approved parties, and is shared in a secure manner.<br>• Processes and procedures are regularly reviewed and updated to reflect legislative changes.<br>• Footage is retained, archived and destroyed in line with policies and procedures. |

| | |
|---|---|
| | • 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 |
|---|---|---|
| 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 |
|---|---|---|---|
| Shirley McLaren | Community Safety Senior Manager | Review Sponsor | 0131 529 5035 |
| 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.

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# 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

EDINBVRGH
THE CITY OF EDINBURGH COUNCIL

# Contents



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

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

Although there 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:<br><br><u>Operating model definition and documentation</u><br><br>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.<br><br>During the review we noted the following ambiguities in the current governance process:<br>• lack of clarity on the process for collating and reporting Programme risks to governance committees;<br>• 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<br>• a plan to bolster PMO capability within the ICT team where this is a service provided by CGI.<br><br><u>Quality of Governance Documentation</u> *(note that these issues are self-identified by ICT)*<br>• 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;<br>• 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)<br>• the Programme Board is a one hour meeting which does not provide sufficient time to review all of the transformation work in progress; and<br>• 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 | Finding Rating |
|---|---|
| • Potential duplication of effort; additional costs; and lack of clarity re roles and responsibilities;<br>• effectiveness of programme delivery could be adversely impacted if governance processes do not operate effectively; and<br>• the Council's ability to deliver transformation is not optimised. | **Medium** |

| Action plans | |
|---|---|
| **Recommendations** | **Responsible Officer** |
| 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 | Derek Masson,<br>Programme and Delivery Manager, ICT Solutions |

| | |
|---|---|
| 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;<br>2. A more relevant cut off date should be agreed for papers to be presented to governance committees;<br>3. Sufficient time should be afforded to Programme Board meetings to allow for full review, discussion, and challenge on the papers provided by CGI; and<br>4. 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. | |
| **Agreed Management Action** | **Estimated Implementation Date** |
| 1. Recommendation agreed. In partnership with CGI, the existing Governance Operational Framework document will be expanded to include detailed coverage of the areas highlighted above;<br>2. 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;<br>3. Recommendation agreed. The duration of the Programme Board meetings will be extended to two hours; and<br>4. Recommendation agreed. Programme Governance reporting will be presented to the Programme Board in a dashboard format. | 31 October 2018<br><br>31 October 2018 (Commencing as per September month end reporting pack.)<br><br>31 August 2018<br><br>31 October 2018 |

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

# Appendix 2 – Terms of Reference

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 | We will:<br>• Review the new CGI governance framework applied by the Council and CGI with focus on oversight of CGI programme delivery;<br>• Assess how the governance framework is designed to identify and escalate risks, issues, and dependencies in CGI's Programme delivery;<br>• 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<br>• Obtain and review a sample of key documents to confirm that the Programme governance framework is effectively and consistently applied. |
| Project Costs | We will:<br>• 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;<br>• Confirm that the governance framework includes monitoring of CGI costs across the programme;<br>• 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<br>• 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 | We will:<br>• Obtain and review the Programme risk, issues and dependencies register(s);<br>• Assess how the Council confirms that Programme risks, issues and dependencies are effectively identified; assessed; escalated; managed and mitigated by CGI;<br>• Review the Council's process for monitoring Programme risks, issues and dependencies to ensure they are actioned appropriately prior to closure; and<br>• 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 | We will:<br>• Determine how the Council ensures that CGI has allocated appropriate resources across the Programme and to individual projects;<br>• Review how issues in resource planning and resource utilisation are escalated through governance; and<br>• Test for three technology projects that resource issues have been escalated in line with the governance model. |

## Internal Audit Team

| Name | Role | Contact Details |
|---|---|---|
| Lesley Newdall | Chief Internal Auditor | lesley.newdall@edinburgh.gov.uk |
| Susan Cummings | Senior Auditor Manager | susan.cummings@pwc.com |

## Key Contacts

| Name | Role | Contact Details |
|---|---|---|
| Bruce Strang | Chief Information Officer | 0131 529 5896<br>bruce.strang@edinburgh.gov.uk |
| Neil Dumbleton | Enterprise Architect | 0131 529 7837<br>neil.dumbleton@edinburgh.gov.uk |
| Jackie Galloway | Commercial Manager | 0131 529 7808<br>jackie.galloway@edinburgh.gov.uk |
| Derek Masson | Programme and Delivery Manager | 07758 073 479<br>derek.masson@edinburgh.gov.uk |
| Carolann Miller | Service Manager | 0131 469 2868<br>carolann.miller@edinburgh.gov.uk |
| Alison Roarty | Commercial Team Lead | 0131 469 3476<br>alison.roarty@edinburgh.gov.uk |

## Timetable

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

EDINBVRGH
THE CITY OF EDINBURGH COUNCIL

# Contents



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

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

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

# 1. Background and Scope

## Background

The 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 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 |
|---|---|
| • Potential foster and kinship carers are not thoroughly vetted;<br>• Incomplete assessment reports are presented to the panel and ADM for approval and decision;<br>• Foster and kinship carers are not fully aware of their own and the Council's responsibilities;<br>• Potential non-compliance with LAC regulations; and<br>• Referrals for foster care placement are submitted without appropriate authority. | **High** |

**Action plans**

| Recommendation | Responsible Officer |
|---|---|
| 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. | Family Based Care Team Manager (Foster Care) - 1, 3, 5 & 7<br><br>Family Based Care Team Manager (Kinship Care) – 2, 4, 6 & 7 |
| 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. | Senior manager for Children's Practice Teams - 6 & 8 |
| 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. | |

| | |
|---|---|
| 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.<br>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**<br>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**<br>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**<br>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**<br>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**<br>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**<br>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.<br>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. | 30 September 2018 |
| **7. Review of Carer Agreements**<br>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.<br>The Kinship carer agreement document will be reviewed separately to this but within the same timescale. | 31 May 2018<br>31 May 2018 |
| **8. Assessment of Need and Risk Forms**<br>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. | Medium |

**Action plans**

| Recommendation | Responsible Officer |
|---|---|
| 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.<br>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.<br>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.<br>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** |
| 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. | 31 May 2018 |
| 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. | 31 May 2018 |
| 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. | 31 May 2018 |

## 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:<br>• 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.<br>• 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.<br>• 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.<br>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.<br>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 | Finding Rating |
|---|---|
| Appropriate arrangements are not established as per the timeframes specified in continuing care legislation. | Medium |

| Action plans | |
|---|---|
| **Recommendation** | **Responsible Officer** |
| 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.<br>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.<br>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. | Neil Kirkpatrick, Business Support Team Manager – 1 & 3<br><br>Looked After Children Service Manager - 2 |
| **Agreed Management Action** | **Estimated Implementation Date** |
| 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. | 31 May 2018 |

| | |
|---|---|
| 2. All placements of 17-year olds to be reviewed and taken to the CPTM meeting to discuss requirement and timescales.<br>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 July 2018<br><br>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 |
|---|---|
| Overpayments are not effectively monitored to ensure prompt settlement of debt. | Low |

**Action plans**

| Recommendation | Responsible Officer |
|---|---|
| 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 |

| | |
|---|---|
| ensure that overpayment and reminder letters are issued, and debtor accounts created on a timely basis;<br>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;<br>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<br>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** | |
|---|---|
| **Use of Electronic Signatures**<br>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. | |
| **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. | **Advisory** |
| **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** | A finding that could have a:<br>• ***Critical*** impact on operational performance; or<br>• ***Critical*** monetary or financial statement impact; or<br>• ***Critical*** breach in laws and regulations that could result in material fines or consequences***; or***<br>• ***Critical*** impact on the reputation or brand of the organisation which could threaten its future viability. |
| **High** | A finding that could have a:<br>• ***Significant*** impact on operational performance; or<br>• ***Significant*** monetary or financial statement impact; or<br>• ***Significant*** breach in laws and regulations resulting in significant fines and consequences***; or***<br>• ***Significant*** impact on the reputation or brand of the organisation. |
| **Medium** | A finding that could have a:<br>• ***Moderate*** impact on operational performance; or<br>• ***Moderate*** monetary or financial statement impact; or<br>• ***Moderate*** breach in laws and regulations resulting in fines and consequences; or<br>• ***Moderate*** impact on the reputation or brand of the organisation. |
| **Low** | A finding that could have a:<br>• ***Minor*** impact on the organisation's operational performance; or<br>• ***Minor*** monetary or financial statement impact; or<br>• ***Minor*** breach in laws and regulations with limited consequences; or<br>• ***Minor*** impact on the reputation of the organisation. |
| **Advisory** | A finding that does not have a risk impact but has been raised to highlight areas of inefficiencies or good practice. |

# Appendix 2 – Terms of Reference

## 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 | • An appropriate strategy is in place to manage the balance of care for looked after children;<br>• Appropriate vetting processes in place ensure that in-house carers recruited meet required service standards;<br>• Processes are in place to collate and assess all needs and risks in relation to each looked after child;<br>• 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;<br>• Emergency placements can be accommodated when required;<br>• Robust processes are in place to re-allocate resources effectively where placements come to an end; and<br>• All relevant sections are notified in a timely manner where a child ceases to be looked after. |
| Support & Monitor | • 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<br>• 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 | • Robust child protection processes apply where allegations are made against foster / kinship carers. |
| Payment | • All allowances and fees paid to in-house and kinship carers are in line with agreed rates in place;<br>• All payments made are subject to review and regular reconciliation; and<br>• Payments are stopped on time when a placement ends. |
| Governance | • All relevant policies and procedures are up to date and complied with;<br>• Processes are in place to ensure compliance with applicable legislation; and<br>• 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 | 18th September 2017 |
| Fieldwork Completed | 13th October 2017 |
| Draft report to Auditee | 27th October 2017 |
| Response from Auditee | 10th November 2017 |
| Final Report to Auditee | 17th 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

# Contents



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

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

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

# 1. Background and Scope

**Background**

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).<br><br>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<br><br>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.<br><br>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.<br><br>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:<br><br>• Standard business cases are not consistently produced. Project approval is often granted based on a paper presented to Council committees;<br>• Failure to identify, record and monitor project benefits (refer Finding 2);<br>• Lack of clearly defined project plans that reflect project critical paths and key project dependencies;<br>• Failure to identify, record, monitor and report project risks, issues, and dependencies;<br>• Project governance minutes (e.g. steering group meeting minutes) do not consistently record attendees or meeting outcomes.<br>• Weaknesses in the management and oversight of third parties involved in projects to ensure that their delivery is in line with contractual requirements;<br>• Lack of secure arrangements supporting transfer of commercially sensitive and confidential information to and from third party suppliers involved in projects;<br>• 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.<br>• Project close reports are not consistently completed when a project is closed. |

| Business Implication | Finding Rating |
|---|---|
| The potential risks and business implications associated with our Findings are:<br><br>• 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 | High |

| | |
|---|---|
| relevant Council scrutiny committees; and are supported by staff with insufficient understanding and training in effective project management and delivery of projects;<br>• Projects are not effectively and consistently managed with the potential for risks, issues, and dependencies to crystallise and adversely impact project delivery;<br>• Consolidated reporting provided by P&G to the Change Board and GRBV is incomplete and inaccurate;<br>• Third party supplier deliverables are not aligned with contractual requirements or Council expectations;<br>• Breach of Data Protection Act requirements or leakage of commercially sensitive information; and<br>• 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;<br>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;<br>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.<br>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.<br>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;<br>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.<br>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 |

| | |
|---|---|
| areas, and considered as part of the business case approval process for all significant projects included in the portfolio of change.<br>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. | |
| **Agreed Management Action** | **Estimated Implementation Date** |
| 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. | 1. 30.06.18 |
| 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. | 2. 30.06.18 |
| 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. | 3. 30.03.18 |
| 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.<br>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. | 4. 30.03.18 – 30.03.19. |
| 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. | 5. 30.04.19 |
| 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 | 6. 30.06.18 |

| | |
|---|---|
| undertaking lessons learned exercise remains the responsibility of individual projects and programmes.<br>7. Project guidance will be updated to reflect the requirements of the recommendation in conjunction with the IGU.<br>**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. | 7. 30.03.19<br>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:<br>• 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;<br>• Benefits are not currently specified as a criterion to determine whether a project should be included in the Change Portfolio;<br>• 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;<br>• When produced, project business cases do not consistently include details of expected project benefits;<br>• 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;<br>• 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<br>• 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 | Finding Rating |
|---|---|
| The potential risks and business implications associated with our Findings are:<br>• Consolidated benefits across the Change Portfolio cannot be monitored or their total contribution to financial savings assessed;<br>• 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;<br>• Project benefits are not completely and accurately assessed and recorded;<br>• Projects are approved that will not deliver benefits and are not aligned with the Council's strategic objectives;<br>• Benefits delivered cannot be measured as the baseline measurements have not been accurately recorded; | **High** |

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

| Action plans | |
|---|---|
| **Recommendations** | **Responsible Officer** |
| 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;<br>2. Benefits should be included as a criterion for inclusion of a project within the Change Portfolio;<br>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;<br>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;<br>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.<br>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;<br>7. P&G should specify their expectations regarding benefits for inclusion in all progress updates received from Project Managers; and<br>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. | Portfolio and Governance Manager, Strategy and Insight |
| **Agreed Management Action** | **Estimated Implementation Date** |
| 1. Agreed. However, responsibility for Benefits Realisation will remain responsibility of the agreed Benefit Owners.<br>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.<br>3. Agreed. This will be part of the toolkit that will be published on the Orb.<br>4. Agreed<br>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 | 1. 31.09.18<br>2. 30.03.18<br>3. 30.03.18<br>4. 30.08.18<br>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** | A finding that could have a:<br>• ***Critical*** impact on operational performance; or<br>• ***Critical*** monetary or financial statement impact; or<br>• ***Critical*** breach in laws and regulations that could result in material fines or consequences***; or***<br>• ***Critical*** impact on the reputation or brand of the organisation which could threaten its future viability. |
| **High** | A finding that could have a:<br>• ***Significant*** impact on operational performance; or<br>• ***Significant*** monetary or financial statement impact; or<br>• ***Significant*** breach in laws and regulations resulting in significant fines and consequences***; or***<br>• ***Significant*** impact on the reputation or brand of the organisation. |
| **Medium** | A finding that could have a:<br>• ***Moderate*** impact on operational performance; or<br>• ***Moderate*** monetary or financial statement impact; or<br>• ***Moderate*** breach in laws and regulations resulting in fines and consequences; or<br>• ***Moderate*** impact on the reputation or brand of the organisation. |
| **Low** | A finding that could have a:<br>• ***Minor*** impact on the organisation's operational performance ; or<br>• ***Minor*** monetary or financial statement impact; or<br>• ***Minor*** breach in laws and regulations with limited consequences; or<br>• ***Minor*** impact on the reputation of the organisation. |
| **Advisory** | A finding that does not have a risk impact but has been raised to highlight areas of inefficiencies or good practice. |

# *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.

# Contents

# 1. Background and Scope

## Background

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

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

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

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

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

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

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

## Scope

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

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

# 2. Executive Summary

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

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

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

**Care Home Action Plans**

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

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

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

**Recommendation for Implementation of a Care Homes Self Assurance Programme**

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

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

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

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

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

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

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

## A. Executive Summary - Internal Audit

### A1. Care Homes Portfolio

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

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

**Changes in the Care Home Portfolio**

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

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

### A2. Financial Controls

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

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

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

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

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

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

**A3. Workforce Controls**

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

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

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

**A4. Resilience**

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

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

**A5. Technology Equipment and User Access Rights**

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

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

**A6. Regulatory**

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

## B. Executive Summary – Health and Safety

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

**B1. Health and Safety Controls**

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

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

**B2. Property and Statutory Controls**

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

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

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

## C. Executive Summary – Information Governance

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

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

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

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

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

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

# 3. Findings and Recommendations

## A. Internal Audit

### A1. Care Homes Portfolio

| A1.1 | Care Homes Self Assurance Framework | High |
|---|---|---|

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

**Recommendations**

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

| A1.2 | Gylemuir | High |
|---|---|---|

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

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

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

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

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

**Recommendations**

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

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

| A1.3 | Additions to the Care Homes Portfolio | High |
|---|---|---|

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

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

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

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

**Recommendation**

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

This should include:

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

| A1.4 | Closure of Care Homes | Medium |
|---|---|---|

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

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

**Recommendation**

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

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

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

## A2. Financial Controls

| A2.1 | Budget Monitoring | High |
|---|---|---|

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

**Recommendation**

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

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

| A2.2 | Purchasing Controls | Medium |
|---|---|---|

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

**Recommendation**

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

| A2.3 | Welfare Fund and Outings Funds | Medium |
|---|---|---|

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

**Recommendation**

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

| A2.4 | Bank Account & Cash Holding | Medium |
|---|---|---|

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

**Recommendation**

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

| A2.5 | Insurance | Medium |
|---|---|---|

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

**Recommendation**

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

| A2.6 | Residents' Savings | Low |
|---|---|---|

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

**Recommendation**

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

| A2.7 | Resident's Assets on death | Low |
|---|---|---|

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

**Recommendation**

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

## A3. Workforce Controls

| A3.1 | Training | Medium |
|---|---|---|

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

**Recommendation**

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

| A3.2 | Recruitment & Induction | Medium |
|---|---|---|

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

**Recommendation**

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

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

| A3.3 | Performance and Attendance Management | Medium |
|---|---|---|

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

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

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

**Recommendation**

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

| A3.4 | Agency Staffing | Medium |
|---|---|---|

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

**Recommendation**

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

| A3.5 | Adequacy of Resources | Medium |
|---|---|---|

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

**Recommendation**

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

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

| A3.6 | Gifts | Low |
|---|---|---|

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

**Recommendation**

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

## A4. Resilience

| A4.1 | Business Continuity Plans | Medium |
|---|---|---|

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

**Recommendation**

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

## A5. Technology Equipment and User Access Rights

| A5.1 | Leavers | Medium |
|---|---|---|

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

**Recommendation**

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

| A5.2 | Asset Registers | Low |
|---|---|---|

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

**Recommendation**

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

# B Health and Safety

## B1. Health and Safety Controls

| B1.1 | Fire safety | High |
|---|---|---|

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

**Recommendation**

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

| B1.2 | Health and safety training | Medium |
|---|---|---|

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

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

**Recommendation**

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

| B1.3 | Health and safety workplace inspections / Housekeeping | Medium |
|---|---|---|

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

**Recommendation**

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

| B1.4 | First-aid arrangements | Medium |
|---|---|---|

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

**Recommendation**

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

| B1.5 | Emergency response | Medium |
|---|---|---|

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

**Recommendation**

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

| B1.6 | Reporting and investigation of incidents | Medium |
|---|---|---|

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

**Recommendation**

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

| B1.7 | Control of contractors | Medium |
|---|---|---|

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

**Recommendation**

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

| B1.8 | Health and safety risk assessments and controls | Medium |
|---|---|---|

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

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

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

**Recommendation**

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

| B1.9 | Health and safety roles and responsibilities | Low |
|---|---|---|

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

**Recommendation**

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

| B1.10 | Health and safety communications | Low |
|---|---|---|

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

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

**Recommendation**

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

| B1.11 | Stress/Employee assistance programme | Low |
|---|---|---|

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

**Recommendation**

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

## B2. Property and Statutory Inspection Controls

| B2.1 | Beds/ furniture | High |
|---|---|---|

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

**Recommendation**

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

| B2.2 | Window restrictors | High |
|---|---|---|

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

**Recommendation**

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

| B2.3 | Statutory inspections | Medium |
|---|---|---|

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

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

**Recommendation**

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

| B2.4 | Water safety (including legionella) | Medium |
|---|---|---|

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

**Recommendation**

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

| B2.5 | Asbestos | Medium |
|---|---|---|

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

**Recommendation**

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

| B2.6 | Condition Surveys | Medium |
|---|---|---|

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

**Recommendation**

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

## C. Information Governance

| C1.1 | Responsibilities | Medium |
|---|---|---|

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

**Recommendation**

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

| C1.2 | Decision making | Medium |
|---|---|---|

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

**Recommendation**

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

| C1.3 | Compliance | Medium |
|---|---|---|

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

**Recommendation**

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

| C1.4 | Availability | Medium |
|---|---|---|

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

**Recommendation**

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

| C1.5 | Retention | Medium |
|---|---|---|

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

**Recommendation**

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

| C1.6 | Disposal | Medium |
|---|---|---|

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

**Recommendation**

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

| C1.7 | Data Quality | Low |
|---|---|---|

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

**Recommendation**

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

# 4. Health and Social Care – Care Home Action Plan

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

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

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

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

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

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

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

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

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

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

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

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

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

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|---|---|---|---|---|
| | 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.<br>Business Support Team Managers will also confirm that oversight has been performed as part of ongoing care home unit visits.<br>Unit Managers will also have oversight and feed any issues into Locality Managers. | Business Support Team Managers<br>Unit Managers | 28th February 2018 |
| B1.4 First-aid arrangements | Arrangements should be put in place for first aid needs to be assessed, implemented, and monitored at each care home. | Guidance from H&S colleagues<br>Handyman role to check & stock first aid boxes and information notices. Add to spreadsheet. Monitored through supervision and monthly spreadsheet checks | Unit Manager<br>Business Support Officer | 28th February 2018<br>28th February 2018 |
| B1.5 Emergency response | Standard lift breakdown procedures information to be displayed at all care homes where there are passenger lifts. | This will be incorporated in the spreadsheet being implemented that has a dual purpose of control mechanism and training needs assessment. Ensuring standard lift breakdown procedures information is displayed will be the responsibility of the handymen.<br>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.<br>Completion will be monitored monthly. | Business Support Officer<br>Operations Manager, Health and Social Care | 28th February 2018 |
| | Bomb threat procedures to be made available to all care home managers. | Care Home evacuation process is Unit Manager responsibility, and these will be updated to reflect the evacuation process in the event of a bomb threat.<br>Resilience will be requested to provide support via a programme work across all 10 Council Care Homes to ensure they receive | Operations Manager, Health and Social Care | 30th April 2018 |

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| | | 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<br>Operations Manager, Health and Social Care | 31st October 2018 |
| B1.7 Control of contractors | Establish standard minimum information to be provided to contractors in liaison with Property and Facilities Management. | 'Do' and 'Don't' A4 briefing sheet to be created for all care homes | Business Support Team Managers | 28th February 2018 |
| B1.8 Health and safety risk assessments and controls | A monitoring/ review process should be introduced to ensure that all risk assessments in all care homes are up to date. | This process will be incorporated within the new self assurance framework to be implemented across all Care Homes. | Interim Chief Officer, Health and Social Care Partnership | 30th June 2019 |
| | Review health surveillance and health assessment requirements at all care homes. | This process will be incorporated within the new self assurance framework to be implemented across all Care Homes. | Interim Chief Officer, Health and Social Care Partnership | 30th June 2019 |
| | Sharing of best practice in risk assessment between care homes should be facilitated and promoted. | The Hospital and Hosted Services Manager has been allocated as lead for Health and Safety in the Health and Social Care Partnership.<br>Best practice in risk assessments will discussed at the newly established Health and Safety Group. | Hospital and Hosted Services Manager<br>Operations Manager, Health and Social Care | 30th June 2018 |
| | Standard Personal Protective Equipment issue log form to be available for all care homes. | Set up and administered by Business Support Officers | Business Support Team Managers | 28th February 2018 |
| B1.9 Health and safety roles and responsibilities | Personal objectives for key staff at all care homes should include health and safety responsibilities as part of the performance framework. | Spotlight conversations for all staff and standing item in supervision.<br>Business Support Officers attended 2017 Health and Safety conference and feed back to staff | Unit Managers/Business Support Officers<br>Business Support Team Managers | 28th February 2018 |

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

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

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

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

# Appendix 1- Basis of our Ratings

## Internal Audit and Information Governance Ratings

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

## Health and Safety Ratings

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

# Appendix 2 – Recommendations Follow Up Process

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

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

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

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

# Appendix 3 - Current Status of Individual Care Home Reports

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

# Appendix Four

# Individual Care Home Report Ratings

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

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

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

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

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

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

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

# Appendix 5

# Care Home Assurance Checklists

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

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

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

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

| Ref | Validation Check |
|---|---|
| **Health and Safety** | |
| **1** | **Health and Safety Roles and Responsibilities** |
| 1.1 | Health and safety roles, responsibilities and accountabilities set out in the Council Health and Safety Policy are understood for key roles, e.g. Care Home Manager, Business Manager, Caretaker/ Handy Person. |
| 1.2 | Roles and responsibilities are clearly set out in the unit, and understood. |
| 1.3 | Health and Safety responsibilities are included in personal objectives for key roles. |
| 1.4 | Policy and Procedures in place to deal with violence and aggression and key staff aware of their responsibilities. |
| 1.5 | Suitable licence holders for SHE Assure have been identified. |
| **2** | **Health and Safety Training** |
| 2.1 | Induction H&S training is carried out for all staff. |
| 2.2 | All other H&S training needs have been identified, and implemented. |
| 2.3 | Training has been provided to all relevant staff on dealing with violence and aggression. |
| **3** | **Health and Safety Communications** |
| 3.1 | The Council Health and Safety Policy and guidance is readily accessible to all staff and third parties. |
| 3.2 | HSE Health and Safety Law Poster is displayed. |
| 3.3 | Employers' Liability Certificate is displayed. |
| 3.4 | Health and safety is discussed at Unit staff meetings. |
| 3.5 | Health and safety information is given to residents and visitors. |
| **4** | **Health and Safety Risk Assessments** |
| 4.1 | Adequate H&S risk assessments in place. |
| 4.2 | Risk assessments are in place for work-related driving of vehicles. |
| 4.3 | COSHH assessments in place for activities with significant exposure to hazardous substances. |
| 4.4 | Manual handling/ moving and handling assessments in place. |
| 4.5 | Working at height assessment(s) in place (risk of falling from height). |
| 4.6 | Workstation/DSE assessments in place, as appropriate. |
| 4.7 | Expectant / nursing mothers risk assessments in place, as appropriate. |
| 4.8 | Noise sources above 80dB(A) have been identified, and risk assessment(s) in place. |
| 4.9 | Risk assessments are in place for all tools, equipment and processes involving exposure to vibration. |
| 4.10 | Risk assessments take into account potential exposure to violence and aggression. |
| 4.11 | Risk assessments take into account risk from ligatures. |
| 4.12 | Risk assessments take into account suffocation risks. |
| **5** | **Health and Safety Control Measures** |
| 5.1 | Controls identified in risk assessments in place. |
| 5.2 | Controls identified for safe needle use are in place. |
| 5.3 | Controls identified for management of used sharps are in place. |
| 5.4 | Controls identified in risk assessments relating to driving at work are in place. |
| 5.5 | Suitable checks on vehicles (including minibuses) are carried out, routinely and prior to use. |
| 5.6 | Permit to work in place for high risk activities (e.g. access to roof). |
| 5.7 | Personal protective equipment is provided. Records available. |
| 5.8 | Controls identified in COSHH assessments are in place. |
| 5.9 | Health surveillance is carried out, as appropriate. |
| 5.10 | Suitable controls are in place for skin health management. |
| 5.11 | Controls identified in manual handling/ moving and handling assessments in place. |
| 5.12 | Controls identified in working at height risk assessments in place. |
| 5.13 | Ladders/ access equipment inspected on a regular basis. Records available. |
| 5.14 | Workstation/DSE adjustments implemented, as appropriate. |
| 5.15 | Controls identified in noise assessments in place. |
| 5.16 | Controls identified in vibration assessments in place. |
| 5.17 | Suitable controls identified to deal with violence and aggression are in place. |
| 5.18 | Suitable control measures have been implemented to identify and remove potential risks with regard to ligatures and ligature points. |
| 5.19 | Suitable control measures identified for suffocation risks are in place. |
| **6** | **Health and Safety Workplace Inspections / Housekeeping** |
| 6.1 | H&S Workplace Inspections are carried out every quarter. |
| 6.2 | Satisfactory standard of housekeeping. |
| 6.3 | Items stored at height are accessible, secure and safe. |
| 6.4 | Suitable cleaning programme in place. |
| 6.5 | Emergency cleaning arrangements in place e.g. to deal with Norovirus outbreak. |
| **7** | **Stress / Employee Assistance Programme** |
| 7.1 | Roles and responsibilities set out in the Council Stress Policy and Toolkit are understood for key roles. |
| 7.2 | Team stress risk assessments are carried out, as appropriate. |
| 7.3 | Individual stress risk assessments are carried out for individuals, as appropriate. |
| 7.4 | Information on the Employee Assistance Programme (EAP is readily available to staff, and staff are aware about the range of services (online, telephone and counselling services) plus EAP support for managers. |
| **8** | **First-aid arrangements** |
| 8.1 | Adequate number of first-aiders have been appointed. |
| 8.2 | First-aider training is up to date (*training records verified*). |
| 8.3 | Information on first-aid arrangements is displayed. |
| 8.4 | First-aid box(es) adequately stocked and checked on a regular basis (verify first aid-boxes contents). |
| 8.5 | First-aid / Treatment room is clean and tidy. |
| **9** | **Fire safety and emergency response arrangements (H&S)** |
| | **Fire safety** |
| 9.1 | Fire risk assessment in place. |
| 9.2 | Fire evacuation plan is in place. |
| 9.3 | Adequate fire prevention measures are in place for residents' smoking area. |
| 9.4 | Have Personal Emergency Evacuation Plans (PEEPs) been carried out where required. |
| 9.5 | Adequate fire signage appropriately displayed including fire action notices, fire exits, assembly point, fire equipment. |
| 9.6 | Planned fire evacuation drills are carried out and recorded. |
| 9.7 | Nominated individual and deputy to co-ordinate emergency response (fire / other emergencies). |
| 9.8 | Adequate number of fire wardens. |
| 9.9 | Fire safety training is up to date. |
| 9.10 | All emergency escape routes, fire doors and assembly routes are free from obstruction. |
| 9.11 | Fire alarm call point is tested weekly (different call point each week). |
| 9.12 | Fire extinguishers accessible, in good condition, inspected within last year. |
| 9.13 | Sprinkler system inspected and tested. |
| 9.14 | Emergency lighting tested at appropriate frequency. |
| 9.15 | Evacuation equipment checked e.g. Ski pads and evac chairs. |
| | **Emergency response** |
| 9.16 | Nurse call alarm system checks are carried out and recorded. |
| 9.17 | Emergency procedure in place for lift breakdowns. |
| 9.18 | Information on emergency procedure for lifts is displayed (near the lift). |
| 9.19 | Bomb threat procedures are in place with roles identified. |
| 9.20 | All emergency shut offs are clearly identified, accessible and functioning. |
| **10** | **Reporting and Investigation of Incidents** |
| 10.1 | All incidents, accidents and work-related ill health cases reported. |
| 10.2 | All incidents, accidents and work-related ill health cases investigated and followed up. |
| 10.3 | Information on incident reporting is communicated to all staff. |
| 10.4 | Arrangements are in place for reporting adverse incidents involving medical devices to the Medicines and Healthcare products Regulatory Agency (MHRA). |
| **11** | **Escalation and monitoring of H&S risks and issues** |
| 11.1 | There is a risk notification procedure that sets a protocol in case of any serious or imminent H&S risk. |
| 11.2 | The risk notification procedure has been communicated to staff and other relevant parties. |
| 11.3 | Implementation of H&S measures identified in H&S workplace inspections & audits is tracked to completion. |
| **12** | **Control of Contractors** |
| 12.1 | All contractors and visitors are required to sign in and out. |
| 12.2 | All contractors and visitors are provided with health and safety information, including emergency procedures. |
| 12.3 | All work undertaken by contractors is authorised by relevant service (e.g. Property). |
| 12.4 | Systems are in place to ensure contractors are adequately monitored. |

| Property & Statutory Inspection Controls | |
|---|---|
| **1** | **Statutory Inspections** |
| | *All statutory tests and inspections are up to date and records are available:-* |
| 1.1 | Fixed electrical systems testing. |
| 1.2 | Portable appliance testing (electrical equipment). |
| 1.3 | Gas safety. |
| 1.4 | Carbon monoxide monitors. |
| 1.5 | Pressure Systems. |
| 1.6 | Ventilation systems e.g. LEV, general ventilation systems. |
| 1.7 | Hoists and mobile lifting equipment. |
| 1.8 | Passenger/ Goods Lifts: "Thorough Examination". |
| 1.9 | Access at height systems (e.g. anchor points, mansafe system). |
| 1.10 | Lightning conductors inspection and test (to assess adequacy of earthing, evidence of corrosion, alterations to structure ), where applicable. |
| 1.11 | Floodlights. |
| 1.12 | Add any others |
| **2** | **Asbestos** |
| 2.1 | Asbestos register readily available identifying the presence and location of asbestos on the premises. |
| 2.2 | Asbestos management plan is in place and implemented (including Condition monitoring of buildings carried out on an annual basis). |
| **3** | **Water safety (including *legionella*)** |
| 3.1 | *Legionella* risk assessment in place. |
| 3.2 | Adequate maintenance and operation of water management system (L8). Records available. |
| 3.3 | Water temperature checks are carried out to prevent scalding. Records available. |
| 3.4 | Thermostatic controls are checked. |
| 3.5 | Temperature of radiators are monitored and maintained to avoid thermal injuries. |
| **4** | **Beds/Furniture** |
| 4.1 | Bed rails (side rails/ cot sides) are inspected and maintained. Records available. |
| 4.2 | Regular checks of bed rails are carried out to ensure that gaps that could cause entrapment of neck, head and chest are eliminated. |
| 4.3 | Electric profiling beds are maintained. |
| 4.4 | Fixed furniture e.g. wardrobes are secured. |
| **5** | **Window restrictors** |
| 5.1 | Window restrictors are checked on a regular basis. |
| 5.2 | Window restrictors suitability check has been carried out in last 12 month.  Records available. |
| **6** | **Traffic Management** |
| 6.1 | There is clearly marked segregation between vehicles and pedestrians. |
| **7** | **Condition Surveys** |
| 7.1 | Condition survey carried out covering: integrity of internal building fabric; services (heating , lighting and ventilation) and external building fabric. |
| **8** | **Walk round inspection** |
| 8.1 | Regular walk round inspections carried out covering the internal fabric of the building and services. |
| 8.2 | Regular walk round inspections carried out covering the external fabric of the building, |

| Ref | Validation Check |
|---|---|
| **Information Governance** | |
| | **General Knowledge** |
| 1.1 | Do staff know how to report an information security incident and/or data protection breach? |
| 1.2 | Have staff completed the e-learning module? |
| 1.3 | Do staff know who to contact to answer IG questions corporately? |
| 1.4 | Do staff know how to recognise and support a statutory request for information (RFI)? |
| 1.5 | Are you able to easily find the information you need to answer the requests? |
| | **Managing Records** |
| 2.1 | Are there any standard processes or procedures for managing records? |
| 2.2 | Are standard templates used? |
| 2.3 | Is version control used to keep track of changes to records? |
| 2.4 | Is there an agreed G drive structure? Is it mapped to the Business Classification Scheme? |
| 2.5 | Are there file naming conventions? |
| 2.6 | Are emails taken out of Outlook at stored in relevant files (paper or electronic)? |
| 2.7 | Is information handover / transfer part of a local leaver's practice? |
| 2.8 | Who manages records? |
| | **Retention** |
| 3.1 | Are staff aware of the retention rules that apply to their area? |
| 3.2 | Is there a record management manual? |
| 3.3 | Are rules consistently applied to electronic and paper records? |
| 3.4 | Are records routinely marked as closed when they become inactive? |
| 3.5 | Are there separate rules for sensitive personal data? |
| | **Disposal** |
| 4.1 | What processes are in place to destroy records? |
| 4.2 | Is redundant, obsolete and trivial information routinely identified and cleared out? |
| 4.3 | Is confidential waste used? |
| 4.4 | Is there a disposal record which details a description of what has been destroyed? |
| 4.5 | Are records transferred to the City Archives? |
| | **Protection** |
| 5.1 | Do staff know how to handle information according to its sensitivity? |
| 5.2 | What controls are in place to protect information on and off site? |
| 5.3 | Are staff provided with sufficient secure Council devices to undertake their job? |
| 5.4 | Is removable media used to store information off the Council network? What controls are in place to manage its use? |
| 5.5 | Are any hosted services (apps or websites) used? How are they managed? |
| 5.6 | Are access controls attached to electronic folders? |
| 5.7 | Are access controls documented and regularly reviewed? |
| | **Collecting Personal Data** |
| 6.1 | What fair processing information is provided when personal data is collected? |
| 6.2 | Do you complete a privacy impact assessment? |
| 6.3 | What processes are in place to review personal data and ensure it is accurate/up to date? |
| 6.4 | Is personal data only used for the purpose for which it was collected? |
| 6.5 | Is consent from service users or their representatives recorded? Is this level of consent reviewed? |
| | **Information Sharing** |
| 7.1 | How is information shared with third parties? |
| 7.2 | Are there any procedures for dealing with ad hoc requests for information, e.g. from police? |
| 7.3 | Are staff aware of existing information sharing agreements? |
| 7.4 | Are there documented arrangements for general information sharing, e.g. dentists, opticians etc coming in? |
| | **Information Risk** |
| 8.1 | Are information risks identified, recorded and monitored within local risk registers? |
| 8.2 | What processes are in place to manage vital records in accordance with business continuity requirements? |

# *The City of Edinburgh Council*

## Internal Audit

### Social Work Centre Bank Account Reconciliations

Final Report

7 April 2018

HSC1714

EDINBVRGH
THE CITY OF EDINBURGH COUNCIL

# Contents



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

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

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

# 1. Background and Scope

**Background**

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

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

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

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

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

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

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

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

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

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

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

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

**Scope**

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

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

The centres chosen for review were:

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

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

For the full terms of reference see appendix 2.

# 2. Executive summary

## Total number of findings

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

## Summary of findings

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

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

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

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

Consequently, two High rated findings have been raised.

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

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

# 3. Detailed findings

## 1. Corporate Appointee Client Fund Management

| Finding |
|---|
| Four of the 7 centres reviewed held Corporate Appointee Contracts (CA) for vulnerable citizens. The total value of funds CEC holds under Corporate Appointee contracts is high, with £1.1M being managed collectively on behalf of clients by the Wester Hailes Healthy Living Bonnington Centres.<br><br>The process for managing Client Funds varied across the 4 centres and the following control gaps were identified:<br><br>• No regular review process has been established to determine whether clients remain eligible with an ongoing need for a CA contract;<br>• 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;<br>• 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;<br>• 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;<br>• 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;<br>• Firrhill Centre did not hold client personal spending money in the safe. It was held in an unlocked cupboard accessible by all employees;<br>• Castle Crags did not hold client spending money in the safe during daytime opening hours but held the funds in a box in the open office accessed by authorised CEC employees;<br>• Firrhill and Castle Crags Business support staff did not have operational responsibility for the daily management of client' spending money. Senior social workers carried out this responsibility without having completed the necessary cash management training;<br>• Firrhill Day centre had inconsistent procedures for the management of client spending money between the 'Blue' and 'Green' Centre teams;<br>• Castle Crags day client team did not follow the good practice evidenced by the residential client team and had no controls in place for the management of day to day client spending money. Due to the high level of risk this presented they were requested by audit to implement the required process immediately. |

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

| | |
|---|---|
| • Potential breach of DWP legislation through continued acceptance of benefit payments when account balances exceed specified maximum savings limits;<br>• Risk of fraud in client funds held under Corporate Appointee contracts.<br>• Misappropriation of client cash provided by relatives for their personal use; and<br>• 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:<br>1. A full review of all Corporate Appointee contracts should be carried out to establish if:<br>  ○ Clients remain eligible with an ongoing need for a CA contract;<br>  ○ All corporate appointees have an allocated Social Worker administering and monitoring their contract,<br>  ○ Funds held on behalf of the client are within the maximum limits set by DWP<br>  ○ DWP should be contacted on behalf of the client to discuss funds held in excess of maximum cap set,<br>  ○ The client had needs which may be met by expenditure from their DWP funds.<br>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.<br>3. Processes in Centres holding Corporate Appointee accounts should be aligned with the afore mentioned Procedure and consistently applied across all Centres.<br>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.<br>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.<br>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.<br>7. Monthly, reconciliation of all funds held for clients should be carried out by a member of staff independent of the daily administration process.<br>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<br>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.<br>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.<br>Following the Care Home Assurance Review, the Partnership is developing a self-assurance control framework. Locality Managers have agreed for corporate appointee arrangements to be included in the assurance framework – which if found to be successful and useful, can be mirrored by the other applicable services in this report. Business Support is working on new guidelines for the administration of Corporate Appointeeship (e.g. new procedures, monthly checklists, etc.), which will support the effective delivery of the framework. | 28 June 2019 |
| **Business Support** - Business Support will enable the review of current processes and guidelines in conjunction with Hub and Cluster Managers with sign off at the Locality Managers Forum.<br>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.<br>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.<br>Regular reporting will be introduced from the revised systems being implemented. This will be provided monthly at Senior Social Work level and annually for H&SC management | 31 May 2018 |
| 2. New guidelines will be written to ensure clarity of responsibilities. Sections will be included detailing Social Work; Business Support; and Transactions team responsibilities. The objective is to create and implement an end to end process that includes eligibility criteria, DWP processes and a full administrative process that will be applied centrally and across Locality offices; clusters; and hubs. | 30 April 2018 |
| 3. Disability residential and day clients cash administration is currently being reviewed and updated. Robust processes have already been implemented and further processes are scheduled for review. Deceased | 30 April 2018 |

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

## 2. Cash Management Controls - Imprest and Emergency Grant Accounts

**Finding**

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

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

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

| Business Implication | Finding Rating |
|---|---|
| • Breach of CEC cash management policies and procedures, and Council standing orders;<br>• Risk of fraud from unauthorised imprest or Emergency Grant payments;<br>• Lack of awareness of Council policy for cash management and bank reconciliations leads to poor practice and errors in banking/cash accounting;<br>• Staff at risk when carrying cash from the bank to the unit, especially as bank locations have reduced significantly in number;<br>• Risk of fraud where staff, who are no longer employed by CEC remain as authorised signatories on accounts; and<br>• 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;<br>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;<br>3. Imprest and Emergency Grant funds should remain separate and effective cash flow management procedures should be established to prevent transfers between funds occurring;<br>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;<br>5. Bank signatories should be reviewed annually and immediately updated following changes in personnel involved the cash management process;<br>6. There should be an annual review of the Insurance provision for cash and items of value held by the unit to confirm that insurance limits remain | Senior Business Support Manager (actions 1 – 6)<br><br>Corporate Finance Senior Manager (action 7). |

| | |
|---|---|
| appropriate. The BSO should ensure that insurance conditions regarding cash limits and key storage are consistently applied; and<br>7. Guidance will be developed detailing the process and relevant authority levels to be applied when writing off unreconciled cash amounts, and communicated to all budget owners. | |
| **Agreed Management Action** | **Estimated Implementation Date** |
| 1. All current Business Support staff responsible for cash handling/management will complete the Council's new Finance Reconciliation E-Learning course. Business Support Team Managers can request confirmation of their teams' E-Learning course completion from The Business Hub. A record will be kept locally for each member of staff as to when their annual refresher is due, this will be tracked on a team spreadsheet. Completion will be evidenced by a screen shot from the E-Leaning module. It is our intention to self-audit periodically that these actions are being adhered to. | 31 May 2018 |
| 2. Business Support induction plans will ensure that all staff responsible for cash handling/management will complete the Council's new E-Learning Finance Reconciliation training and confirm awareness of Policy and Procedures prior to commencing cash handling activities. Induction plans are signed off by both staff member and line manager. Completion will be evidenced by a screen shot from the E-Leaning module. It is our intention to self-audit periodically that these actions are being adhered to.<br><br>To ensure Clients Cash and Emergency Grant fund administration is performed in line with the Council's Imprest Procedures, Bank Reconciliation Procedures, and the Procedure for Adults at Risk (section 12 funds), a separate weekly reconciliation of the funds held in both Clients Cash and Emergency Grants will be completed by staff employed and trained to handle cash in every centre. | 30 April 2018 |
| 3. A note to all staff will be sent reminding them that it is policy and procedure not to mix the two accounts cash and reiterate that if there are any issues in complying with this instruction, it should be escalated to both the relevant Business Support Manager and Business Support Team Manager. | 31 May 2018 |
| 4. Copies of the signed reconciliations are to be stored within the relevant teams' G Drive folder with the spreadsheets. A spot check of these requirements will be carried out and recorded by Business Support Managers.<br><br>Business Support Team Managers will complete a monthly review of financial processes within their team to ensure Clients Cash and Emergency Grant funds remain separate and effective cash flow management procedures are followed to prevent transfers between funds occurring. The Business Support Team Managers responsible for Residential Units have a large number of bank accounts so in these instances a spot check of different accounts every month will be completed. | 30 April 2018<br><br>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.<br><br>Additional guidance in this area will also be included in refreshed imprest guidance which will be published on the Council's Orb and communicated to all relevant budget managers. | 28th June 2018 (subject to Council approval) |

# Appendix 1 - Basis of our classifications

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

# Appendix 2 – Terms of Reference

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

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

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

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

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

### Background

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

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

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

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

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

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

### Scope

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

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

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

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

## Limitations of Scope

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

## Approach

Our audit approach is as follows:

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

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

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

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

## Internal Audit Team

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

## Key Contacts

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

## Timetable

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

**Follow Up Process**

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

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

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

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

# Appendix 1: Information Request

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

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

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

# *City of Edinburgh Council*

## Internal Audit

### Edinburgh Integration Joint Board - Review of Social Care Commissioning

Final Report

20 July 2018

EIJB1702

# Contents



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

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

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

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

# 1. Background and Scope

## Background

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

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

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

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

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

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

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

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

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

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

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

## Scope

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

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

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

# 2. Executive summary

## Total number of findings

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

## Summary of findings

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

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

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

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

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

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

## Management Response

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

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

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

# 3. Detailed Findings

### 1. Maturity of social care commissioning

| Finding |
|---|
| Social care commissioning processes are not fully established and as mature as would be expected by this point in the Partnership lifecycle, and existing commissioning processes do not adequately meet the requirements detailed in the EIJB Directions, or the recommendations made by the Care Inspectorate in their May 2017 report.<br><br>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.<br><br>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.<br><br>However, it is essential to ensure that there is also sufficient focus on ensuring that effective commissioning processes are established and maintained across all social care services. This was recognised by the interim Partnership management team and has been included in the Improvement Programme. |

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

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

| | |
|---|---|
| • forecast future demand for services at appropriate levels based on accurate demographics; historic growth analysis; and realistic future growth assumptions;<br>• analyse current and future internal and external provider capacity;<br>• assess current financial performance against budget; and<br>• estimate future funding requirements based on forecast demand and cost of care.<br>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<br>3. Demand management strategies should be developed and implemented to support effective risk based management of social care waiting lists, whilst ensuring that urgent cases are prioritised. | |
| **Agreed Management Action** | **Estimated Implementation Date** |
| These recommendations will be addressed within scope of he strategic management action detailed in the Executive Summary at Section 2. | |

## 2. Management Capacity and Roles and Responsibilities

| **Finding** | |
|---|---|
| Whilst permanent appointments to the roles of Chief Officer; Head of Operations; and Chief Finance Officer have now been made, the Partnership has faced significant challenges in terms of turnover; extended vacancies and interim appointments at senior management level during the last twelve months.<br><br>Additionally, employees with extensive knowledge of client demographics and commissioning are scheduled to leave the Partnership in June 2018.<br><br>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.<br><br>The findings raised in our audit of the Health and Social Care purchasing budget highlighted the need to ensure that the budgeting processes are aligned to reflect the localities operating model; and that holistic social care delivery processes and procedures are established across all teams involved in delivering the service. The report also highlighted a number of control gaps in the processes applied by the Partnership's contracts team that need to be addressed. | |
| **Business Implications** | **Findings Rating** |
| Insufficient commissioning skills and experience within the Partnership to support effective commissioning and delivery of the improvement plan. | **Medium** |
| **Action plans** | |
| **Recommendation** | **Responsible Officers** |
| 1. The commissioning structure across the partnership should be reviewed and refreshed to ensure that: there is sufficient capacity; skills; and | |

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

# Appendix 1 - Basis of our classifications

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

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

| Direction | Title | Page | Narrative |
|---|---|---|---|
| EDI_2017/18_1 | Locality working | 7 | 'work with local people and community organisations to increase the resilience and **capacity** of communities to promote wellbeing and support their members to live independently' |
| EDI_2017/18_4 | Primary care | 13 | build and expand GP premises to increase **capacity** to meet increasing demand as already agreed, |
| EDI_2017/18_5 | Older people | 16 | finalise **capacity** plans and prepare detailed proposals for implementation; consider whether care at home contract delivers **capacity**.<br>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<br>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<br>Recommendation 10 | | **56** | The Partnership should produce a revised and updated **joint strategic commissioning plan** with detail on:<br>• how priorities are to be resourced<br>• how joint organisational development planning to support this is to be taken forward<br>• how consultation, engagement and involvement are to be maintained<br>• fully costed action plans including plans for investment and disinvestment<br>• based on identified future needs<br>• expected measurable outcomes. |
| Appendix C<br>Recommendation 12 | | **56** | The partnership should ensure that there are clear pathways to **accessing** services |

# Appendix 3 – Terms of Reference

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

To: Michelle Miller;

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

## Introduction and Background

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

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

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

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

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

## Scope

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

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

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

## Limitations of Scope

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

### Approach

Our approach will involve:

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

## Internal Audit Team

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

## Key Contacts

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

## Indicative Timetable

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

# *The City of Edinburgh Council*

## Internal Audit

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

Final Report

20 July 2018

# Contents



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

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

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

# 1. Background and Scope

**Background**

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

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

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

**Directions**

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

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

**Partnership Budget**

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

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

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

**Service Delivery and Technology Systems**

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

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

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

**Scope**

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

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

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

# 2. Executive summary

## Total number of findings

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

## Summary of findings

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

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

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

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

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

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

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

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

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

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

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

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

## Management Response

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

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

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

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

# 3. Detailed findings

## 1. Purchasing Budget Allocation

| Findings |
|---|
| Whilst an overall Partnership purchasing budget has been established, the budget had not been appropriately devolved / allocated across the localities as at December 2017. Additionally, care package cost data maintained on the Swift system is not aligned with the localities operating model, and no locality financial management information is currently available.<br><br>Locality Management has advised that they are aware of these issues.<br><br>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.<br><br>We understand that a 'purchasing realignment group' has been established to resolve allocation of budgets across the localities. |

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

| Action plans | |
|---|---|
| **Recommendation** | **Responsible Officer** |
| 1. A detailed financial budget allocation delivery plan should be developed with defined timescales for each stage of the implementation of the locality operating model budgets.<br>2. A consistently applied budget monitoring process should be clearly defined, documented, implemented, and communicated to all budget managers within the Locality operating model; with training provided to budget managers on how budgets should be managed.<br>3. The budget monitoring process should include, but not be restricted to:<br>• Agreement on how overspends should be managed against increasing demand for services;<br>• Responsibility for ongoing oversight of locality budgets and upward reporting to relevant governance forums / committees; and<br>4. A detailed plan should be developed and implemented, to ensure that the Swift system is updated so that H&SC Swift system care costs and recharges are aligned with and set against the relevant locality budgets. | 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 |
|---|---|
| • Non-compliance with the requirements of the Social Care (Self-directed Support) (Scotland) Act 2013;<br>• Financial decisions are made outwith approved authority levels;<br>• Variations in cost of care are not appropriately authorised;<br>• Income is not maximised<br>• Clients are incorrectly charged for contributions to service provision; | **High** |

| | |
|---|---|
| • Ineffective supplier management and overpayments for services provided;<br>• Inconsistent pricing applied to packages of care;<br>• Packages of care are overpriced;<br>• Potential risk of fraud;<br>• Inaccurate payments; and<br>• 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;<br>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.<br>A process should also be established and implemented to ensure that evidence of approval in line with delegated authorities is recorded and retained.<br>An appropriate owner of delegated authorities should be established and timeframes established for their ongoing review and refresh;<br>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.<br>A process should be established to confirm that these charges are consistently applied.<br>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.<br>An appropriate owner of the charging policy should be established and timeframes established for its ongoing review and refresh;<br>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;<br>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.<br>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.<br>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<br>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;<br>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;<br>10) Key person dependency and segregation of duties issues within the Transactions team should be addressed immediately;<br>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<br>12) A risk based approach should be designed; implemented; and consistently applied to support ongoing review of client paper based returns for Direct payments within the Business Support team, with all instances of inappropriate expenditure escalated for immediate reclaim. | |
| **Agreed Management Action** | **Estimated Implementation Date** |
| 1. Management has advised that they will 'risk accept' this recommendation on the basis that the Partnership is compliant with the spirit of SDS legislation as funding is being allocated on the basis of the SDS legislation. 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.<br>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.<br>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.<br>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.<br>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.<br>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.<br>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. | 1. N/A<br>4. 31 January 2019 for decision re charging team; and<br>29 March 2019 for SWIFT replacement<br>8. 29 March 2019<br>10. 31 October 2018<br>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.<br>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 recorded in the 'My Steps to Support Review Tool' on the Swift / AIS system or in a Case note titled 'Review Outcome' for ease of identification; and
- There was evidence supporting completion of client reviews in Swift, however, the outcomes and decisions are not always consistently recorded in the Outcomes' and 'Decisions' tabs within the system. Some review outcomes were included within case notes; however, these outcomes /decisions were not always clear due to the volume of information included within the case notes.

**5. Technology Issues**

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

| Business Implication | Finding Rating |
|---|---|
| • End to end processes supporting service delivery risks are not clearly understood and are not effectively managed;<br>• Poor quality service for clients;<br>• For care requests received from hospitals, providers may not fully understand the needs of the client and client needs may not be met;<br>• Clients are not effectively matched with the most appropriate service provider;<br>• Incorrect client data is copied into the Swift system and populated in Assessment of Needs Forms;<br>• 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;<br>• Review outcomes are not identified and required changes in levels of care not communicated to care providers and associated costs revised;<br>• There is no clear link from assessments through to revised personal support plans; changes in care provided; and the associated cost; | **High** |

| | |
|---|---|
| • Current processes supporting generation of key documents via the mail merge process are unsustainable. | |
| **Action plans** | |
| **Recommendation** | **Responsible Officer** |
| 1) A review of holistic social care processes should be performed from point of origination / referral to ongoing review and payment processes; and new processes designed and implemented.<br>These processes should include (but not be restricted to) responsibilities and accountabilities and hand offs between the teams involved.<br>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;<br>2) The process for recording client reviews in Swift should be specifically documented; implemented and consistently applied; and<br>3) ICT should be formally engaged to ensure that an alternative solution is found for the generation of key client documents via Swift; prior to support for Microsoft 2013 being removed. | |
| **Agreed Management Action** | **Estimated Implementation Date** |
| These recommendations will be addressed within scope of the strategic management action detailed in the Executive Summary at Section 2. | |

## 4. Supplier and Contract Management

**Findings**

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

### 1. Contract Authorisation

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

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

### 2. Contracts Team

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

Review of the contracts team established that:

- they currently have no established operational processes and procedures;

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

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

**3. <u>Care at Home Contract</u>**

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. <u>Spot Contracts</u>**

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;<br>• The contracts team is not operating and supporting the Partnership effectively;<br>• Inconsistent pricing applied to packages of care;<br>• Inability to confirm that client care needs are being effectively met by ISF service providers;<br>• Overpayment to 'on contract' where service has not been provided to clients for four consecutive weeks;<br>• Excessive use of spot contracts that are not appropriately priced;<br>• Inconsistent terms in spot contracts issued; and<br>• 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:<br>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;<br>2) Revised authorities for contract approval should be communicated and implemented across the Partnership;<br>3) A solution should be implemented to prevent issue of electronically signed contracts by former employees;<br>4) A process should be established to ensure that contract delegated authorities are revised to reflect all new starts and leavers;<br>5) A formal owner of contract authorities should be established and timeframes agreed for their ongoing review;<br>6) Procedures should be established to support the operation of the Partnership contracts team;<br>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.<br>Costs of care per the guide to price should be updated in the Swift system.<br>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;<br>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.<br>The process should include a clear escalation procedure where it is identified that clients are not receiving the expected level of care.<br>The review performed should be a risk based sampling approach, with all results and actions taken clearly documented and retained;<br>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;<br>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;<br>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.<br>A formal owner of the contract template should be established and timeframes agreed for ongoing review of the content;<br>12) Guidance should be established detailing when spot contracts can be used, and communicated across the partnership.<br>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;<br>13) Management information detailing the volume and value of spot contracts issues should be produced (at least monthly) and provided to budget managers; and<br>14) A process for review and retention of spot contracts should be established, enabling rates applied to be agreed to invoices processed by Business Support prior to invoice payment. | |
| **Agreed Management Action** | **Estimated Implementation Date** |
| These recommendations will be addressed within scope of the strategic management action detailed in the Executive Summary at Section 2. | |

# Appendix 1 - Basis of our classifications

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

# Appendix 2 – Financial approval guidance applied across the Partnership

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

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

# Appendix 3 – Partnership Support Teams

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

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

| Team | Service Area | Location | Role and Responsibilities |
|---|---|---|---|
| **Substance Misuse Manager** | | | • Social work assessment and support, Mental Health Officer team,<br>• Alcohol and drug prevention and rehabilitation services |
| **Locality Development Manager** | HSCP | Locality Offices | Developed Draft Hub Standard Operating Procedures. |
| **Allocated Workers** | HSCP | Locality Offices | Allocated workers include:<br>• Senior Social Workers<br>Responsible for the management of all social work teams; allocation of assessments; reviews; and other tasks across the community and hospital sites.<br>• Social Workers<br>• Occupational therapist<br>• Community Care Assistant<br>Responsible for assessments; support planning; and review of people in hospital and in the community.<br>A number of allocated workers were contacted during the course of the audit review to clarify key stages of the end to end process. |
| **Social Care Direct** | Resources | Waverley Court | All service referrals are processed through the Social Care Direct team. SCD, who log all referrals onto data systems and progress new referrals to Locality Hub |
| **Service Matching Unit** | HSCP | Locality Offices | Matches requests for Care at Home Services to third party providers. |
| **Contracts Team** | HSCP | Waverley Court | Responsible for negotiating contracts; monitoring supplier performance; and management of agreed third party provider rates. |
| **Business Support** | Resources | Waverley Court / Locality Offices | Business Support provides a business partnering approach between Business Support and services promoting joint working to provide a strong and strategic centre supporting frontline services across the four localities. Responsibilities include:<br>• Personal Support Plans<br>• Spot Contracts<br>• Payment of Invoices and<br>• 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:<br>• Individual Service Funds<br>• Direct Payments<br>• Care Home Contracts<br>• Spot Contracts<br>• Payment of Invoices and<br>• 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.<br>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.<br>Advised via email by Contracts Officer that:<br>"… 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.<br><u>Action to be taken</u><br>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.<br><u>Action to be taken</u><br>ICT Solutions (Swift Team) to remove signature from spot contracts. |
| **10 January 2018** | SMU Business Support Manager contacts each of the four 'Locality Managers' to request that they agree to the use of their 'electronic signature' for the Locality that they are responsible for. |

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

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

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

| Date | Description of events |
|---|---|
| | SE Locality Manager advised that she is liaising with Transactions Team Manager regarding this issue. |
| **16 April 2018** | Transaction Team Manager contacted Internal Audit to advise that she had been in contact with the contracts Team and Legal regarding the use of electronic signatures.<br>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.<br>However, the Transitions Team Manager noted that there is no current list of signatories in place.<br>The Transactions Team Manager has noted that she is currently having to remove the former Senior Manager's Signature from the contracts and manually sign each one. |
| **16 April 2018** | IA met with Interim Chief Officer and Operations Manager as part of initial audit close out meeting and advised them of the email received from the Transactions Team Manager. The Operations Manager agreed to take this forward. |
| **17 April 2018** | IA met with Transactions Team Manager to discuss the closure of the audit review and the issue she had raised in respect of the electronic signatures.<br>The Transactions Team Manager advised that she is not a Designated signatory but that there is no current list of Designated Signatories in place. It was established that ISFs were still being issued in the former Senior Manager's name. The Transactions Team Manager advised that this process would stop that day. |
| **17 April 2018** | Email from IA to the Interim Chief Officer (HSCP) and Head of Customer Services and IT to advise of current position. It was suggested that a meeting be held by all relevant parties to discuss and agree a way forward. Both the Interim Chief Officer (HSCP) and Head of Customer agreed that this was the correct approach. |
| **20 April 2018** | Operations manager has set up a 'Short Life Working Group' with the first meeting to be held on 23 April 2018 with the following members of the group required to attend:<br>• SE Locality Manager (HSCP)<br>• Operations Manager (HSCP)<br>• ICT/Swift - Systems Development Team Lead (Resources)<br>• Transaction Team Manager (Resources)<br>• SMU Business Manager (HSCP)<br>• Business Support – Business Services Manager and / or Business Support Manager. (Resources)<br><u>Action to be taken</u><br>Objective: to produce 'end to end' interim flow processes for Chief Officer and Head of Customer Services and IT approval. |
| **23 April 2018** | Short life working group meeting held. |
| **26 April 2018** | Operations Manager issued draft "Interim Purchase Budget Management Process for Localities" document to IA for comment.<br>IA Comments were returned to the Operations Manager |
| **02 May 2018** | Operations Manager issues the "Interim Purchase Budget Management Process |

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

# Appendix 5 – Terms of Reference

## Health and Social Care – Purchasing Budget Management

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

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

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

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

### Background

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

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

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

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

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

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

The main drivers of increased purchasing costs are:

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

### Scope

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

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

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

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

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

## Approach

Our audit approach is as follows:

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

## Limitations of Scope

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

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

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

| Sub - process | Control Objectives |
|---|---|
| 1. Review and prioritisation of initial service requests | • There is a clearly defined process for recording, assessing, and responding to all requests for assessments received.<br>• 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.<br>• The process has been communicated across all Localities and is consistently applied. |

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

| Sub - process | Control Objectives |
|---|---|
| | • There is a clear audit trail in Swift demonstrating that all care packages and costs have been reviewed and approved by managers. |
| 5. Cessation of Service | • There is a clearly defined process supporting cessation or reduction of services on a temporary or permanent basis,<br>• The process has been communicated across all Localities and is consistently applied.<br>• Swift records are updated to record the change in service. |
| 6. Completeness and accuracy of charging and payments made to clients and third-party suppliers | • All payments made (arranged and manged by the Council; ISFs; and DPs) have been checked to Swift prior to payment to confirm accuracy.<br>• All charges to be applied to clients have been identified and completely and accurately invoiced,<br>• All payments made to block 3rd party suppliers are in line with contractual terms and conditions.<br>• Block payments are only authorised where service delivery volumes have been achieved.<br>• Payments to spot 3rd party suppliers are only made when supported with payment requests that have been authorised in line with applicable authorities or standing orders. |
| 7. Ongoing budget management | • Locality managers have clear visibility of their devolved care purchasing budgets.<br>• Budgets are regularly monitored and reviewed and considered when making decisions in relation to demand and management of waiting lists.<br>• Budget transfers are performed to address emerging overspends.<br>• H&SC senior management have clear visibility of the total H&SC purchasing budget.<br>• 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<br>0131 469 3216 (x 43216) |
| Karen Sutherland | Internal Auditor | karen.sutherland@edinburgh.gov.uk<br>0131 469 3451 (x 43451) |

## Key Contacts

| Name | Title | Role | Contact Details |
|---|---|---|---|
| Michelle Miller | Interim Chief Officer, Health and Social Care | Review Sponsor | 0131 553 8201 |
| Wendy Dale | Strategic Commissioning Manager | Key Contact | 0131 553 8322 |
| Lyn McDonald | Health and Social Care Operations Manager | Key contact | 07540 334 800 |
| Patrick Jackson | Locality Manager, South West | Key contact | 0131 453 9010 |
| Angela Lindsay | Locality Manager, North East | Key Contact | 0131 469 3927 |
| Marna Green | Locality Manager, North West | Key Contact | 0131 553 8318 |
| Nikki Conway | Locality Manager, South East | Key Contact | 0131 553 8364 |
| John Connarty | Senior Manager – Business Partnering, Finance, Resources | Key Contact | 0131 469 3188 |
| Karen Dallas | Principal Accountant, (Health and Social Care), Finance, Resources | Key Contact | 0131 529 7937 |
| Eleanor Cunningham | Lead Officer Strategy and Insight Planning | Key Contact | 0131 553 8220 |
| Jo McStay | Corporate Manager, Strategy and Insight | Key Contact | 0131 529 7950 |
| Edel McManus | Data Services Manager, Strategy and Insight | Key Contact | 0131 469 3285 |
| Mary McIntosh | Business Services Manager, Customer, Resources | Key Contact | 0131 529 2138 |
| Jon Ferrer | Quality, Governance & Regulation Senior Manger | Key Contact | 0131 553 8396 |
| Katie McWilliam | Strategy Planning & Quality Manager, Older People | Key Contact | 0131 553 8382 |
| Liz Davern | Team Manager, Transactions Social Care Finance, Customer, Resources | Key Contact | 0131 553 8232 |

## Timetable

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

## Follow Up Process

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

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

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# 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*

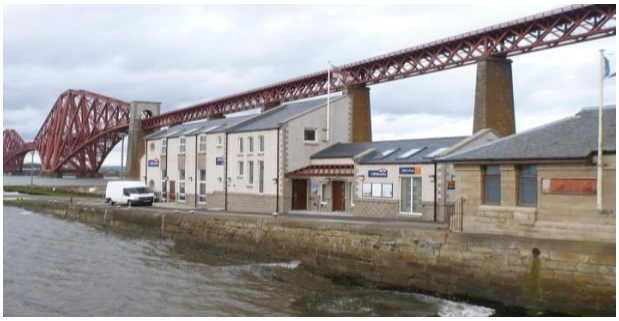
# Internal Audit

## Review of Hawes Pier Port Facility Security Plan (PFSP)

Final Report

18 May 2018

MIS1701

# Contents



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

| Business Implications | Findings Rating |
|---|---|
| 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. | High |

| Action plans | |
|---|---|
| **Recommendation** | **Responsible Officer** |
| 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), | Head of Place Management |
| **Agreed Management Action** | **Estimated Implementation Date** |
| Agreed<br><br>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);<br><br>2. Shipping agent / Security company will be sent the "Hawes Pier Cruiseliners Security Procedures – Requirements" document for verbal agreement prior to the cruiseliner season.<br><br>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. | 31/05/2018 to enable IA follow-up.<br><br>31/05/2018<br><br>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 and individual.<br><br>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).<br><br>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.<br><br>The principal activities of the role involve:<br>• Management and maintenance of the PFSP and attendance at appropriate Committee and liaison meetings;<br>• Ensuring that security arrangements specified in the PFSP are applied on the specific days when cruise ships are visiting;<br>• Being on call and able to respond in the event of incidents.<br><br>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 | Findings Rating |
|---|---|
| • Potential non-compliance with DfT security requirements; and<br>• Potential financial loss or reputational damage if cruise ships are unable to use the facility;<br>• The PFSP is not refreshed and maintained; and<br>• Inability to respond in the event of a security incident. | **Medium** |

| Action plans | |
|---|---|
| **Recommendation** | **Responsible Officer** |
| 1. Management should demonstrate ongoing compliance with DfT requirements, despite the extended vacancy.<br>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<br>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. | Head of Place Management |
| **Agreed Management Action** | **Estimated Implementation Date** |
| Agreed, | |

| | |
|---|---|
| 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)<br>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.<br>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.<br>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. | 31/05/2018 to enable IA follow-up.<br><br>01/06/2018<br><br>01/07/2018 |

## 3. Compliance with Dft requirements for security exercises

| **Findings** | |
|---|---|
| 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.<br><br>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.<br><br>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. | |
| **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,<br><br>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** | |
|---|---|
| **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,<br>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.<br>A drill has already been completed for the first quarter January - March, the next drill will be undertaken between April – June 2018.<br>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<br><br>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.<br>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<br><br>31/05/2018 |

## 5. Implementation of Department for Transport recommendations

| Findings | |
|---|---|
| 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.<br><br>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:<br><br>• Ensuring that crew lists are received in advance of arrival;<br>• 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;<br>• Better co-ordination of pass issue arrangements for visitors to the ship; and<br>• Being more specific in the PFSP about how patrols are recorded and where this documentation will be retained.<br><br>Management has advised that these matters are being addressed, and that the delay is due to the ongoing PFSO vacancy. | |
| **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** |
| Agreed,<br><br>The PFSO will ensure that all recommendations made by the DfT from the last inspection have be actioned and addressed.<br><br>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 | 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:<br>• Undertaking the required six-monthly review and refresh of the PFSP with evidence of review documented (last version update noted was 22 February 2017);<br>• Details of new or acting PSFO arrangements to be included along with confirmation of training being successfully completed;<br>• Renewal dates of Counter Terrorism Check (CTC) clearance for staff who can act as Deputy PFSO to be updated;<br>• 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;<br>• 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<br>• 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,<br>All points identified will be implemented within the current Port Facility Security Plan. (PFSP)<br>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.<br>The minor errors with regards to TRA / RA will be rectified during the 6-monthly review. | 31/05/2018 - to enable IA follow-up.<br>21/08/2018 |

# Appendix 1 - Basis of our classifications

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

# Appendix 2 – 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

EDINBVRGH
THE CITY OF EDINBURGH COUNCIL

# Contents



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

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

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

# 1. Background and Scope

## Background

The 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.<br><br>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 |
|---|---|
| • 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;<br>• 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<br>• 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. | **Medium** |

**Action plans**

| Recommendation | Responsible Officer |
|---|---|
| 1. 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.<br>Once developed, ensure that this is clearly documented, communicated to all staff and that relevant individuals are appropriately trained.<br>2. Ensure that the existing bomb threat emergency procedure is clearly communicated to all relevant staff. E.g. via toolbox talks. | Andy Williams, Waste, and Cleansing Service Manager |
| **Agreed Management Action** | **Estimated Implementation Date** |
| 1. 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<br>2. 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 | 1. 28 September 2018<br>2. 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<br><br>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.<br><br>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 | Finding Rating |
|---|---|
| • H&S risks, particularly around building safety, may not be effectively managed if operational roles and responsibilities are not clearly defined and communicated;<br>• 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<br>• There may also be potential financial, legal and reputational implications if the Council is found to be non-compliant. | **Medium** |

| Action plans | |
|---|---|
| **Recommendation** | **Responsible Officer** |
| 1. Identify H&S site and equipment checks to be carried out;<br>2. Agree responsibilities for carrying these out between waste and cleansing, property services and facilities management;<br>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 | 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<br>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<br>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.<br><br>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.<br><br>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** | **Finding Rating** |
|---|---|
| • 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<br>• 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. | **Medium** |
| **Action plans** | |

| Recommendation | Responsible Officer |
|---|---|
| 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;<br>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<br>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. | Andy Williams, Waste and Cleansing Service Manager |
| **Agreed Management Action** | **Estimated Implementation Date** |
| 1. To hold briefings with all Drivers / Crew Leaders to reinforce H&S roles and responsibilities;<br>2. To ensure the first phase of the mobile supervisor model is linked to implementation of the 4 day week; and<br>3. To ensure that a suitable checklist is developed to coincide with mobile supervisor roll out. | 1. 31 July 2018<br>2. 21 December 2018<br>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.<br>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.<br>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 |
|---|---|
| • 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.<br>• The council may be held liable if an incident should occur involving an employee that is found to be insufficiently trained. | **Medium** |

**Action plans**

| Recommendation | Responsible Officer |
|---|---|
| 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.<br>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.<br>3. Define a procedure to be followed if employees have not completed mandatory H&S training and outline potential implications, e.g. | Andy Williams, Waste, and Cleansing Service Manager |

| | |
|---|---|
| disciplinary action. Ensure that this procedure is communicated to employees as required.<br>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. | |
| **Agreed Management Action** | **Estimated Implementation Date** |
| 1. Develop Business Case for training officer roles and, if approved, recruit;<br>2. Identify within training matrix the training that is core and non-core;<br>3. Work with HR to define procedure for training compliance. Ensure Training consultation with staff covers non-attendance;<br>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 | 1. 28 September 2018<br>2. 28 September 2018<br>3. 31 October 2018<br>4. 31 October 2018 |

## 5. Health and safety metrics

| **Finding** | |
|---|---|
| Waste and Cleansing H&S metrics are not currently monitored or analysed locally within the service on a regular basis.<br>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.<br>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.<br>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. | |
| **Business Implication** | **Finding Rating** |
| • 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.<br>• Incident and near miss trends may highlight where training could be improved, e.g. via toolbox talks.<br>• 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. | **Low** |

| Action plans | |
|---|---|
| **Recommendation** | **Responsible Officer** |
| 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.<br>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. | Andy Williams, Waste, and Cleansing Service Manager |
| **Agreed Management Action** | **Estimated Implementation Date** |
| 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<br>2. H&S performance to be included within Looking Ahead conversations | 1. 31 July 2018<br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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 |
|---|---|
| • 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. | Low |

| Action plans | |
|---|---|
| **Recommendation** | **Responsible Officer** |
| 1. 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** |
| 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. | This action has been closed by management and validated by IA prior to issuing the final report. |

# Appendix 1 – Basis of our classifications

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

# Appendix 2 – Terms of Reference

## 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 | • 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;<br>• 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;<br>• 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.<br>• Adequate co-ordination for H&S arrangements at 3rd party sites.<br>• Adequate H&S arrangements for agency staff.<br>• Appropriate engagement and consultation with Trades unions.<br>• Significant incident procedure is in place and has a good level of awareness. |
| Health and Safety Performance | • Appropriate assurance and governance arrangements have been established by management to confirm ongoing compliance with health and safety requirements;<br>• 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<br>• Metrics include incident statistics, breach reporting and details of any significant or recurring incidents and training attendance and completion; |

| | |
|---|---|
| | • 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;<br>• 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;<br>• 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<br>• 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 | 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.<br>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. |

## Internal Audit Team

| Name | Role | Contact Details |
|---|---|---|
| Lesley Newdall | Chief Internal Auditor | lesley.newdall@edinburgh.gov.uk<br>0131 429 3216 |
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## Key Contacts

| Name | Role | Contact Details |
|---|---|---|
| Andy Williams | Waste and Cleansing Service Manager | Andy.Williams@edinburgh.gov.uk<br>0131 469 5660 |
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| | | |
|---|---|---|
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| Rab Farquhar | Area Supervior – Waste and Cleansing Operations (East) | robert.farquhar@edinburgh.gov.uk |
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| Karen Reeves | Technical Manager | Karen.reeves@edinburgh.gov.uk<br>0131 469 5196 |

**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.<br><br>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). | Pending - There is no set risk notification procedure throughout waste. Resilience team are working on a council wide process.<br><br>N/A – Team has provided feedback to H&S that they are not clear on what a “risk notification procedure” is. |