# Governance, Risk and Best Value Committee

**10.00am, Tuesday 30 October 2018**

# Edinburgh Health and Social Care Partnership: Internal Audit Update Report and Assurance Arrangements

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| **Item number** | 7.4 |
| **Report number** | |
| **Executive/routine** | |
| **Wards** | |
| **Council Commitments** | |

## Executive Summary

This report sets out affirmative actions that are underway to address internal audit assurance challenges and associated risks affecting health and social care services in Edinburgh.

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# Report

# Edinburgh Health and Social Care Partnership: Internal Audit Update Report and Assurance Arrangements

## 1. Recommendations

1.1 Committee is recommended to note:

1.1.1 that Internal Audit Team (IA) is currently reviewing a significant quantity of evidence provided by the Edinburgh Health and Social Care Partnership (the Partnership) and Council Directorates/Divisions to support closure of open and overdue findings during August. A five-week window (to 5 October 2018) has been given to services to address and resolve any subsequent IA queries raised prior to findings being formally recorded as overdue (where appropriate);

1.1.2 of current governance and assurance arrangements in place for progressing all historic, current and new internal risk findings; and

1.1.3 the status update for all overdue IA items for Health and Social Care/IJB.

## 2. Background

2.1 The Edinburgh Integration Joint Board (IJB) is responsible for ensuring that its business is conducted in accordance with the law, statutory guidance and appropriate standards. The IJB also aims to foster a culture of continuous improvement in its and to make arrangements to secure best value.

2.2 In discharging these responsibilities, the IJB is required to have in place processes to ensure an oversight of quality of delivery and in doing so, as well as having in place internal processes it must also place reliance on the City of Edinburgh Council (the Council) and NHS Lothian's own systems of internal control which support compliance with those organisations' policies.

2.3 At its meeting on 26 September 2018, this committee requested a scoping report with outline activity to address the outstanding actions for Health and Social Care with an appendix highlighting who is responsible for each. This report is in response to that instruction.

2.4 The Chief Officer has now set up an Assurance Oversight Group which oversees all internal audit risk findings activities for current, overdue and historic items with the objective of getting a fuller understanding of any aspects or issues that are cross

cutting and which might prevent progress being made on agreed management actions against internal audit risk recommendations. This group considers audit reports and actions across all IJB audits – Council, NHS and IJB specific.

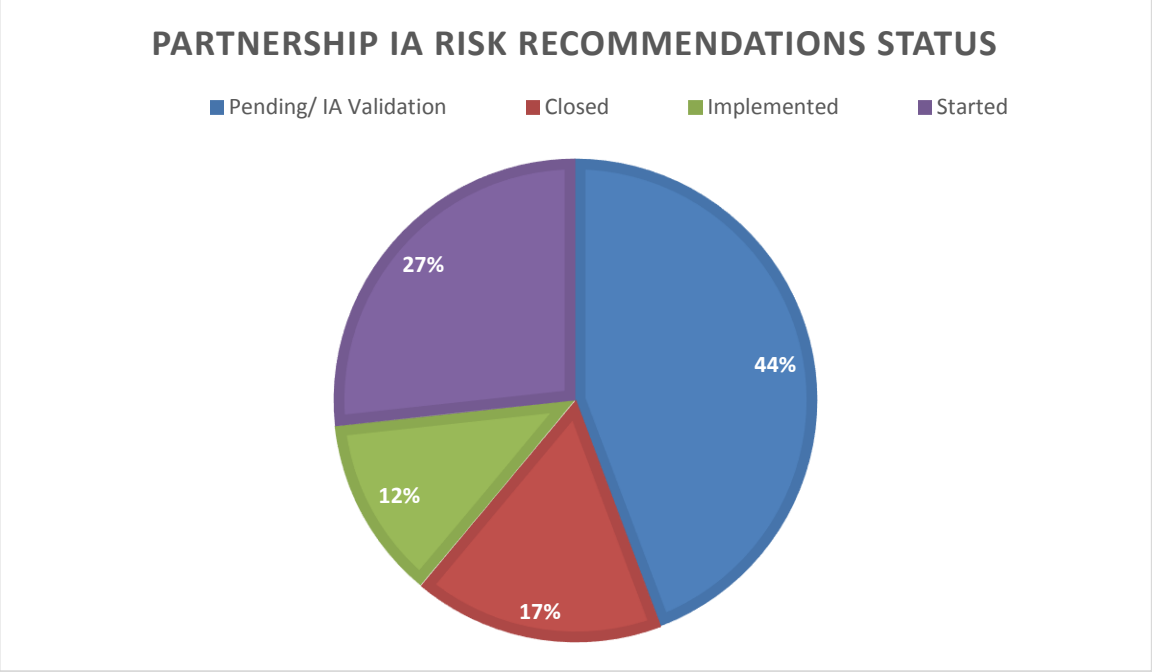
## 3. Main report

**Wider Internal Audit Risk Findings Overview**

3.1 As of the 1st October 2018, the Partnership is monitoring the performance of 131 IA recommendations identified from 44 IA risk findings. Of these 131 recommendations:

- 24 are not yet due;
- 28 have been rescheduled and are not yet due;
- 41 are pending*;
- 16 have reported the recommendation as 'implemented'; and
- 22 have been recently closed.

3.2 Table 1: 01/10/2018 Partnership IA Risk Recommendations % Status Graph




*** Open and Pending Findings**

3.3 In terms of Council 93 recommendations are currently open. The Partnership and its business partners from various Council service areas have been actively providing evidence to support the closure of these recommendations. 35 of these recommendations have received evidence to support progress and are marked as 'started'.

3.4 The remaining 58 recommendations have had evidence submitted supporting their full closure prior to the end of August 2018. Their status is currently marked as 'pending'. These are being validated by IA.

3.5 Where evidence provided was not fully sufficient to support closure, the 'IA validation in progress' status was maintained until Friday 5 October, enabling service areas to respond and provide additional evidence, before changing the status to overdue (where appropriate).

**Pending/Outstanding IA items - Scope**

3.6 The following 11 IA reports have items which are currently being validated by IA – these include the recommendations with a deadline ending before 31 August 2018:

- Use of Demographics in the Budgeting Process (historic)
- Continuous Testing-Standby, On Call & Disturbance Payments (historic)
- Care Home Debt Management (historic)
- Management Information (historic)
- SWIFT Access Controls (historic)
- Self-Directed Support – Option 3 (historic)
- IJB Data Integration and Sharing
- Health and Social Care: Care Homes – Corporate Report
- Social Work Centre Bank Account Reconciliation
- Edinburgh Alcohol and Drug Partnership – Contract Management
- Social Work: Pre-Employment Verification

**Outstanding IA Agreed Management Actions – Partnership Only**

3.7 Following IA's initial validation (from 12 October 2018), 31 IA agreed management actions owned by Health and Social Care/IJB are currently outstanding.

3.8 Table 2: October Outstanding Management Actions Breakdown:

| Progress Status | Number | % |
|---|---|---|
| Implemented/Pending IA Validation | 19 | 61% |
| Started (90% or above) | 7 | 23% |
| Started (60% or less) | 5 | 16% |
| **Total:** | **31** | |

3.9 Outstanding management actions with an 'Implemented/Pending IA Validation' status have been actioned by the service area, however, additional evidence, assurance or clarification is being pursued by the IA team prior to closure.

3.10 Started (90% or above) have been marked for items where implementation by the service is imminent within the next 4 weeks.

3.11 Started (60% or less) require further senior management input to progress. These will be escalated by exception to the Chief Officer's Assurance Oversight Group (see 3.13).

3.12 Appendix 1 provides a full breakdown of Health and Social Care/IJB outstanding items which details audit finding, timelines (original and revised), status update and action owner(s).

**Audit Oversight Group**

3.13 Not all of the Partnership's IA risk findings are within the Partnership's sole gift to remediate. The majority rely on Council or NHS Lothian services to take appropriate actions to mitigate risks.

3.14 In order to seek comprehensive updates on progress against actions from these recommendation owners, the Chief Officer has formed an Assurance Oversight Group (AOG). The AOG is composed of the Partnership's Executive Team, the Chief Internal Audit Officer and relevant Council Head of Service whose officers are accountable for the delivery of the Partnership's wider internal audit programme.

3.15 The AOG aims to gain a fuller understanding of any aspects or issues that are cross-cutting and which might prevent progress being made. Where there is a discrepancy to delivery timescales or deviation to agreed management actions, the Chief Officer will be provided with a rationale and a remedial proposal for consideration and sign off.

3.16 The AOG will also review all agreed management action plans for new and upcoming reports for final approval, as will be the case for the Purchasing Budget Management report – its action plan will be due to be submitted by December 2018.

**Partnership IA Programme**

3.17 The Partnership's IA programme is currently being managed by the Partnership's Operations Manager. All recommendations are being closely monitored through the programme and where appropriate, relevant recommendation owners will meet on a regular basis to discuss progress with the Operations Manager and raise any issues for escalation. If these issues are unable to be resolved at an operation level, an exception report will be completed for submission to the AOG.

3.18 Various existing working or action groups have been assigned to oversee the progress of more complex risk findings where a multi-service approach has been necessary to mitigate control gaps, address risk and ultimately provide evidence to close down risk findings.

3.19 Where an established group was deemed inappropriate to action a particular risk finding, a short-life working group has been sanctioned by the AOG to progress the actions or develop an action plan until the relevant risk findings' closure. For high risk findings, the Chief Officer will also nominate a member of her Executive Team to lead this group to ensure that she is regularly updated on progress.

**IA Validation Timeframes**

3.20 The Partnership and other Council Service Areas were given until 5 October 2018 to provide evidence to support closure of recommendations.

3.21 Any remaining risk items classified as 'overdue' is subject to AOG scrutiny and all residual closure management actions will prioritised by the group.

## 4. Measures of success

4.1 Continued improvement on governance and assurance over all IA recommendations and relevant risk findings.

4.2 An increase in effective implementation and closure of IA findings within their agreed dates.

## 5. Financial impact

5.1 No direct financial impact.

## 6. Risk, policy, compliance and governance impact

6.1 If IA findings and associated management actions are not implemented, the Partnership will be exposed to the risks set out in the relevant detailed IA reports. IA findings are raised as a result of control gaps or deficiencies identified during reviews therefore overdue items inherently impact upon effective risk management, compliance, and governance.

## 7. Equalities impact

7.1 Recommendations arising from IA reports for health and social care services in Edinburgh promote improvements which have an impact on protected characteristics groups.

## 8. Sustainability impact

8.1 Not applicable.

## 9. Consultation and engagement

9.1 Not applicable.

## 10. Background reading/external references

10.1 None.

**Judith Proctor**

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Edinburgh Health and Social Care Partnership

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## 11. Appendices

Appendix 1: Health and Social Care/IJB Outstanding IA Agreed Management Actions List

| Group | Issue Type | Finding | Recommendation Title | Recommendation | Agreed Management Action | Recommendation State | Final Audit Report Completion Date | Estimated Implementation Date | Revised Implementation Date | Last Status Update | Owner | Contributor |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Project Code: CW1801 | | | | | | | | | | | | |
| Project Name: Historic Unimplemented Findings | | | | | | | | | | | | |
| Issue Title: HSC1502 - issue 1 No regular review of user access | | | | | | | | | | | | |
| Health & Social Care | Medium | There is no regular review of an individual's user access rights to check that their access remains appropriate. | Recommendation 2a | Regular revalidation of users is introducedA regular revalidation of all users should be performed. Line managers should check each individual's access to Swift and ensure that the type of access they have is appropriate. | On a six monthly basis, managers will be sent a report detailing all active end user accounts listed against the teams they manage, requesting active confirmation that access rights for all these individuals is correct. This will have a confirmation turnaround date of 2 weeks. Failure to comply will be escalated to Swift Governance Board. These reports will be circulated in November and May. | Implemented | Nov-15 | 31/12/2015 | 30/08/2018 | New Swift user access right validation process is now in place. First validation exercise was run in September. As anticipated, the first report has generated a large amount change requests (eg line management, team changes, etc.). ICT are updating every indivual requests manually, which will take some time to fully complete - updates will hopefully be completed by early November 2018.<br><br>The next round of checks is scheduled for March 2019. | Judith Proctor,Chief Officer | ICT<br>Partnership (Operations) |
| Issue Title: HSC1503 - SDS Option 3 - Sign off process - Assessments and Budgets | | | | | | | | | | | | |
| Health & Social Care | Medium | To ensure segregation of duties and the quality of assessments, all assessments (which include the user's budget) are checked and then authorised or returned by the assessor's senior. Where a special service (e.g. a care home placement) is required, then the assessment and personal support plan also need to be authorised by the Sector Manager. We analysed all cases that were added to the Swift database between April 2015 and January 2016 and compared the user ID of the person who completed the budget to the user ID of the person who signed off the budget. We identified 65 cases out of 2,525 (2.6%) where the system recorded the assessor who prepared the budget also signing it off. | Recommendation 6a | All assessments and budgets should be signed off by a senior in accordance with HSC policy. 'Workarounds' on Swift should be deactivated to prevent this breach of segregation of duties recurring. | Workarounds' on Swift will be deactivated by 31 December 2016:Extract of Agreed Management Action from Audit Report (Final)'Workarounds' on Swift will be deactivated by 31 December 2016:Work is being taken forward through the Health and Social Care Transformation Project (Governance, Devolved Budgets and Budget Management) to implement the budget management functionality within SWIFT which will address issues around separation of duties. A working group has been established and identified all the workstreams required to implement delegated budget management. A workshop will be held in mid-May 2016 to agree new operational processes including the management of budgets through SWIFT with authorisation limits and the facility for budget holders to authorise within the system. Further progress is dependent on the agreement of budget and staffing structures across localities in order to avoid the need to set up these structures twice on SWIFT which would represent a significant duplication of work.This Action also relates to work being undertaken to address Iss2 from Audit RS1245. | Implemented | Aug-16 | 31/12/2016 | 31/07/2018 | Recent process changes have been made to the personal support plan to ensure budget managers are taking responsibility for reviewing, coding and signing off all purchased services within EHSCP.<br><br>Changes are as follows;<br><br>• The PSP has been amended with an authorisation section added and the manager must apply the correct cost centre and electronically sign off the plan.<br>• Business Support will no longer apply a cost centre to a package of care and in the event of missing information it will be returned to the approving manager to code and sign off agreed packages.<br><br>These changes will come into effect over the next couple of weeks when the finance migration has happened, all SWIFT/AIS processes have been amended and this information has been communicated to all managers in preparation for this change.<br><br>GO LIVE by 22 October 2018. | Judith Proctor,Chief Officer | Partnership (Operations)<br>ICT<br>Business Support (Resources)<br>Finance |
| Health & Social Care | Medium | To ensure segregation of duties and the quality of assessments, all assessments (which include the user's budget) are checked and then authorised or returned by the assessor's senior. Where a special service (e.g. a care home placement) is required, then the assessment and personal support plan also need to be authorised by the Sector Manager. We analysed all cases that were added to the Swift database between April 2015 and January 2016 and compared the user ID of the person who completed the budget to the user ID of the person who signed off the budget. We identified 65 cases out of 2,525 (2.6%) where the system recorded the assessor who prepared the budget also signing it off. | Recommendation 6b | All assessments and budgets should be signed off by a senior in accordance with HSC policy. 'Workarounds' on Swift should be deactivated to prevent this breach of segregation of duties recurring. | Work is being taken forward through the Health and Social Care Transformation Project (Governance, Devolved Budgets and Budget Management) to implement the budget management functionality within SWIFT which will address issues around separation of duties. A working group has been established and identified all the workstreams required to implement delegated budget management. A workshop will be held in mid-May 2016 to agree new operational processes including the management of budgets through SWIFT with authorisation limits and the facility for budget holders to authorise within the system.Further progress is dependent on the agreement of budget and staffing structures across localities in order to avoid the need to set up these structures twice on SWIFT which would represent a significant duplication of work. This Action also relates to work being undertaken to address Iss2 from Audit RS1245. | Implemented | Aug-16 | 31/12/2016 | 31/07/2018 | See above (6a) update.<br><br>This will GO LIVE by 22 October 2018 | Judith Proctor,Chief Officer | Partnership (Operations)<br>ICT<br>Business Support (Resources)<br>Finance (Resources) |
| Project Code: EIJB1701 | | | | | | | | | | | | |
| Project Name: Purchasing Budget Management | | | | | | | | | | | | |
| Issue Title: Financial Controls | | | | | | | | | | | | |
| Health & Social Care | High | 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: Funding allocation modelThere 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. Delegated financial authoritiesNo 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 | Financial Controls - Issue 2 - Partnership Working Group | See 'Summary of Findings' of Final Audit Report | 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.<br><br>The Partnership working group will be established by the Chief Finance Officer by 28 September 2018. | Implemented | Jul-18 | 28/09/2018 | | Ongoing IA Validation<br><br>Purchasing Budget Implementation Group met on 14 September 2018.<br><br>IA have advised that as representatives from Strategy and Insight and Contract Teams were absent in the first meeting, they would be unable to close this action down until confirmation that these team members have attended/been actively engaged within the group.<br><br>Email confirmation has been received from Strategy and Insight and Contracts teams that a representative will be in attendance at the next meeting on 23 October 2018. | Judith Proctor,Chief Officer | Partnership (Operations & Finance)<br>Finance (Resources)<br>Business Support (Resources)<br>Strategy and Inisght<br>ICT |
| IA | | | | | | | | | | | | |
| Health & Social Care | High | 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: Locality Processes and ProceduresDraft Hub Standard Operating Procedures were created | Operational structure and processes - Issue 3 - Partnership Working Group | See 'Summary of Findings' of Final Audit Report. | 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 | Pending | Jul-18 | 28/09/2018 | | As above.<br><br>Further evidence is required to allow this management action to be closed. | Judith Proctor,Chief Officer | Partnership (Operations & Finance)<br>Finance (Resources)<br>Business Support (Resources)<br>Strategy and Inisght<br>ICT |
| Issue Title: Purchasing Budget Allocation | | | | | | | | | | | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Health & Social Care | High | Whilst an overall Partnership purchasing budget has been established, the budget had not been appropriately devolved / allocated across the localities as at December 2017. Additionally, care package cost data maintained on the Swift system is not aligned with the localities operating model, and no locality financial management information is currently available. Locality Management has advised that they are aware of these issues. Finance senior management confirmed that a draft report was presented to the Partnership senior management team in April highlighting the need for alignment of financial budgets; income and cost centres with the localities operating model. The draft report notes that this exercise is a significant undertaking as it requires amendments to the general ledger; Swift; and other core financial systems. We understand that a 'purchasing realignment group' has been established to resolve allocation of budgets across the localities. | Purchasing Budget Allocation - Issue 1 - Partnership Working Group | See 'Summary of Findings' of Final Audit Report. | 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. | Pending | Jul-18 | 28/09/2018 | | As above.<br><br>Further evidence is required to allow this management action to be closed. | Judith Proctor,Chief Officer | Partnership (Operations & Finance)<br>Finance (Resources)<br>Business Support (Resources)<br>Strategy and Inisght<br>ICT |
| Issue Title: Supplier and Contract Management | | | | | | | | | | | | |
| Health & Social Care | High | 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. Contract AuthorisationThe 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. Contracts TeamThe 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 | Supplier and Contract Management - Issue 4 - Partnership Working Group | See 'Summary of Findings' of Final Audit Report. | 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. | Pending | Jul-18 | 28/09/2018 | | As above.<br><br>Further evidence is required to allow this management action to be closed. | Judith Proctor,Chief Officer | Partnership (Operations & Finance)<br>Finance (Resources)<br>Business Support (Resources)<br>Strategy and Inisght<br>ICT |
| Project Code: HSC1503 | | | | | | | | | | | | |
| Project Name: Personalisation SDS - Option 3 | | | | | | | | | | | | |
| Issue Title: Sign offs - Personal Care Plans | | | | | | | | | | | | |
| Health & Social Care | Medium | Since October 2015, all personal care plans must be signed off by a senior. This is a measure introduced to improve the quality of personal support plans. We obtained a report of all personal support plans completed between October 2015 and January 2016. We identified 44 cases out of 811 (5.4%) where the system recorded that the assessor who prepared the personal support plan also signed it off. This was reflected in the variable quality of the 25 personal care plans we reviewed as part of our audit work. | Sign offs - Personal Care Plans | All personal care plans should be signed off by a senior, as required by HSC policy. 'Workarounds' on Swift should be deactivated to prevent this breach of segregation of duties recurring. | Ensure that there is a mechanism in place on SWIFT for the senior to record that they have signed off the support plan. At present any edits made by the senior at the time of the review will show that the senior has both prepared and reviewed the plan.Data quality reports will be set up to identify any support plan signed off by the assessor who produced the plan. Sector Managers and seniors to ensure appropriate oversight and sign off by senior for the personal care plans | Started | Aug-16 | 30/06/2016 | 30/09/2018 | Head of Operations agreed on 3 October 2018 to transfer ownership of this action from Business Support (Resources).<br><br>To be discussed at the next Partnership Assurance Oversight Group via Exception Report. | Judith Proctor,Chief Officer | Partnership (Operations)<br>Partnership (Resources)<br>Partnership (ICT) |
| Project Code: HSC1604 | | | | | | | | | | | | |
| Project Name: IJB Data Integration & Sharing | | | | | | | | | | | | |
| Issue Title: Hardware compatibility and connectivity in NHS and CEC locations | | | | | | | | | | | | |
| Integration Joint Board | Medium | During our audit procedures, we observed there are compatibility and connectivity issues when using CEC hardware at NHS locations or to access NHS owned systems and vice versa. CEC staff have experienced difficulties in connecting through Wi-Fi at NHS sites (and vice versa) in order to access their emails, and some systems cannot be accessed using specific hardware such as mobile devices (i.e. tablets, mobile phones). | Connectivity and Hardware compatability | The IJB should ask for a review of connectivity and hardware compatibility to be conducted in NHS and CEC sites, to ensure all staff can be fully operational wherever they are located. | The ICT and Information Governance Steering Group will request a review of connectivity and hardware compatibility to be conducted across all sites housing integrated teams and consider any recommendations arising from that review. | Started<br><br>60% Completed | May-17 | 30/06/2017 | 31/05/2018 | ICT Priority work to be taken on by the ICT and Information Governance Steering Group - now to be Chaired by Partnership's Head of Operations.<br><br>To be discussed at the next Partnership Assurance Oversight Group via Exception Report. | Judith Proctor,Chief Officer | Partnership (Operations)<br>ICT (Council & NHS Lothian)<br>Information Governance (Council - Startegy and Insight & NHS Lothian)<br>Change Strategy (Strategy and Insight |
| Issue Title: Lack of available training, policies and guidance | | | | | | | | | | | | |
| Integration Joint Board | Medium | Training processes do not meet the changing requirements imposed by newly provisioned access to NHS or CEC data sets. CEC and NHS employees receive mandatory training as part of their induction to CEC and NHS respectively. However where CEC staff are provided access to NHS data (and vice versa) there are no additional training requirements. As a result NHS or CEC staff may handle data inappropriately as they have not been briefed on specific requirements.Training is not regularly refreshed or reviewed, and there are no clear policies that staff are required to follow when receiving new access to systems to positively affirm compliance. | Data Protection Training | Training should be mandatory for employees accessing a system for the first time (particularly where that system holds sensitive information). This should be defined in a training plan. | The nominated officer with responsibility for ICT and Information Governance will work with relevant colleagues in the Council and NHS Lothian to develop an integrated approach to data protection training taking account of the role and responsibilities of the IJB. | Started<br><br>60% Completed | May-17 | 31/12/2017 | 30/09/2018 | Partnership's Data Protection Officer (Council's Information Governance Manager) met with Partnership Operations Manager on 27 September 2018 to discuss actions arising from Information Governance Survey that was completed by management teams across the Partnership. Further work is required with NHS Lothian's Information Governance Unit to agree on which training module (Council or NHS Lothian) integrated teams should complete. Both organisations jointly recognise that information governance compliance principles Fare for the most part the same, as such, it is likely that one presentation/training module will be sufficient with only minor amendments to comply with mandatory training requirements on GDPR.<br><br>To be discussed at the next Partnership Assurance Oversight Group. | Judith Proctor,Chief Officer | Partnership (Operations)<br>Information Governance (Council & NHS Lothian) |
| Integration Joint Board | Medium | Training processes do not meet the changing requirements imposed by newly provisioned access to NHS or CEC data sets. CEC and NHS employees receive mandatory training as part of their induction to CEC and NHS respectively. However where CEC staff are provided access to NHS data (and vice versa) there are no additional training requirements. As a result NHS or CEC staff may handle data inappropriately as they have not been briefed on specific requirements.Training is not regularly refreshed or reviewed, and there are no clear policies that staff are required to follow when receiving new access to systems to positively affirm compliance. | Compliance with training plan | Depending on the systems, this training should be monitored either by CEC or NHS, and supervised by the IJB. | A training plan will be developed to ensure all existing staff who need to access systems belonging to both the Council and NHS Lothian receive the appropriate training to enable them to use the system appropriately with due regard to data protection. Training on all systems to be used by a postholder will become part of the mandatory training for new appointments. Compliance with this arrangement will be overseen by the nominated officer with responsibility for ICT and Information Governance. | Started<br><br>60% Completed | May-17 | 31/03/2018 | 30/09/2018 | Draft project plan to be discussed at the next ICT Steering Group. Responses received from Survey Monkey questionnaire to staff in integrated team will define the project/workstream's scope.<br><br>To be discussed at the next Partnership Assurance Oversight Group via Exception Report. | Judith Proctor,Chief Officer | Partnership (Operations)<br>ICT (Council & NHS Lothian)<br>Information Governance (Council - Startegy and Insight & NHS Lothian)<br>Change Strategy (Strategy and Insight ) |
| Issue Title: The existing processes lack robustness (access management, data protection) | | | | | | | | | | | | |

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| Integration Joint Board | High | During interviews conducted with NHS and CEC, it was noted that two processes (specifically access management and communication protocols for data sharing) do not fully support the objectives of the IJB. Responsibilities for ensuring that access rights to NHS and CEC systems remains appropriate have not been established. Currently, managers within NHS should notify CEC and vice versa of staff joiners, leavers or movers. This allows access rights to be updated in line with revised operational requirements. However, there is no formal documented process or guidance that sets out the requirement to notify the two bodies of staff changes, and interviewees reported that access control is inconsistently applied (for example not all managers notify their 'non-home' organisation' of staff changes).Currently, communication protocols for data sharing are in place. However, we observed that these protocols were not fully established and not sufficiently mature enough on data protection to properly support the objectives of IJB. | Access management | The processes for notifying system owners of staff changes should be well defined and communicated to stakeholders.Controls should be implemented to ensure access to CEC and NHS systems remain appropriate. This should include processes to ensure that changes are applied in a timely manner and access rights are regularly recertified. This would provide assurance to system owners over the operating effectiveness of these controls. | The existing processes within the Council and NHS Lothian for notifying system owners of staff changes will be communicated to all managers of integrated teams. Establishing an integrated system setting out the systems access requirements for all posts and the mechanism for gaining access for new staff and notifying system owners of leavers and changes in role will be a priority for the nominated officer to be identified in respect of ICT and Information Governance. | Started | May-17 | 30/09/2017 | 30/09/2018 | Draft project plan to be discussed at the next ICT Steering Group. Responses received from Survey Monkey questionnaire to staff in integrated team will define the project/workstream's scope.<br><br>To be discussed at the next Partnership Assurance Oversight Group via Exception Report. | Judith Proctor,Chief Officer | Partnership (Operations)<br>ICT (Council & NHS Lothian)<br>Information Governance (Council - Startegy and Insight & NHS Lothian)<br>Change Strategy (Strategy and Insight ) |
| Project Code: HSC1701 | | | | | | | | | | | | |
| Project Name: H&SC Care Homes - Corporate Report | | | | | | | | | | | | |
| Issue Title: A1.2: Gylemuir | | | | | | | | | | | | |
| Health & Social Care | 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. | A1.2(1) | 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 | Started<br>95% | Feb-18 | 28/02/2018 | IA Validation | Following IA validation, further evidence has been requested to close down this item. | Judith Proctor,Chief Officer | Partnership (Chief Nurse) |
| Health & Social Care | 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. | A1.2(5) | Clear guidance is required in relation to management and oversight of NHS team members employed at Gylemuir. This guidance should be developed and applied to all care homes where it is expected that NHS and CEC team members will work together in partnership. | The staffing model at Gylemuir house has been reviewed, a Senior Charge Nurse has been seconded in to support direct management and professional support of NHS staff while the recruiting process continues to identify a substantive Senior Charge Nurse. NHS staff continue to operate under NHS governance and are professionally accountable through the nursing line. It is expected that this post will be permanently filled by April 2018 Nursing staff remain under NHS terms and conditions. The Senior Charge Nurse is directly managed by the Care Home manager and professionally accountable to the professional lead in North West locality | Started<br>90% Completed | Feb-18 | 30/04/2018 | IA Validation | Staffing Model is now in place and operational in Gylemuir.<br><br>Following IA Validation, the handover document submitted as evidence was requested to include systems access details for NHS Lothian and Council staff. This work is being prioritised to close down this item. | Judith Proctor,Chief Officer | Partnership (Chief Nurse)<br>Partnership (Operations) |
| | 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. | A1.2(3) | A specific risk should be recorded in the Health and Social Care risk register reflecting the strategic risk associated with operation of the Gylemuir care home. | A new risk was added to the Edinburgh Integration Joint Board risk register in relation to Gylemuir. The H&SC risk register is in the process of being refreshed with specific locality risks being developed that will be recorded in Datex (NHS risk Management system). A specific risk for Gylemuir will be recorded in the relevant locality risk register and in the consolidated Health and Social Care risk register. | Started<br>99% Completed | Feb-18 | 28/02/2018 | 31/07/2018 | Gylemuir's Risk Register was developed and put in place in July.<br><br>The actual risk register was well received, however IA have asked for further assurances on how the Gylemuir's strategic risk will be made visible to the Partnership's Executive Team and also to specify ownership of a particular risk.<br><br>A meeting with the Chief Internal Audit Officer and Chief Nurse is to be arranged in October to discuss and agree residual actions to fully close off this item. | Judith Proctor,Chief Officer | Parnership (Chief Nurse)<br>Partnership (Operations) |
| Issue Title: A3.3: Performance & Attendance Management | | | | | | | | | | | | |

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| Health & Social Care | 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. | A3.3(1) Health & Social Care Teams | Care home managers should be trained in the new Performance Conversation framework. | Health and Social Care Teams Will ensure that performance conversation training has been attended by all H&SC line managers in Care Homes. | Started<br>99% Completed | Feb-18 | 30/06/2018 | | All 10 Care Homes Managers have completed their Performance Conversation Training. iTrent report request to HR Business Hub to confirm attendance and completion. | Judith Proctor,Chief Officer | Partnership (Operations)<br>HR (Resources) |
| Health & Social Care | 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. | A3.3(2) Health & Social Care Teams | Six monthly and annual performance conversations should be completed for all employees and the outcomes recorded on the iTrent human resources system. | Health and Social Care Teams Will ensure that annual performance conversations (once completed) are recorded on the iTrent system. | Started<br>90% Completed | Feb-18 | 30/06/2018 | | Assurance for annual performance conversations completion will be provided through the Care Home Self-Assurance Framework that is currently scheduled to be launched in early November 2018. Care HomeManagers will be prompted with the following question on a quarterly basis:<br><br>'Six monthly and annual performance conversations have been completed for all employees and the outcomes have been recorded on the iTrent human Resources system'. | Judith Proctor,Chief Officer | Partnership (Operations) |
| Health & Social Care | 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. | A3.3(4) Health & Social Care Teams | The iTrent system should be reviewed on a quarterly basis by business support managers to confirm that absences and performance conversations are completely and accurately recorded. | This is the responsibility of the Unit manager for their direct reports. The Business Support Officer will ensure that the Unit Manager is aware on a monthly basis for Domestics and Handymen reporting to them The Business Support Officer is required to monitor and report through the Customer process on a monthly basis. The staff nurse / charge nurse to be appointed at Gylemuir will ensure that this is performed for all NHS staff. | Started<br>90% Completed | Feb-18 | 30/06/2018 | | Assurances will be provided through the Care Home Self-Assurance Framework - scheduled for launch in early November 2018. | Judith Proctor,Chief Officer | Partnership (Operations)<br>Business Support (Resources) |
| Health & Social Care | 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. | A3.3(4) Gylemuir | The iTrent system should be reviewed on a quarterly basis by business support managers to confirm that absences and performance conversations are completely and accurately recorded. | This is the responsibility of the Unit manager for their direct reports. The Business Support Officer will ensure that the Unit Manager is aware on a monthly basis for Domestics and Handymen reporting to them The Business Support Officer is required to monitor and report through the Customer process on a monthly basis. The staff nurse / charge nurse to be appointed at Gylemuir will ensure that this is performed for all NHS staff. | Started<br>90% Completed | Feb-18 | 30/06/2018 | | Assurances will be provided through the Care Home Self-Assurance Framework - scheduled for launch in early November 2018. | Judith Proctor,Chief Officer | Partnership (Operations)<br>Business Support (Resources) |
| Project Code: HSC1715 | | | | | | | | | | | | |
| Project Name: Edinburgh Alcohol and Drug Partnership (EADP) – Contract Management | | | | | | | | | | | | |
| Issue Title: Key Person Dependency and Process Documentation | | | | | | | | | | | | |
| Health & Social Care | Medium | Management of the two Treatment Services and Counselling contracts is performed by two key EADP partnership team members - the Joint Programme Manager and the Commissioning Manager; who have specialised contract and budget management knowledge specific to these contracts. The Joint Programme Manager has left the Council in October 2017. It is understood that the Commissioning Manager will assume some of the Joint Programme Manager's responsibilities. with a more senior manager providing overview.Our review of the existing contract management process established that the current contract management process has not been documented and that existing contract management documentation is not maintained in line with the requirements of the Council's Records Management Policy. Specifically: There are no documented operational procedures supporting the current contract management process. There is no established escalation process for reporting supplier performance issues. There is no list of key supplier contacts. Evidence supporting the current contract monitoring process (including emails) is retained on a server, however, documents are not stored in a format consistent with the Council's Records Management policy, including retention and disposal of records as per prescribed policy requirements. It is understood that an Administrator previously dealt with the administration of contract monitoring documents including adherence to timescales for receipt and review of third party quarterly returns This resource has now been removed from the team as part of the Council's transformation programme. | Rec 3 - Document of Escalation Process | The escalation process referred to within the "Risk and Supplier Performance Management issue (recommendation 2)" should be documented within the new contract management processes. | The existing contract management procedures will be summarised in a single document. It will include the dates information needs to come in, the key contacts, the escalation process in the event of non-performance and the priority metrics that would trigger those processes (waiting times, numbers taken onto caseloads, planned discharges). There will still be subject knowledge and judgement involved in monitoring the contracts; the escalation process cannot be reduced to an algorithm. To be agreed with the providers to confirm our shared understanding and shared with the EADP core group by January 2018. | Pending | Nov-17 | 31/01/2018 | 30/06/2018 | IA Ongoing Validation meeting held with EADP Officer and IA on 18 October 2018. Additional information has been requested to supplement the EADP Contract Framework Document. This will be reviewed with a Partnership Contract Officer as a priority. | Judith Proctor,Chief Officer | Partnership (Strategic)<br>Partnership (Finance)<br>Partnership (Operations) |

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| Health & Social Care | Medium | Management of the two Treatment Services and Counselling contracts is performed by two key EADP partnership team members - the Joint Programme Manager and the Commissioning Manager; who have specialised contract and budget management knowledge specific to these contracts. The Joint Programme Manager has left the Council in October 2017. It is understood that the Commissioning Manager will assume some of the Joint Programme Manager's responsibilities. with a more senior manager providing overview.Our review of the existing contract management process established that the current contract management process has not been documented and that existing contract management documentation is not maintained in line with the requirements of the Council's Records Management Policy. Specifically: There are no documented operational procedures supporting the current contract management process. There is no established escalation process for reporting supplier performance issues. There is no list of key supplier contacts. Evidence supporting the current contract monitoring process (including emails) is retained on a server, however, documents are not stored in a format consistent with the Council's Records Management policy, including retention and disposal of records as per prescribed policy requirements. It is understood that an Administrator previously dealt with the administration of contract monitoring documents including adherence to timescales for receipt and review of third party quarterly returns This resource has now been removed from the team as part of the Council's transformation programme. | Rec 4 - Key Supplier Contracts | A list of key supplier contacts for each of the individual contracts should be prepared and maintained. | The existing contract management procedures will be summarised in a single document. It will include the dates information needs to come in, the key contacts, the escalation process in the event of non-performance and the priority metrics that would trigger those processes (waiting times, numbers taken onto caseloads, planned discharges). There will still be subject knowledge and judgement involved in monitoring the contracts; the escalation process cannot be reduced to an algorithm. To be agreed with the providers to confirm our shared understanding and shared with the EADP core group by January 2018. | Pending | Nov-17 | 31/01/2018 | 30/06/2018 | IA Ongoing Validation meeting held with EADP Officer and IA on 18 October 2018. Additional information has been requested to supplement the EADP Contract Framework Document. This will be reviewed with a Partnership Contract Officer as a priority. | Judith Proctor,Chief Officer | Partnership (Strategic)<br>Partnership (Finance)<br>Partnership (Operations) |
| Health & Social Care | Medium | Management of the two Treatment Services and Counselling contracts is performed by two key EADP partnership team members - the Joint Programme Manager and the Commissioning Manager; who have specialised contract and budget management knowledge specific to these contracts. The Joint Programme Manager has left the Council in October 2017. It is understood that the Commissioning Manager will assume some of the Joint Programme Manager's responsibilities. with a more senior manager providing overview.Our review of the existing contract management process established that the current contract management process has not been documented and that existing contract management documentation is not maintained in line with the requirements of the Council's Records Management Policy. Specifically: There are no documented operational procedures supporting the current contract management process. There is no established escalation process for reporting supplier performance issues. There is no list of key supplier contacts. Evidence supporting the current contract monitoring process (including emails) is retained on a server, however, documents are not stored in a format consistent with the Council's Records Management policy, including retention and disposal of records as per prescribed policy requirements. It is understood that an Administrator previously dealt with the administration of contract monitoring documents including adherence to timescales for receipt and review of third party quarterly returns This resource has now been removed from the team as part of the Council's transformation programme. | Rec 5 - Records Management Policy | To ensure ongoing compliance with the Council's Records Management policy, a process should be established specifying the contract management records and information to be retained; detailing, where the information should be stored and specifying dates for archiving and disposal. | Records retention policy: Direction will be requested from the Information Governance team in relation to Records Management Policy requirements and how they should be applied to retention, archiving and destruction of contract management information. Any lessons learned will be shared with the Health and Social Care contracts management team. | Pending | Nov-17 | 30/03/2018 | 30/06/2018 | IA Ongoing Validation meeting held with EADP Officer and IA on 18 October 2018. Additional information has been requested to supplement the EADP Contract Framework Document. This will be reviewed with a Partnership Contract Officer as a priority. | Judith Proctor,Chief Officer | Partnership (Finance) |
| Health & Social Care | Medium | Management of the two Treatment Services and Counselling contracts is performed by two key EADP partnership team members - the Joint Programme Manager and the Commissioning Manager; who have specialised contract and budget management knowledge specific to these contracts. The Joint Programme Manager has left the Council in October 2017. It is understood that the Commissioning Manager will assume some of the Joint Programme Manager's responsibilities. with a more senior manager providing overview.Our review of the existing contract management process established that the current contract management process has not been documented and that existing contract management documentation is not maintained in line with the requirements of the Council's Records Management Policy. Specifically: There are no documented operational procedures supporting the current contract management process. There is no established escalation process for reporting supplier performance issues. There is no list of key supplier contacts. Evidence supporting the current contract monitoring process (including emails) is retained on a server, however, documents are not stored in a format consistent with the Council's Records Management policy, including retention and disposal of records as per prescribed policy requirements. It is understood that an Administrator previously dealt with the administration of contract monitoring documents including adherence to timescales for receipt and review of third party quarterly returns This resource has now been removed from the team as part of the Council's transformation programme. | Rec 2 - Contract Management Processes | Contract management processes should be documented. | The existing contract management procedures will be summarised in a single document. It will include the dates information needs to come in, the key contacts, the escalation process in the event of non-performance and the priority metrics that would trigger those processes (waiting times, numbers taken onto caseloads, planned discharges). There will still be subject knowledge and judgement involved in monitoring the contracts; the escalation process cannot be reduced to an algorithm. To be agreed with the providers to confirm our shared understanding and shared with the EADP core group by January 2018. | Started | Nov-17 | 31/01/2018 | 30/06/2018 | IA Ongoing Validation meeting held with EADP Officer and IA on 18 October 2018. Additional information has been requested to supplement the EADP Contract Framework Document. This will be reviewed with a Partnership Contract Officer as a priority. | Judith Proctor,Chief Officer | Partnership (Operations) |
| Issue Title: Risk and Supplier Performance Management | | | | | | | | | | | | |

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| Health & Social Care | High | Risk Management Risks associated with contract management and supplier performance have not been recorded and there is no evidence to confirm that risks are being managed or reported to relevant governance forums. Two risks have already crystallised: Supplier Sustainability - in June 2017, one third party provider went into administration and the Council were unaware of this until the provider advised the Joint Programme Manager a few days before. Whilst no issues occurred in this instance as services were transferred to a new provider via a TUPE agreement by the existing supplier, this risk was not documented and was not identified via ongoing contract management. Key Person Dependency - The Joint Programme Manager has left the Council in October 2017 and no contingent resource has been established to fulfil this role.Supplier Performance Management Whilst we have been advised that third party supplier performance is mostly outcomes based, there are a number of expectations and success measures included in the contract specification documentation supporting the contracts. We identified one service specification included within the Adult Treatment Services contract that was not delivered in a timely manner or appropriately escalated when not delivered. This related to the requirement for provision of an NHS nurse to support training for staff on 'dried blood spot testing'. This training was not provided until almost the end of the first year of the contract due to lack of NHS funding, and could have significantly impacted on service delivery and customer experience. This service issue occurred due to lack of a clear escalation process to ensure that supplier performance issues are identified and resolved in a timely manner. We also established that: Success measures included in the contract specification documentation are not prioritised or ranked in terms of service delivery importance, The contract specification includes the requirement for receipt of quarterly supplier returns, however, submission dates have not been specified, and There is no independent validation of management information supporting success measures provided by 3rd parties. | Rec 1 - Risk Management | Risk management and reporting should be established with quarterly reviews of risk registers performed to identify and prioritise all new and emerging risks, determine actions required and allocate ownership. Risk registers should also be reviewed and approved by relevant committees / governance forums. | A contracts management risk register will be developed describing, prioritising, and addressing risks to delivery. The risk register will be shared with and approved by the Core group by January 2018. The risk register will be refreshed quarterly and reviewed by the Core Group. | Pending | Nov-17 | 30/03/2018 | 30/06/2018 | IA Ongoing Validation meeting held with EADP Officer and IA on 18 October 2018. Governance clarity is being sought on the EADP Contract's risk register. Report to be drafted for discussion with Chief Officer's Executive Team, the Council's Chief Risk Officer and IJB Audit and Risk Committee. | Judith Proctor,Chief Officer | Partnership (Strategic)<br>Partnership (Finance)<br>Risk (Resources)<br>Partnership (Operations) |
| Health & Social Care | High | Risk Management Risks associated with contract management and supplier performance have not been recorded and there is no evidence to confirm that risks are being managed or reported to relevant governance forums. Two risks have already crystallised: Supplier Sustainability - in June 2017, one third party provider went into administration and the Council were unaware of this until the provider advised the Joint Programme Manager a few days before. Whilst no issues occurred in this instance as services were transferred to a new provider via a TUPE agreement by the existing supplier, this risk was not documented and was not identified via ongoing contract management. Key Person Dependency - The Joint Programme Manager has left the Council in October 2017 and no contingent resource has been established to fulfil this role.Supplier Performance Management Whilst we have been advised that third party supplier performance is mostly outcomes based, there are a number of expectations and success measures included in the contract specification documentation supporting the contracts. We identified one service specification included within the Adult Treatment Services contract that was not delivered in a timely manner or appropriately escalated when not delivered. This related to the requirement for provision of an NHS nurse to support training for staff on 'dried blood spot testing'. This training was not provided until almost the end of the first year of the contract due to lack of NHS funding, and could have significantly impacted on service delivery and customer experience. This service issue occurred due to lack of a clear escalation process to ensure that supplier performance issues are identified and resolved in a timely manner. We also established that: Success measures included in the contract specification documentation are not prioritised or ranked in terms of service delivery importance, The contract specification includes the requirement for receipt of quarterly supplier returns, however, submission dates have not been specified, and There is no independent validation of management information supporting success measures provided by 3rd parties. | Rec 2 - Escalation Process | An escalation process should be established and agreed with third party suppliers and appropriate committees / governance forums (such as the Core Group) to ensure that all significant supplier performance management issues are identified and resolved. This will include specification of thresholds to raise an issue, and a process to ensure that all issues are communicated to suppliers and resolution monitored. | The existing contract management procedures will be summarised in a single document. It will include the dates information needs to come in, the key contacts, the escalation process in the event of non-performance and the priority metrics that would trigger those processes (waiting times, numbers taken onto caseloads, planned discharges). There will still be subject knowledge and judgement involved in monitoring the contracts; the escalation process cannot be reduced to an algorithm. To be agreed with the providers to confirm our shared understanding and shared with the EADP core group by January 2018. | Pending | Nov-17 | 31/01/2018 | 30/06/2018 | IA Ongoing Validation meeting held with EADP Officer and IA on 18 October 2018. Additional information has been requested to supplement the EADP Contract Framework Document. This will be reviewed with a Partnership Contract Officer as a priority. | Judith Proctor,Chief Officer | Partnership (Strategic)<br>Partnership (Finance)<br>Partnership (Operations) |
| Health & Social Care | High | Risk Management Risks associated with contract management and supplier performance have not been recorded and there is no evidence to confirm that risks are being managed or reported to relevant governance forums. Two risks have already crystallised: Supplier Sustainability - in June 2017, one third party provider went into administration and the Council were unaware of this until the provider advised the Joint Programme Manager a few days before. Whilst no issues occurred in this instance as services were transferred to a new provider via a TUPE agreement by the existing supplier, this risk was not documented and was not identified via ongoing contract management. Key Person Dependency - The Joint Programme Manager has left the Council in October 2017 and no contingent resource has been established to fulfil this role.Supplier Performance Management Whilst we have been advised that third party supplier performance is mostly outcomes based, there are a number of expectations and success measures included in the contract specification documentation supporting the contracts. We identified one service specification included within the Adult Treatment Services contract that was not delivered in a timely manner or appropriately escalated when not delivered. This related to the requirement for provision of an NHS nurse to support training for staff on 'dried blood spot testing'. This training was not provided until almost the end of the first year of the contract due to lack of NHS funding, and could have significantly impacted on service delivery and customer experience. This service issue occurred due to lack of a clear escalation process to ensure that supplier performance issues are identified and resolved in a timely manner. We also established that: Success measures included in the contract specification documentation are not prioritised or ranked in terms of service delivery importance, The contract specification includes the requirement for receipt of quarterly supplier returns, however, | Rec 3 - Performance Expectations | Supplier performance expectations should be prioritised and communicated and agreed with third party suppliers. | The existing contract management procedures will be summarised in a single document. It will include the dates information needs to come in, the key contacts, the escalation process in the event of non-performance and the priority metrics that would trigger those processes (waiting times, numbers taken onto caseloads, planned discharges). There will still be subject knowledge and judgement involved in monitoring the contracts; the escalation process cannot be reduced to an algorithm. To be agreed with the providers to confirm our shared understanding and shared with the EADP core group by January 2018. | Pending | Nov-17 | 31/01/2018 | 30/06/2018 | IA Ongoing Validation meeting held with EADP Officer and IA on 18 October 2018. Additional information has been requested to supplement the EADP Contract Framework Document. This will be reviewed with a Partnership Contract Officer as a priority. | Judith Proctor,Chief Officer | Partnership (Strategic)<br>Partnership (Finance)<br>Partnership (Operations) |

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| | | the requirement for receipt of quarterly supplier returns, however, submission dates have not been specified, and There is no independent validation of management information supporting success measures provided by 3rd parties. | | | | | | | | | | |
| Health & Social Care | High | Risk Management Risks associated with contract management and supplier performance have not been recorded and there is no evidence to confirm that risks are being managed or reported to relevant governance forums. Two risks have already crystallised: Supplier Sustainability - in June 2017, one third party provider went into administration and the Council were unaware of this until the provider advised the Joint Programme Manager a few days before. Whilst no issues occurred in this instance as services were transferred to a new provider via a TUPE agreement by the existing supplier, this risk was not documented and was not identified via ongoing contract management. Key Person Dependency - The Joint Programme Manager has left the Council in October 2017 and no contingent resource has been established to fulfil this role.Supplier Performance Management Whilst we have been advised that third party supplier performance is mostly outcomes based, there are a number of expectations and success measures included in the contract specification documentation supporting the contracts. We identified one service specification included within the Adult Treatment Services contract that was not delivered in a timely manner or appropriately escalated when not delivered. This related to the requirement for provision of an NHS nurse to support training for staff on 'dried blood spot testing'. This training was not provided until almost the end of the first year of the contract due to lack of NHS funding, and could have significantly impacted on service delivery and customer experience. This service issue occurred due to lack of a clear escalation process to ensure that supplier performance issues are identified and resolved in a timely manner. We also established that: Success measures included in the contract specification documentation are not prioritised or ranked in terms of service delivery importance, The contract specification includes the requirement for receipt of quarterly supplier returns, however, submission dates have not been specified, and There is no independent validation of management information supporting success measures provided by 3rd parties. | Rec 4 - Timeframes | Timeframes for receipt of quarterly supplier returns should be established and agreed with third party suppliers. | The existing contract management procedures will be summarised in a single document. It will include the dates information needs to come in, the key contacts, the escalation process in the event of non-performance and the priority metrics that would trigger those processes (waiting times, numbers taken onto caseloads, planned discharges). There will still be subject knowledge and judgement involved in monitoring the contracts; the escalation process cannot be reduced to an algorithm. To be agreed with the providers to confirm our shared understanding and shared with the EADP core group by January 2018. | Pending | Nov-17 | 31/01/2018 | 30/06/2018 | IA Ongoing Validation meeting held with EADP Officer and IA on 18 October 2018. Additional information has been requested to supplement the EADP Contract Framework Document. This will be reviewed with a Partnership Contract Officer as a priority. | Judith Proctor,Chief Officer | Partnership (Strategic)<br>Partnership (Finance)<br>Partnership (Operations) |
| Health & Social Care | High | Risk Management Risks associated with contract management and supplier performance have not been recorded and there is no evidence to confirm that risks are being managed or reported to relevant governance forums. Two risks have already crystallised: Supplier Sustainability - in June 2017, one third party provider went into administration and the Council were unaware of this until the provider advised the Joint Programme Manager a few days before. Whilst no issues occurred in this instance as services were transferred to a new provider via a TUPE agreement by the existing supplier, this risk was not documented and was not identified via ongoing contract management. Key Person Dependency - The Joint Programme Manager has left the Council in October 2017 and no contingent resource has been established to fulfil this role.Supplier Performance Management Whilst we have been advised that third party supplier performance is mostly outcomes based, there are a number of expectations and success measures included in the contract specification documentation supporting the contracts. We identified one service specification included within the Adult Treatment Services contract that was not delivered in a timely manner or appropriately escalated when not delivered. This related to the requirement for provision of an NHS nurse to support training for staff on 'dried blood spot testing'. This training was not provided until almost the end of the first year of the contract due to lack of NHS funding, and could have significantly impacted on service delivery and customer experience. This service issue occurred due to lack of a clear escalation process to ensure that supplier performance issues are identified and resolved in a timely manner. We also established that: Success measures included in the contract specification documentation are not prioritised or ranked in terms of service delivery importance, The contract specification includes the requirement for receipt of quarterly supplier returns, however, submission dates have not been specified, and There is no independent validation of management information supporting success measures provided by 3rd parties. | Rec 5 - Independent Validation | Management should consider whether independent validation of 3rd party management information should be performed (perhaps on a sample basis). If validation is implemented, the process applied and the outcomes should be documented. If validation is not implemented, risk of receipt of inaccurate supplier information should be recorded in the relevant risk register. | The Health and Social Care quality assurance team will be approached to discuss the potential for an annual audit review that may reduce our dependence on provider generated data. They will provide an options paper to the Core group by January 2018 confirming whether this is possible. Implementation Date 31.01.2018. If the QA team can support completion of an annual review, the first annual review will be performed by June 2018. If this is not possible, management will accept this risk on the basis that there is insufficient resource capacity within the contract management team. Implementation Date 29.06.2018. | Pending | Nov-17 | 31/01/2018 | | IA Ongoing Validation meeting held with EADP Officer and IA on 18 October 2018. Additional information has been requested to supplement the EADP Contract Framework Document. This will be reviewed with a Partnership Contract Officer as a priority. | Judith Proctor,Chief Officer | Partnership (Strategic)<br>Partnership (Finance)<br>Partnership (Operations) |
| Issue Title: Supplier Sustainability | | | | | | | | | | | | |
| Health & Social Care | Medium | No reviews are currently performed to confirm ongoing sustainability of 3rd party service providers. In June 2017, one third party provider went into administration and the EADP team were unaware of this until the provider advised the Joint Programme Manager a few days before. It is noted that no issues occurred in this instance as services were transferred to a new provider via a TUPE agreement by the existing supplier.The risk of Supplier Sustainability was not recorded on any risk register to manage the risk of loss of service provision due to loss of provider. | Rec 1- Supplier Sustainability Risk | A Supplier Sustainability risk should be recorded on the appropriate risk register. | A supplier sustainability risk will be recorded in the risk register to be developed by March and implemented by March 2018 | Pending | Nov-17 | 30/03/2018 | 30/06/2018 | IA Ongoing Validation meeting held with EADP Officer and IA on 18 October 2018. Governance clarity is being sought on the EADP Contract's risk register. Report to be drafted for discussion with Chief Officer's Executive Team, the Council's Chief Risk Officer and IJB Audit and Risk Committee. | Judith Proctor,Chief Officer | Partnership (Strategic)<br>Partnership (Finance)<br>Risk (Resources)<br>Partnership (Operations) |

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| Health & Social Care | Medium | No reviews are currently performed to confirm ongoing sustainability of 3rd party service providers. In June 2017, one third party provider went into administration and the EADP team were unaware of this until the provider advised the Joint Programme Manager a few days before. It is noted that no issues occurred in this instance as services were transferred to a new provider via a TUPE agreement by the existing supplier.The risk of Supplier Sustainability was not recorded on any risk register to manage the risk of loss of service provision due to loss of provider. | Rec 2 - Contingency Plans | Contingency plans for ongoing emergency Service Provision should be prepared to ensure ongoing Service Provision in the event of supplier failure. Any involvement required form existing suppliers should be discussed and agreed with them, and the plans documented and approved by the Core Group | Contingency plans will be developed, discussed with existing suppliers, and approved by the Core Group. | Pending | Nov-17 | 31/01/2018 | | IA Ongoing Validation meeting held with EADP Officer and IA on 18 October 2018. Additional information has been requested to supplement the EADP Contract Framework Document. This will be reviewed with a Partnership Contract Officer as a priority. | Judith Proctor,Chief Officer | Partnership (Strategic)<br>Partnership (Finance)<br>Partnership (Operations) |
| Project Code: SW1601 | | | | | | | | | | | | |
| Project Name: Social Work: Pre-Employment Verification | | | | | | | | | | | | |
| Issue Title: Recruitment of Existing Employees | | | | | | | | | | | | |
| Health & Social Care | Medium | There was insufficientevidence to support the PVG checks of three nominated candidates who were 'existing Council employees'. The original PVG certificate is destroyed at the initial point of employment. Therefore recruiting managers of nominated candidates, who are existing employees, may not be aware of the 'vetting information' included in the original PVG Check. This restricts managers' ability to make an informed decision to proceed with the employment. It should be noted that Scheme Record Updates (which carry out a check between the original PVG Certificated issued; to the date of the requested update) do not include details of any 'vetting information' held within the original certificate. The current "Recruitment and Selection Guidance for Managers Pre-Employment Checks for Nominated Candidates" states that "no further check is required if the individual is a PVG Scheme member in the Council for the same type of 'regulated work'. There is potential for staff to be recruited to a role which is not appropriate given their previous convictions. For example; a person with fraud convictions may properly be recruited to a care home if they are not handling cash but a future appointment to the homecare service; with access to vulnerable people's funds may be approved without due consideration of the risk.In October 2016 a carer in East Lothian was convicted of Fraud amounting to £46,000 from two clients. | Recruitment of Existing Employees | All nominated candidates should be requested to bring their copy of the PVG certificate to the pre-employment checks meeting; in order to allow mangers to make an informed decision as to whether to proceed with the recruitment process or to rescind the offer. | Locality Managers to obtain confirmation from their recruiting managers that nominated candidates are being requested to bring their PVG certificate to the pre-employment checks meeting. This requirement has been effectively communicated to all relevant managers / staff and a mechanism will be introduced to ensure that the requirement is being adhered too. This procedure will be embedded within the HSC and Safer & Stronger Communities protocol. | Pending | Jan-17 | 31/03/2017 | 30/04/2018 | Following a discussion with the Chief Officer, a briefing report summarising the risk finding, current recruitment process, HR position/policy and other departmental inputs will be shared for discussion at an upcoming Partnership Executive Team meeting. | Judith Proctor,Chief Officer | Partnership (Operations) |