Governance, Risk and Best Value

10am, Tuesday 13 August 2019

Edinburgh Health and Social Care Partnership Annual Assurance Statement

Executive/routine
Wards
Council Commitments

1. Recommendations

It is recommended that Governance, Risk and Best Value Committee:

1.1 note the annual assurance statement for 2017/18

1.2 note the areas where the Partnership is partially compliant and note the actions taken within appendix 2 to strengthen the controls to ensure compliance for the 2018/19 assurance statement.

Judith Proctor

Chief Officer – Edinburgh Health and Social Care Partnership

Contact: Angela Ritchie, Senior Executive Assistant

E-mail: angela.ritchie@edinburgh.gov.uk | Tel: 0131 529 4050

Report

Edinburgh Health and Social Care Partnership Annual Assurance Statement

2. Executive Summary

2.1 The purpose of this report is to present the annual assurance schedule covering 17/18 for the Edinburgh Health and Social Care Partnership (the Partnership) to Governance Risk and Best Value Committee for scrutiny. The report also highlights areas where controls need to be enhanced.

3. Background

3.1 Every year, the Council requires all Executive Directors and the Chief Officer to review the effectiveness and appropriateness on controls within their areas of responsibility and complete a certificate of assurance. The certificate of assurance supports the drafting of the Council's annual governance statement which is a part of the Council's statement of accounts.

3.2 To support the Executive Directors and Chief Officer review their control environment, annual assurance statements are sent out which cover the following areas: risk and resilience, policy, governance and compliance, information governance, health and safety, performance, contract management, financial control, inspection reports and internal audit.

3.3 The Partnership was created by the City of Edinburgh Council and NHS Lothian as the vehicle for delivering services delegated to the Edinburgh Integration Joint Board (EIJB) and further information on the governance relationship between the EIJB and the Council is included as background reading.

3.4 Although staff remain employed by the Council or NHS Lothian, they work in an integrated organisational structure. The budget allocated to the Partnership is approximately £600 million and almost 6000 staff deliver the following services:

- social work services for adults, including disabilities, mental health, older people, sensory impairment and substance misuse
- support for carers
- primary care services including GP's and community nursing

- allied health professionals, such as occupational therapists, psychologists and physiotherapists
- community dental, ophthalmic and pharmaceutical services
- continence services
- unplanned admissions to hospitals.

4. Main report

4.1 The certificate of assurance requires Heads of Service, Executive Directors and Chief Officer to confirm that:

- They have considered the effectiveness of controls in their service area / directorate, including controls in place to mitigate major risks to their service area / directorate's objectives.
- To the best of their knowledge, appropriate controls are in operation upon which they can place reasonable assurance and that there are no significant matters arising that should be raised specifically in the Annual Governance Statement (or otherwise): and
- They have identified actions that will be taken to continue improvement

4.2 A completed annual assurance statement was completed by each Head of Service within the Partnership.

4.3 This was then taken as the basis of the Chief Officers assurance statement which is attached as appendix 1. The Chief's Officers assurance statement was returned to the Governance Team within Strategy and Insight for review and subsequently the Chief Officer is asked to sign a certificate of assurance. The Partnership's assurance statement along with the other directorate assurance statements were used to draft the Council's annual governance statement as part of the Unaudited Annual Accounts on 28 June 2018.

4.4 As part of the completion of the assurance statement, the Partnership felt that there was partial compliance in the following areas:

- Risk Management
- Health and Safety (in terms of reporting and recording of accidents and incidents and risk assessments)
- Contract management (in terms of named contract managers and management contractual changes)
- Change and Project Management

4.5 On 31 July 2018, the Chief Internal Auditor as part of her annual opinion reported that there were control weaknesses ending 31 March 2018. The Governance, Risk and Best Value therefore asked for an action plan from each directorate indicating how controls will be strengthened. On 7 August 2018, Corporate Policy and

Strategy Committee also considered the Internal Audit Opinion and called for an update report on Directorate actions to strengthen controls including the timescales for implementation.

4.6 Attached at appendix 2 is an action plan highlighting what additional control have or will be in place to strengthen controls in key areas.

5. Next Steps

5.1 The Partnership is working to deliver the actions noted within appendix 2 to strengthen controls in key areas.

6. Financial impact

6.1 The annual assurance process and production of the annual governance statement is contained within relevant service area budgets.

7. Stakeholder/Community Impact

7.1 The annual assurance schedule is an activity concerned with internal controls and does not require consultation or external engagement.

8. Background reading/external references

https://democracy.edinburgh.gov.uk/Data/Governance,%20Risk%20and%20Best%20Value%20Committee/20190319/Agenda/item_710_-_the_governance_relationship_between_the_council_and_the_eijbpdf.pdf

9. Appendices

Appendix 1 Annual Assurance Statement – Edinburgh Health and Social Care Partnership

Appendix 2 Action Plan – Edinburgh Health and Social Care Partnership

Appendix 1

Executive Director's Schedule to Support Evidence of Assurance for the Annual Governance Statement

For the year end 31 March 2018

Directorate	Edinburgh Health and Social Care Partnership				
Completed by	**Angela Ritchie**	**Job title**	Senior Executive Assistant	**Date completed**	23.04.18
Signed off by	**Michelle Miller**	**Job title**	Interim Chief Officer		
Print name of signatory		**Date of signature**	23.04.18		

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Introduction
The Statement of Accounts 2017/2018 includes the Annual Governance Statement signed by the Council Leader, the Chief Executive and the Head of Finance. The Annual Governance Statement is supported by Certificates of Assurance from each of the Executive Directors.

The Certificates of Assurance require Executive Directors to confirm that:

1. they have considered the effectiveness of controls in their directorates, including controls in place to mitigate major risks to their directorate's objectives;
2. to the best of their knowledge, appropriate controls are in operation upon which they can place reasonable assurance and that there are no significant matters arising that should be raised specifically in the Annual Governance Statement (or otherwise); and
3. they have identified actions that will be taken to continue improvement.

Completing this schedule helps prompt Executive Directors to consider various aspects of their control environment before signing their Certificate of Assurance. Executive Directors should seek assurance through issue of a similar schedule to their Heads of Service to satisfy themselves that effective controls are in place across all service areas.

This schedule should be used as a prompt to think about good governance and the internal control environment and is not an exhaustive list.

Guidance on completing the schedule
The schedule should be completed by the Executive Director or by a nominated senior manager (suggested managers to provide information and/or responses are highlighted below). Additional guidance notes are provided throughout the document.

Before signing the Certificate of Assurance Executive Directors should ensure that this schedule has been completed accurately. Please note that although evidence does not need to be attached to the completed schedule, accurate reference should be made to any supporting evidence because **responses made in the schedule may be subject to audit at a later date.**

Your assessment should consider how your directorate's arrangements would stand up to external scrutiny. When completing the schedule please include your assessment of the directorate's compliance and, if your assessment is partially or not compliant, please note planned improvement actions in the relevant column.

Please return your completed schedule to governance@edinburgh.gov.uk no later than **Friday 27 April 2018**.

Section	Requirements	Supporting officers
Section 1	Internal Control Environment	Head of Service
Section 2	Risk and Resilience	Service Area Risk Committee Representative/Resilience Co-ordinator
Section 3	Workforce Controls	Head of Service
Section 4	Council Companies	Senior Relationship Lead / Company Observer(s)
Section 5	Policy	Head of Service
Section 6	Governance and Compliance	Head of Service
Section 7	Information Governance	Directorate Record Officers
Section 8	Health & Safety	SMT Health & Safety Lead
Section 9	Performance	Head of Service
Section 10	Commercial and Contract Management	Head of Service
Section 11	Change and Projects	Head of Service
Section 12	Financial Control	Service Area Financial Manager or Representative
Section 13	Group Accounts	RESOURCES only
Section 14	National Agency Inspection Reports	Head of Service
Section 15	Internal Audit, External Audit & Review Reports	Head of Service
Section 16	Progress	Executive Director

For further information or assistance please contact:

Gavin King
Democracy, Governance and Resilience Senior Manager
Strategy & Insight
529 4239 or gavin.king@edinburgh.gov.uk

Laura Callender
Governance Compliance Manager
Strategy & Insight
529 3655 or laura.callender@edinburgh.gov.uk

1	Internal Control Environment requirements	Guidance notes	Response and reference to evidence	Assessment	Improvement actions
1.1	You must have internal controls and procedures in place throughout your directorate that are proportionate, robust, monitored and operate effectively.	Please describe and/or give examples of the controls and procedures that you have in place and how these are monitored, tested, and reported.	Internal controls are in place across Edinburgh Health and Social Care Partnership (EHSCP) that are robust, proportionate, monitored and operating effectively. Examples of controls in place are set out below: **Financial Monitoring** Budget is a standing item on the monthly EHSCP meeting, with the Chief Finance Officer and the relevant financial Business partners both the Council and NHS Lothian in attendance. Financial reports are scrutinised to identify variances, risks, pressures and to ensure adequate controls are in place and any necessary remedial action is taken. There is a regular savings governance group chaired by the Chief Finance Officer, that has representation from all areas of the Partnership. The group has a focus on savings delivery. Regular meetings are held between senior managers and finance officers on the budget. **Performance Management** Performance is a standing item on the monthly EHSCP management team and performance is considered by the senior management team across the Partnership in a variety of arenas (e.g. Delayed Discharge meetings).	Compliant	

			Performance is also scrutinised by officers, elected members, and external stakeholders at a range of Council and NHS Committees (Edinburgh Integration Joint Board, Governance, Risk and Best Value). There is also statutory performance reporting to regulatory bodies, including the Care Inspectorate for matters relating to registered services. **<u>Procurement Monitoring</u>** An EHSCP Procurement Board, including representation from procurement services and relevant service areas has been set up to manage procurement activity across the Partnership in a coherent and joined up way. Service areas engage with the procurement team regularly. Contract management arrangements for commissioned services are in place and monitored regularly. **<u>Internal Audit</u>** 11 internal audits have been carried out across the EHSCP in 17/18. All open and outstanding findings are monitored by the Partnership's Operations Manager through monthly update reporting. Action owners are asked to demonstrate progress on their open items and any evidence (for action/ closure) is quality checked prior to submission. Frequent and informal meetings between action owners and internal auditors have been useful in		

			keeping track on progress. **Risk Management** A risk management governance structure has been established. Divisional and service area risk registers are being developed. **Health and Safety** The Health and Safety Group has been established with a cross section of staff from the Partnership, led by the Hospital and Hosted Services Manager. **Policies and Procedures** Service area policies and procedures are in place and updated on a regular basis (e.g. annually or whenever there is a relevant policy change) and reported to elected members as appropriate. Policies and procedures are held on a corporate policy / procedure register. A quality assurance framework is in place for all social work services, which include regular case file audits, practice evaluation and self-evaluation activity.		

1.2	You must have controls and procedures in place to manage the risks in delivering services through council companies, partners and third parties.	Please describe and/or give examples of the controls and procedures that you have in place and how these are monitored, tested and reported.	Controls and procedures are in place to manage risk in delivering services through Council companies, partners and third agencies. Grants have been approved by the relevant Council Committee and a monitoring regime is in place. A grants register is in place to manage Council grants and allows for co-ordination of grant funding decisions. Commissioning strategies are in place for a range of external suppliers and third sector organisations. As part of the commissioning of these services, they are expected to deliver against performance or outcome targets. All procurement is compliant with the Council's Contract Standing Orders and European Regulations. Where it is identified that commissioned organisations have received complaints regarding service quality or reputational issues, this is noted on the contracts risk register and effectively monitored to resolve any concerns. There are regular meetings to address performance issues for services delivered through contracts or grants on behalf of the Council. One example is the multi-agency quality assurance group, which identifies, and remedies concerns regarding the quality of care offered by individual provider organisations. A Care Service Feedback procedure is also used to extend the gathering of information about the quality of care services.	Compliant	

1.3	Your internal controls and procedures and their effectiveness must be reviewed regularly.	Please describe how these are reviewed, by whom and how often.	All internal controls and procedures and their effectiveness are reviewed regularly. The effectiveness of services delivered under contract or via grants funding is considered by divisional teams or more frequently, if risks have been identified. Any contract issues are escalated to the Senior Management Team or the Procurement Board. EHSCP financial position, Health and Safety, improvement activity, inspection or audit findings are discussed and scrutinised monthly. There are also several workstreams managed through their own governance arrangements (e.g. programme co-ordination meetings, Health and Safety Group, Senior Management Team meetings).	Partially compliant	
1.4	Did the last review of your internal control environment identify any weaknesses that could have an impact on the Annual Accounts?	Please include the date of the last review, whether any weaknesses were identified and, if so, how these have been or will be addressed.	There were no weaknesses identified at the last review.	No	
1.5	Has the monitoring process applied to funding/operating agreements identified any problems that could have an impact on Annual or Group Accounts?	Please describe the arrangements you have in place, including an overview of the monitoring process and frequency of reporting, and summarise any problems that have been identified.	There is regular financial scrutiny between the Finance team and the Partnership service areas. Budgets are also scrutinised at the monthly management team, to identify and mitigate the risk of any material variances impacting on the annual or group accounts.	No	

2 Risk and Resilience requirements		Guidance notes	Response and reference to evidence	Assessment	Improvement actions
2.1	Your risk management arrangements should identify the key risks to your directorate (and the Council) including those arising from: 1. Change (e.g. structural, service delivery, demographic and/or management) 2. Partnerships (external and internal) 3. Projects 4. Legal or regulatory action(s), and 5. Reputational damage.	Please describe your risk management arrangements and confirm that these adequately cover the three categories listed.	The Edinburgh Integration Joint Board Audit and Risk Committee oversees the risk register and management of risk on behalf of the IJB; (supporting documents IJB risk register and minutes of the IJB Audit and Risk Committee). The risk register for the IJB has been decoupled from the Partnership, with the IJB register focused on strategy, scrutiny, and performance, and the Partnership focusing on high level operational risks. IJB risk owners are currently assessing their identified risks. They are responsible for identifying, implementing and maintaining appropriate controls in their associated area of responsibility and for reporting breaches of controls or risk appetite on a regular basis to the IJB Audit and Risk Committee. The Partnership Risk Register has been circulated to the Partnership management team for comments. Work has started to developed risk registers for service area and this will feed into the Partnership risk register. All risks are being assessed by using 5x5 risk matrix methodology to define the level of risk by considering the category of probability vs the consequence. It has been agreed that there will be one risk management system (Datix) to manage risk for the IJB and the Partnership.	Partially Compliant	

2.2	You must have effective controls and procedures in place to manage the risks identified above to a tolerable level or actions put in place to mitigate and manage the risk.	Please describe the controls and procedures that you have in place.	Work is ongoing to develop a risk governance framework for Partnership risks as well as IJB risks. This will also include an escalation route for risks that require further discussion at a senior level. Controls and actions identified in risk registers are used to manage risks.	Partially compliant	
2.3	The robustness and effectiveness of your risk management arrangements must be regularly reviewed.	Please describe how you review your risk management arrangements, who does this and how often.	As part of the development of a risk governance framework, work is ongoing to develop an assurance mechanism to ensure that risk management arrangements are robust and effective. Project risks are managed via project governance arrangements. Specific risks are considered as they arise.	Partially compliant	
2.4	Did the last review identify any weaknesses that could have an impact on the Annual Accounts?	Please include the date of the last review, any weaknesses that were identified and how these will be addressed.	The last review did not identify any weaknesses that could impact on the Annual Accounts.	No	
2.5	There must be appropriate escalation/communication to the directorate Risk Committee and CLT Risk Committee (as appropriate) of significant issues, risks and weaknesses in risk management.	Please describe the process for escalation/communication to the relevant Risk Committees.	Work is ongoing to develop the risk governance arrangements across the Partnership to ensure that there is appropriate escalation for risks relating to performance, finance, care quality, procurement, and workforce issues. An improvement programme has been developed covering a range of work streams in recognition of the performance issues in relation to assessments,	Partially compliant	

			delayed discharge, and establishing efficient and consistent business processes.		
2.6	You should have arrangements in place throughout your directorate for the identification, recording and minimising of bribery risks.	Please describe these arrangements and how they are monitored and reported.	As part of the annual conversation process, all staff must read all essential policies and sign that they have read and understood them. Managers are aware of the Anti-Bribery Policy, Anti-Bribery Procedure, and Anti-Bribery Risk Assessment Toolkit.	Partially compliant	
2.7	You should have arrangements in place to promote and support the embedding of the Council's Whistleblowing Policy and procedures, including raising awareness of the routes for concerns to be raised.	Please describe the arrangements you have in place, including the reporting of disclosures received by management to the Council's independent service provider.	All staff are aware of the Whistleblowing policy and how to raise an issue. Managers have completed the relevant e-learning modules and face to face training programmes in relation to these key procedures.	Compliant	
2.8	You should have arrangements in place throughout your directorate for the recording and addressing of audit actions.	Please describe these arrangements and how they are monitored and reported.	The Chief Officer and Senior Management Team are all personally committed to ensuring that any audit actions are addressed, and the Operations Manager is proactively working with the teams in terms on internal audit actions as well as any health and safety audit actions to ensure that these are resolved as soon as possible.	Partially compliant	

2.9	Your directorate should have appropriate resilience arrangements in place, including: 1. A Service Area Resilience Group and Workplan 2. A Resilience Coordinator and deputies for each essential activity area 3. A Counterterrorism Coordinator and deputy 4. A Building Incident Manager for each staffed Council premise. All who should have received the appropriate training.	Please confirm your compliance with each requirement and how you ensure each is managed.	The Partnership has developed a Business Continuity Plan that is scheduled to go to the IJB on the 18 May. The Chief Nurse is the Partnership's Resilience Lead with the Operations Manager as the Resilience Coordinator. Once the Business Continuity Plan has been approved, the Partnership's monthly Resilience Group will be responsible for carrying out service areas Business Impact Analysis (BIA) for the Partnership. The Operations Manager is the Counter Terrorism Coordinator, however, a deputy has yet to be identified. Facilities Management is responsible for multi-occupied sites, including Lothian Chambers, City Chambers, Waverley Court. For all other multi-occupied buildings, the most senior manager (with the highest number of employees) will be the Building Incident Manager. Building Incident Managers have been nominated for each Council staffed premises. The Chief Officer is the owner of the Council's Rest Centre Plan. The Care for People Group, chaired by the Operations Manager is responsible for updating the Plan and ensuring all essential activities, including appropriate training, equipment stock and contact lists are current and valid.	Compliant	
2.10	Your business continuity plans, and arrangements should mitigate the business continuity risks	Please detail the plans and arrangements you have in place and explain how and when these are reviewed and	Business continuity risks for the Partnership are reviewed on a regular basis, with the Resilience Co-ordinator attending regular meetings of the Council and NHS Lothian resilience groups to	Partially Compliant	

	facing your directorate's essential activities.	reported.	review progress on key actions. Work is underway to complete Business Impact Analysis for Partnership activities. Following this severe winter event, the Partnership is improving its winter weather plan. It will align with the Partnership's new overarching business continuity plan.		
3 Workforce Control requirements		**Guidance notes**	**Response and reference to evidence**	**Assessment**	**Improvement actions**
3.1	You should have arrangements in place to ensure workforce resources are managed properly, including compliance with payroll policies, overtime controls, absence management and performance e.g. home/remote working.	Please describe these arrangements and how they are monitored and reported.	Payroll issues are managed corporately, with problems resolved by the payroll team. Overtime controls are managed by Senior Manager with anyone over grade 8 requesting overtime to be approved by the Chief Officer. All managers are aware of the absence policy and how staff absence should be managed. Absence statistics are circulated to each Senior Manager, and challenge panels are scheduled regularly to scrutinise absence in their areas to ensure the policy is being applied consistently.	Compliant	
3.2	You should have robust controls in place to manage off-payroll workers/contractors, including agency workers and consultants, ensuring approved framework contracts have been used and that those engaged are wholly compliant with the provisions of IR35 Council guidance and procedures.	Please detail the controls you have in place to ensure compliance and explain how these are monitored and reported.	All agency staff are procured the Council's agency framework.	Compliant	

3.3	You must ensure that recruitment and selection is only undertaken by appropriately trained individuals and is fully compliant with Council policies and procedures, including vacancy approvals and controls.	Please describe how you ensure compliance.	All managers are clear that they should not be carrying our recruitment if they haven't completed recruitment and selection training. Where a recruitment request has been submitted, this is manually checked and where this training has not been completed, the recruitment is not approved until the manager has completed the training.	Compliant	
3.4	You should have robust controls in place to manage new starts, movers and leavers, including induction and mandatory training, IT systems security (access and removal) and access to buildings and service users' homes.	Please describe the controls and monitoring in place.	All managers will manage new starts by organising the relevant systems and building access. Induction will be organised within the first 7 weeks of a new start. Services identify and organise relevant training for new starts. Care homes have developed and implemented a starter/leavers checklist.	Compliant	
3.5	You must have robust controls in place to ensure that statutory workforce requirements are met, e.g. PVG/disclosure checks, statutory registration/qualification, European Working Time Directive, right to work in the UK.	Please describe the controls you have in place, including monitoring and reporting arrangements.	Right to work documentation is checked by the recruiting manager as part of the pre-employment checks. Where a post requires PVG scheme membership, this is done as part of the pre-employment checks.	Partially compliant	

3.6	You should have arrangements in place to manage staff health and wellbeing, ensuring sickness absence is managed in compliance with the policy, including stress risk assessments and referrals to occupational health.	Please describe the arrangements you have in place to ensure compliance.	Managers are aware of the key policies to support staff and use these as part of 1:1 discussion and where staff have been absent. Where staff have been absent from work, managers can refer to the Council's Occupational Health service.	Compliant	
3.7	You must ensure compliance with essential training requirements and support learning and development appropriately, including professional CPD requirements.	Please detail how you monitor to ensure compliance.	Training needs for staff are identified as part of annual performance conversations and 1:1 discussion. Mandatory learning for generic and specific roles is monitored by managers.	Compliant	
3.8	You should have arrangements in place to support and manage staff performance e.g. regular 1:1/supervision meetings, performance/spotlight conversations.	Please describe the arrangements you have in place.	All managers have regular 1:1s with their staff and an annual performance conversation to review objectives and to set new ones for the forthcoming year.	Compliant	

3.9	You must ensure compliance with HR policies and procedures across all service areas, e.g. Code of Conduct, Disciplinary, Grievance, Bullying and Harassment.	Please describe how you monitor compliance across all service areas, e.g. maintaining a register of gifts and hospitality, recording conflicts of interest, recording and approving secondary employment where required.	All staff have signed that they have read and understand the code of conduct. There is a register of gifts and hospitality. The process for checking secondary employment and conflict of interest is checked annually	Compliant	
4 Council Company requirements		**Guidance notes**	**Response and reference to evidence**	**Assessment**	**Improvement actions**
4.1	You must have arrangements in place for the oversight and monitoring of the council companies you are responsible for, that give you adequate assurance over their operation and delivery for the Council.	Please describe the arrangements you have in place, including observer attendance at board meetings, monitoring and reporting on performance/development/risks, Governance Hub, etc.	Edinburgh Health and Social Care Partnership has no responsibility for Council companies, however, the services do contract out services to third parties who provide a service on behalf of the Council. There are regular contract management meetings whereby budget, performance and customer satisfaction are reviewed.	Compliant	
4.2	You must ensure that an appropriate Service Level Agreement, or other appropriate legal agreement, is in place for each Arm's Length External Organisation that you are responsible for.	Please confirm that this is the case, that each agreement is up to date and the frequency of review.	Not applicable.	Compliant	

4.3	You must regularly consult and engage with recognised trade unions.	Please describe the arrangements you have in place.	There are monthly Partnership meetings with trades unions representing both Council and NHS Lothian staff. There is a quarterly Departmental Joint Consultative Committee. Any service redesign or organisational reviews include weekly engagement with trades unions. NHS Lothian staff side representatives are invited to the Partnership's Senior Management Team meetings. Both the Partnership's Health and Safety Group and Resilience Group have union representation at each meeting.		
5	**Policy requirements**	**Guidance notes**	**Response and reference to evidence**	**Assessment**	**Improvement actions**
5.1	You should have arrangements in place to ensure all directorate staff are made aware of and fully understand the implications of relevant existing and new council policies.	Please describe the arrangements you have in place at directorate level e.g. Employee Handbook requirements, as well as locally in relation to operational and/or role specific requirements.	Relevant service specific policies are recorded on the Council policy register and are subject to regular review and appropriate reporting to elected members via committee. Various quality review groups exist across services to monitor performance and review policy and practice to ensure consistent application of policy. There are various quality action groups where senior managers monitor performance, develop, and review policy compliance. In addition, there is a Customer Services Quality Action Group and various forums to progress Customer Service Excellence and ISO actions.	Compliant	

			All staff must sign that they have read and understood key policies and procedures. Managers are then expected to record completion on the HR system. All staff should complete the mandatory induction checklist within 7 weeks of commencing employment.		
5.2	You should have arrangements in place for the annual review of policies owned by your directorate, via the relevant executive committee, to ensure these comply with the Council's policy framework.	Please describe the arrangements you have in place to ensure the policies you are responsible for are up to date and fit for purpose (reflecting organisational changes, best practice, operational experience and legislative changes).	Policies and procures are reviewed annually or where there has been a policy or legislative change.	Compliant	
5.3	You should ensure that policies and procedures of relevance to services within your directorate are implemented in a planned and consistent manner.	Please describe the arrangements you have in place eg. action plans, training programmes, etc.	Policies and procedures are reviewed annually or where there has been a policy or legislative change. Any new policy requirements are implemented in a planned manner usually through the establishment of a project team with appropriate membership that will identify the tasks required, timescales, risks and action plans. All updated policies and procedures are placed on the Council's intranet and cascaded to staff through line management arrangements.	Compliant	

6 Governance and Compliance requirements		Guidance notes	Response and reference to evidence	Assessment	Improvement actions
6.1	You must ensure directorate staff are aware of their responsibilities in relation to the Council's governance framework eg. Committee Terms of Reference and Delegated Functions, Scheme of Delegation, Contract Standing Orders, Financial Regulations.	Please describe the arrangements you have in place to ensure operational decisions and activities are carried out within agreed parameters.	Senior managers and appropriate staff are aware of the scheme of delegation, contract standing orders, approval limits, reporting requirements and other financial guidance to ensure compliance with Council governance policies and procedures. All polices, and guidance are available on the Council's intranet. There is a strong working relationship with the procurement team, which allows for the dissemination of amendments to relevant governance policy and procedures and for clarification of any specific practice changes required in the Directorate. The relationship also ensures compliance in respect of the award, management, extension or making of other significant changes to contracts.	Compliant	
6.2	The authority, responsibility and accountability levels within your directorate should be clearly defined, with proper officer designation delegated, recorded, monitored, revoked and reviewed regularly to meet the requirements of the Scheme of Delegation.	Please describe the process for this including how this is undertaken, by whom and the frequency of review.	Proper Officer and delegated authority letters are held with relevant managers.	Compliant	

6.3	You should have arrangements in place to ensure your directorate's activities are fully compliant with relevant Scottish, UK and EU legislation and regulations.	Please describe the arrangements you have in place, including risk assessment, monitoring and compliance with statutory reporting requirements.	Compliance with Council Standing Orders combined with access to Legal Service advice where any doubts exist. Typically, this will involve establishing whether any 'cross border' interest in potential contract awards exists, and if so, taking appropriate procurement procedural action to ensure full compliance. This issue would also be discussed at the Procurement Board.	Compliant	
7 Information Governance requirements		**Guidance notes**	**Response and reference to evidence**	**Assessment**	**Improvement actions**
7.1	Directorate staff must be made aware of their responsibilities in relation to the proper management of Council information, including the need to adhere to Council policies, procedures and guidance around: information governance; records management; data quality; information rights; information compliance; information security; and ICT acceptable use.	Please describe the arrangements in place and how these are monitored and reported.	All FOI requests are dealt with through the corporate FOI team and in accordance with Council procedures and policies. All FOIs are managed through a generic mailbox for the Partnership. The Strategy and Innovation Senior Manager signs off all FOI responses for the Partnership. Relevant staff are aware of the obligation to adhere to Council policies and procedures in relation to intellectual property rights, data security protocols, FOI requests, etc. Cross directorate enquiries are co-ordinated through the Director's support team. All information governance policies and guidance are easily accessible on the Council's intranet if additional guidance is required. Records management plans are in place. Work is ongoing to cleanse electronic records on the SWIFT system. All staff must sign that they have read and understood the ICT acceptable use policy.	Compliant	

7.2	Data sharing arrangements with third parties must be recorded, followed and regularly reviewed throughout all service areas in your directorate.	Please describe the arrangements in place and how these are monitored and reported.	Data protection mandates are completed by all customers prior to the sharing of personal data with third parties and these are reviewed bi-annually. All data sharing agreements are confirmed with the Information Compliance Manager and reviewed in line with the service requirements to which the agreement refers. A Memorandum of Understanding (MoU) has been agreed between the Edinburgh Integration Joint Board, the City of Edinburgh Council and NHS Lothian, which sets out high-level arrangements concerning the management of information in integrated services, including information sharing. To support effective service delivery and compliance with information governance legislation, the Memorandum will be underpinned by local documentation setting out practical arrangements and responsibilities. Although news of the MoU has been communicated to all staff, it has been identified that a work stream would be needed to align respective NHS Lothian and Council information governance practices for the Partnership, particularly for integrated services. This work stream is being led by the Operations Manager.	Compliant	

7.3	Privacy impact assessments must be completed to assess risks to processes that handle personal data (when appropriate) throughout all service areas in your directorate.	Please describe the arrangements in place and how these are monitored and reported.	Privacy Impact Assessments are completed where there is handling of personal data. They are completed in consultation with the Information Compliance Manager.	Compliant	
7.4	All directorate staff must be made aware of their responsibilities to report and manage data protection and information security breaches.	Please describe the arrangements in place and how these are monitored and reported.	All staff employed by the Council are required to confirm that they have read and understood the Council's Information Governance Policy, Data Protection Policy, Data Quality Policy, Freedom of Information Policy and what constitutes a data breach and how to report one. Data protection responsibilities for all staff regarding are covered as part of staff induction and as part of the mandatory policies reading, which all staff must complete annually. Staff are aware of the obligation to adhere to Council policies and procedures in relation to intellectual property rights, data security protocols, FOI requests, etc. All policies and procedures are accessible on the Council's intranet if additional guidance is required.	Compliant	

7.5	Information risks should be routinely recorded in risk registers and managed throughout all service areas in your directorate.	Please describe the arrangements in place and how these are monitored and reported.	Risks relating to information governance are recorded on the Partnership risk register. Where information risks are identified, these are managed through the relevant service area. Any significant risk regarding information is escalated appropriately and highlighted to the information governance team.	Compliant	
7.6	Processes that manage Council records, created and used within your directorate, must be documented within approved procedures.	Please describe the arrangements in place for both core service records and business support records (e.g. Finance, HR, Health & Safety, Procurement etc.), as well as how these arrangements are reviewed and updated.	There are retention rules in place across the Council with which all services comply. All records are updated and reviewed when appropriate and stored or disposed of in line with record retention rules. SWIFT and LSCMI have guidance for managing core service records and business support records.	Compliant	
7.7	All Council records within your directorate should be routinely disposed of according to their relevant record retention rules and these disposals should be documented.	Please describe the arrangements in place and how these are monitored for compliance.	The Partnership has a records retention officer in place. Services areas have processes in place to ensure records are reviewed and stored or disposed of in line with record retention guidelines.	Compliant	
8 Health & Safety (H&S) requirements		**Guidance notes**	Response and reference to evidence	**Assessment**	**Improvement actions**
8.1	Directorate staff must be made aware of their responsibilities under relevant H&S policies and procedures, including: Council Health and Safety	Please describe the arrangements you have in place to meet these requirements and how these are monitored.	All staff are required to familiarise themselves with all the policies and procedures on an annual basis and inform their line manager that they have done so as part of the Annual Conversation.	Compliant	

	Policy; Fire Safety Policy and Procedures; First-aid and Emergency Procedures; Stress Policy and Procedures; Accident, incident and work-related ill health reporting and investigation procedure; all other relevant health and safety policies and procedures (e.g. Asbestos, Water Safety).		All new starts must complete the mandatory induction checklist within 7 weeks of commencing employment and managers are responsible for recording this on MyPeople. Health and Safety is a standing agenda item for all management teams across the Partnership. A Health and Safety Group has been established for the Partnership, chaired by the Hospital and Hosted Services Manager. The Operations Managers is the Partnership's Health and Safety Coordinator. Governance structures and processes are being established to ensure robust implementation of health and safety policies and procedures. Staff must report incidents and accidents. This is done through SHE for Council Staff and Datix for NHS Lothian staff. Service areas receive quarterly incident reports that are analysed, and appropriate action is taken.		
8.2	You must have appropriate arrangements in place for establishing, implementing and maintaining procedures for the ongoing hazard identification, risk assessment and determination of necessary controls to ensure all H&S risks are adequately controlled.	Please describe the arrangements you have in place and how these are monitored, reviewed and reported.	Regular workplace inspections are carried out, with identified hazards captured, progressed as relevant and closed via the SHE portal. Integrated teams currently benefit from NHS Lothian's quarterly self-assessment process, which over the course of 12 months will have covered 12 health and safety risks. The Health and Safety Group hopes to roll this framework out for all Partnership services in 2018/2019. Partnership risk assessments are in development.	Partially compliant	

			Details of accidents and incidents should be recorded, reported, and investigated in line with Council and NHS Lothian incident reporting policies and procedures.		
8.3	You must have competencies, processes and controls in place to ensure that all service areas in your directorate, and any other areas of responsibility, operate in compliance with all applicable H&S laws and regulations.	Please describe the arrangements you have in place and how these are monitored, reviewed and reported.	As part of its remit, the Partnership's Health and Safety Group is responsible for implementing health and safety plans and overseeing the successful delivery of health and safety audit findings, which may include training requirements, compliance issues, RIDDOR reporting, etc. Accident and incident dashboards are monitored at the Partnership's Health and Safety Group, the Council's Health and Safety Consultation Forum, and NHS Lothian Health and Safety Committee.	Partially compliant	
8.4	You must have appropriate arrangements in place for the identification and provision of H&S training necessary for all job roles, including induction training.	Please describe the arrangements you have in place and how these are monitored, reviewed and reported.	The Council's Health and Safety team is developing a training matrix. The Health and Safety Group will review its findings and align it to staff's personal development plans.	Partially compliant	
8.5	You must have a robust governance and reporting structure for H&S in your directorate.	Please provide the name of the SMT member in your directorate who sits on the Council H&S Group. Please also describe your governance and reporting structure for H&S and how you ensure that H&S issues across your directorate are brought to the attention of the Council H&S Group as	Robust governance arrangements for the Partnership are under development. The Health and Safety Group takes ownership of health and safety matters. The chair of the group part of the senior management team and can therefore escalate any issues directly to SMT. Memberships: The Chief Officer is a member of the Council's	Partially compliant /	

		appropriate.	Corporate Health and Safety group. The Hospital and Hosted Services Manager is a member of NHS Lothian's Health and Safety Committee. The Operations Manager is a member of the Council's Consultation Forum.		
9 Performance requirements		**Guidance notes**	**Response and reference to evidence**	**Assessment**	**Improvement actions**
9.1	Where performance monitoring identifies inadequate service delivery or poor value for money, you must have arrangements in place for reporting to CLT, Committee and/or Council.	Please describe your performance monitoring arrangements, including frequency of reporting, and provide detail of any such reports during the reporting period.	Performance reports are discussed on a regular basis in service areas, as well as at the Senior Management Team and Corporate Leadership Team reporting. Performance is also reported monthly to the IJB. Performance is a key focus of the IJB Performance and Quality Sub-Group, and is discussed at a range of internal NHS Lothian and Council meetings.	Compliant	
9.2	You should have arrangements in place to implement and monitor improvement measures to address any service delivery or performance problems.	Please describe the arrangements you have in place and give details of improvement measures introduced during the reporting period, eg. exception reporting to CLT, and any outstanding issues.	Corrective and improvement actions are identified through the appropriate governance arrangements. Any areas where there are performance issues is subject to the relevant scrutiny and improvement plans developed and implemented.	Compliant	

9.3	You should have appropriate arrangements in place throughout your directorate for recording, monitoring and managing customer service complaints and customer satisfaction, including: 1. Compliance with the complaints procedure, including stage 1 and 2 processes. 2. Recording and analysing all complaints to identify service improvement. 3. Implementation of improvement actions in relation to common complaints. 4. Adherence to the Council's Managing Customer Contact in a Fair and Positive Way Policy, to support staff in handling difficult situations. 5. Addressing recommendations from the SPSO in relation to the service area.	Please describe the arrangements you have in place and how these are monitored, reviewed and reported.	Complaints are monitored and managed in accordance with Council policies and procedures in line with the Scottish Public Services Ombudsman's (SPSO) complaints handling requirements. All complaints relating to social work services are logged on Capture and performance is reviewed. All adult social work complaints are recorded by the Social Work Advice and Complaints Service on the DATIX system. Complaints are monitored continuously to identify potential themes, patterns, or emerging trends. Complaint reports detailing performance outcomes and service improvements generated from investigation findings are provided to relevant service areas for quality assurance purposes. Social work stage 2 complaints subject to a formal investigation are co-ordinated and managed by the Social Work Advice and Complaints service. All investigations are undertaken in accordance with the Council's complaints procedure and approved by the relevant Service Manager. Complaint responses are also signed off by the senior manager to ensure a robust and consistent approach to complaints management. The Integration Joint Board deals with any concerns regarding its strategic planning functions (rather than service delivery). In line with SPSO guidance, the IJB has developed a Complaints Handling Procedure.	Compliant	

			All SPSO complaints are co-ordinated and recommendations monitored through the relevant team in Strategy and Insight.		
10	**Commercial and Contract Management requirements**	**Guidance notes**	**Response and reference to evidence**	**Assessment**	**Improvement actions**
10.1	You must have arrangements in place to ensure all goods, services and works are procured and managed in compliance with the Contract Standing Orders.	Please describe the arrangements in place and how these are monitored and reported.	All goods, services and works are procured in compliance with Council Standing Orders. Where services need to be procured, this is done in consultation with the procurement team to ensure compliance with the relevant legislation.	Compliant	
10.2	You must have arrangements in place to ensure that there are named contract managers in place for every contract managed by the directorate and they are made aware of their contract monitoring and record keeping responsibilities.	Please describe these arrangements and how they are monitored and reported.	The contract team monitors Partnership contracts. These contracts vary in value and complexity and the team's resources are targeted accordingly.	Partially compliant	

10.3	You must have controls and procedures in place to ensure that contract and supplier monitoring is carried out and recorded in accordance with the contract terms.	Please describe the arrangements in place and how these are monitored and reported.	Contracts are managed robustly within the Partnership, where there are contract failures, these are managed appropriately through the relevant route.	Compliant	
10.4	You must have arrangements in place to ensure that changes to contracts or supplier details are recorded and communicated to relevant parties.	Please describe the arrangements in place and how these are monitored and reported.	The processes to ensure changes to contracts and supplier details are appropriately cascaded and communicated are under review.	Partially compliant	
11 Change and Project Management requirements		**Guidance notes**	**Response and reference to evidence**	**Assessment**	**Improvement actions**
11.1	All projects/programmes must have a clear business justification, as a minimum this should articulate outcomes and benefits, normally via a business case prior to commencing delivery.	Please outline the arrangements you have in place.	All Partnership projects have the appropriate governance arrangements in place and are managed through Prince 2. All projects have a business case / business justification with a clear remit or rationale for the project. For the improvement programme, there is several workstreams that have business cases in place and project governance arrangements in place.	Partially compliant	

11.2	Your project/programme management arrangements should have appropriate governance in place to support delivery. As part of governance, clear roles, responsibilities, and accountabilities are articulated and demonstrated by all members of the project/programme team.	Please outline the arrangements you have in place.	All Partnership projects have the appropriate governance arrangements in place and are managed through Prince 2. All projects have a business case / business justification with a clear remit or rationale for the project. The improvement programme includes several work streams with business cases and governance arrangements. Strategy and Insight provides project / programme support.	Partially compliant	
11.3	You must have effective controls in place to track delivery progress, take corrective action if required, and ensure ongoing viability of your projects and programmes.	Please outline the controls you have in place and confirm that these adequately ensure delivery and ongoing viability.	Projects have plans in place and a mechanism for tracking project outputs and benefits.	Partially compliant	
11.4	You should have a robust benefits management framework in place, including clear benefit measures, owners and realisation plan.	Please outline the arrangements you have in place.	Projects have plans in place and a mechanism for tracking project outputs and benefits.	Partially compliant	

11.5	You must undertake end stage reviews and once the project has delivered the required outputs a formal closure process should be undertaken, including a final lessons learned exercise.	Please outline the arrangements you have in place.	Projects have plans in place and a mechanism for tracking project outputs and benefits.	Partially compliant	
12 Financial Control requirements		**Guidance notes**	**Response and reference to evidence**	**Assessment**	**Improvement actions**
12.1	The operation of financial controls in your directorate must be effective in ensuring the valid authorisation of financial transactions and maintenance of accurate accounting records.	Please describe your financial controls.	The Partnership utilises corporate accounting systems and authorisation and control protocols. Payments from the SWIFT system for purchased services are processed through the P2P, which feeds into the Council's ledger. A Data and Compliance Project Team has been established as part of the Partnership's Improvement Plan. All operational functions carried out by the Council on behalf of Edinburgh Integration Joint Board (EIJB) use corporate accounting systems, authorisation and control protocols. Internal Audit has conducted reviews of care homes and Health and Social Care bank reconciliations and the Partnership is implementing the management actions from these reports. An Internal Audit report on the review of Purchasing Budget Management is due to be published in May. The Partnership is fully committed to the implementation of the audit recommendations.	Compliant	

			The Business Support Manager is implementing actions arising from audit recommendations and continues to work on the audit of business processes which includes financial controls and authorisation of financial transactions. The Care Inspectorate and Healthcare Improvement Scotland published their joint report on the inspection of Edinburgh's older people's services in April 2017. In response, the Health and Social Care Partnership produced a high-level statement of intent setting out the 7 key areas requiring intensive remedial action. One of the 7 key areas is the development of a Financial Framework, which is focused on the best use of resources and well managed financial accountability. Progress is being made with the re-establishment of the savings governance board, work on the delegation of financial resources to localities and a review of charging for Council-run care homes.		
12.2	The arrangements you have in place to monitor expenditure/budget variances should identify control problems or variances that could have an effect on the Annual Accounts.	Please give details of the arrangements you have in place and if any control problems or variances have been identified.	Throughout the financial year 2017/18 regular monitoring reports and financial updates have been presented to the Senior Management Team, the Council's Finance and Resources Committee and the Edinburgh Integration Joint Board. These reports highlighted risks to delivery of approved savings, the forecast overspend position and mitigating actions. Following consideration of monitoring reports at months 3 and 5, mitigating action was agreed by the IJB and Council to return the projected overall position for 2017/2018 to a balanced position.	Compliant	

			The underlying budget pressures identified in 2017/18 have been factored into the baseline budget for 2018/19 and work continues to develop and monitor mitigating measures with overall progress on the delivery of projects comprising the financial recovery plan monitored by the Savings Governance Board.		
12.3	You should have arrangements in place to ensure all material commitments and contingent liabilities (i.e. undertakings, past transactions or events resulting in future financial liabilities) are notified to the Chief Financial Officer.	Please describe the arrangements you have in place and provide details of any such notifications to the Chief Financial Officer.	Regular meetings with Finance colleagues and committee reporting as appropriate are in place as well as ad hoc engagement with Finance staff where appropriate. The accounts have been closed in line with the instructions on the closure of final accounts issued by the Head of Finance for the Council.	Compliant	
12.4	You should have arrangements in place to protect assets against theft, loss and unauthorised use and identify any significant losses.	Please describe the arrangements you have in place and if there have been any significant losses please detail these and outline any corrective action that has been, or will be, taken.	Security arrangements are in place and are reviewed regularly. Arrangements for the protection of assets against theft, loss and unauthorised use have been reviewed by Business Services. All mobile devices are encrypted. Laptops are equipped with appropriate security measures (e.g. bit locker passwords). No significant losses have been identified within 2017/2018.	Compliant	

12.5	You should have arrangements in place to review the adequacy of insurance provision and its adequacy in covering the risk of loss across your directorate.	Please describe the arrangements you have in place including the frequency of review and date of last review.	The Council's Finance Rules state that directors must notify the Head of Finance promptly of all new risks, properties, vehicles, plant, equipment, etc., which require to be insured, any alterations, and changes in activities or procedures that may affect existing insurance arrangements. Directors must notify the Head of Finance of all major capital and revenue projects at an early stage if insurance cover or specialised insurance advice is required. The Council's insurance arrangements are tendered on a regular basis and risk appetite is addressed as part of this process. There is a renewal review each year. The Scottish Government notified the Council that it is vicariously liable for the clinical / medical risks where these are carried out in an integrated management and operational structure. The Council has entered the national Clinical Negligence and Other Risks Scheme (CNORIS) as allowed by Public Bodies (Scotland) Act 2014 in respect of Officials Indemnity insurance and has its own insurance arrangements in respect of medical malpractice.	Compliant	
12.6	You should have arrangements in place for identifying any weaknesses in your directorate's compliance with Council financial policies or statutory/regulatory requirements.	Please describe the arrangements you have in place, detail any weaknesses that have been identified and (if any) how these have been or will be addressed.	Arrangements in place include: regular reports on budget monitoring and financial management arrangements; appointment of the IJB Chief Financial Officer to the Partnership Senior Management Team; regular independent review of aspects of operational matters through Internal Audit, External Audit and the Care Inspectorate and implementation of associated improvement actions; governance and scrutiny through various management groups, including the Partnership	Compliant	

			Senior Management Team, the Savings Governance Board and the Procurement Board. Political governance and scrutiny, including the IJB and Council's Finance and Resources and Governance, Risk, and Best Value Committees.		
12.7	You should have arrangements in place that would identify any internal control, risk management or asset valuation problems within service areas that could affect the Annual Accounts?	Please describe the arrangements you have in place and detail any problems that have been identified.	Work is ongoing to develop risk management governance arrangements for the Partnership, now that the IJB and Partnership risk registers are agreed. Arrangements in place include: internal audit review of key areas; and contract monitoring arrangements.	Compliant	
13 Group Accounts (Resources only)		**Guidance notes**	Response and reference to evidence	**Assessment**	**Improvement actions**
13.1	Have there been any developments during the year that should lead to additions, deletions or amendments to the companies included in the Group Accounts?	This question requires a Yes/No response. If the response is Yes, please provide details.	**Not Applicable**	Yes / No	

13.2	You should have arrangements in place to identify any internal control, risk management or asset valuation problems with Council companies that could affect the Group Accounts.	Please describe the arrangements in place and detail any problems that have been identified during the reporting period.	**Not Applicable**	Compliant / Partially compliant / Not compliant	
14 National Agency Inspection Reports		**Guidance notes**	**Response and reference to evidence**	**Assessment**	**Improvement actions**
14.1	You should have arrangements in place to identify any reports relating to your directorate that could impact on the signing of the Annual Governance Statement.	Please describe the arrangements you have in place, list the inspection reports published during the year, detail any issues that could have an impact and explain how these have been reported.	Quality Assurance meetings regularly review grades from National Agency Inspection Reports and implement recommendations accordingly. All meetings are minuted. There are systems in place whereby our public protection committees review lessons learned from National Agency Inspection Reports.	Compliant	
14.2	You should have arrangements in place that adequately monitor and report on the implementation of recommendations.	Please describe the arrangements you have in place.	Any recommendations and requirements arising from Inspection Reports are subject of individual action plans submitted by the service concerned. This is the registered manager of the service concerned in the first instance and overseen by the senior manager responsible.	Compliant	

<table>
<tr><th colspan="2">15 Internal Audit, External Audit and Review Report Requirements</th><th>Guidance notes</th><th>Response and reference to evidence</th><th>Assessment</th><th>Improvement actions</th></tr>
<tr><td>15.1</td><td>Have there been any internal audit, external audit or review reports published during the year that have highlighted high, medium or significant control deficiencies?</td><td>This question requires a Yes/No response. Please also list the reports published during the year and highlight any that have flagged high, medium or significant control deficiencies.</td><td>The following internal audits have been carried out in the Partnership over the last financial year:

<table>
<tr><th>Ref</th><th>Title</th><th>Issued</th><th>High</th><th>Med</th></tr>
<tr><td>HSC1715</td><td>Edinburgh Alcohol and Drug Partnership Contract Management</td><td>Nov 2017</td><td>1</td><td>2</td></tr>
<tr><td>HSC1701</td><td>Final Thematic Care Home Report: Internal Audit; Health and Safety; and Information Governance. (Summary of the below reports)</td><td>Feb 2017</td><td>7</td><td>29</td></tr>
<tr><td></td><td>Marionville Care Home IA Report</td><td>Sep 2017</td><td></td><td></td></tr>
<tr><td></td><td>Oaklands Care Home IA Report</td><td>Oct 2017</td><td></td><td></td></tr>
<tr><td></td><td>Ferrylee Care Home IA Report</td><td>Jul 2017</td><td></td><td></td></tr>
<tr><td></td><td>Drumbrae Care Home IA Report</td><td>Aug 2017</td><td></td><td></td></tr>
<tr><td></td><td>Clovenstone Care Home IA Report</td><td>Jul 2017</td><td></td><td></td></tr>
<tr><td></td><td>Inchview Care Home IA Report</td><td>Jul 2017</td><td></td><td></td></tr>
<tr><td></td><td>Jewel Care Home IA Report</td><td>Aug 2017</td><td></td><td></td></tr>
<tr><td></td><td>Gylemuir Care Home IA Report</td><td>Nov 2017</td><td></td><td></td></tr>
<tr><td></td><td>Fords Road Care Home IA Report</td><td>Jul 2017</td><td></td><td></td></tr>
<tr><td>HSC1714</td><td>Social Work Centre Bank Account Reconciliations</td><td>7 April 2018</td><td>2</td><td></td></tr>
</table></td><td>Yes</td><td></td></tr>
</table>

			A Council wide issue has recently been identified where Internal Audit findings raised dating back to 1 April 2016 have either not been implemented; or were implemented, but have not been sustained, resulting in unnecessary exposure to service delivery risk. The Corporate Leadership Team agreed that each Directorate would review the full population of IA High and Medium rated findings and confirm (via a self-attestation process) whether these had been implemented; not implemented; implemented but not sustained; or were no longer applicable, with any findings that had not been implemented, or were implemented but not sustained, reopened by Internal Audit to ensure that these risks are effectively addressed. The results for Health and Social Care confirmed that a total of 4 High and 5 Medium rated findings will be reopened. The Chief Officer and Senior Management Team are all personally committed to ensuring that this historic position is addressed, together with timely resolution of our existing population of open IA findings. Action plans have been developed and sufficient resources allocated to ensure that this will be achieved within appropriate timeframes.		

15.2	You should have arrangements in place to ensure all recommendations from these reports have been (or are being) implemented and that this is monitored effectively.	Please describe your implementation, monitoring and reporting arrangements and provide detail of any recommendations that are outstanding at the end of the reporting period.	The Operations Manager is working on the outstanding and new audit finding with managers to ensure that recommendations are implemented. The Chief Officer receives monthly IA updates on all open and overdue risk findings.	Partially compliant	
16 Progress		**Guidance notes**	**Response and reference to evidence**	**Assessment**	**Improvement actions**
16.1	All outstanding issues or recommendations arising from this exercise, commissioned reviews, committee reports and other initiatives in previous years should have been addressed satisfactorily.	Please detail how any remaining outstanding issues or recommendations are being addressed.	There are several outstanding actions from internal audit reports that are being proactively managed to ensure completion as soon as practicable. I am satisfied that action plans have been developed and are being prioritised by managers according to agreed timescales.	Partially compliant	

Reviewed by		**Role**	Internal Audit	**Date**	
Reviewed by		**Role**	Democracy, Governance and Resilience Senior Manager	**Date**	

Appendix 2 – Action Plan

Control Area	Paragraph of Schedule	Issues	Action	Senior Responsible Officer	Completion Date
Internal Controls	1.3	Your internal controls and procedures and their effectiveness must be reviewed regularly	Controls continue to be reviewed regularly. Contract management continue to be monitored frequently and there is a formal escalation mechanism in place for escalation of risks. The Partnerships financial position is subject to regular updates to the EIJB / development sessions and there are regular focused discussions at the fortnightly Executive Team (ET). An assurance oversight group has been set up to scrutinise and support closure of outstanding and historic audit actions. Risk and Health and Safety governance arrangements within the Partnership are now in place and is being embedded across the Partnership. Integrated risk and health and safety reports are now reported to the Executive team on a regular basis giving the Executive Team visibility of any emerging issues.	Executive Team	March 2019
Risk and Resilience	2.1	Your risk management arrangement should identify the key risks to your directorate (and the Council) including those arising from: change, partnerships, projects, legal / regulatory, reputational damage	Risk management is led by the Chief Nurse for the Partnership. An integrated approach is being developed with a view to creating integrated reporting (taking account of both partner organisation reporting requirements. Workshops with Executive Team and senior leaders across the Partnership has been held to embed the risk management approach and consistent identification of risk.	Chief Nurse	July 2019
	2.2	You must have effective controls and procedures in	Risks have been identified across the Partnership through the utilisation of the 5X5 risk methodology and appropriate	Chief Nurse	

		place to manage risk identified above to a tolerable level or actions put in place to mitigate and manage the risk	mitigation strategies have been put in place to manage key risks. Work is ongoing to look at how to ensure appropriate linkage between the strategic risks that sit within Executive Team and the operational risks that sit within areas of the Partnership.		
	2.3	The robustness and effectiveness of your risk management arrangements must be regularly reviewed.	An assurance mechanism is being developed to ensure that there is regular review of the Partnership risk management arrangements, however Executive Team do carry out regular review of the Partnership risks as do operational teams.	Chief Nurse	July 2019
	2.5	There must be appropriate escalation / communication to the directorate risk committee and CLT risk committee	An assurance mechanism is being developed to ensure that risk management arrangements are robust and effective and allow for the appropriate escalation and provides assurance to the CLT risk committee.	Chief Nurse	Dec 2019
	2.6	You should have arrangements should in place throughout your directorate for the identification, recording and minimising of bribery risks	Staff must read all essential policies and agree that they have read and understood them, however further work to put in place a control mechanism for the identification and minimising of bribery risks.	Chief Nurse	Dec 2019
	2.8	You should have arrangements in place throughout the directorate for the recording and addressing of audit actions	EHSCP has progressed and closed several historic and outstanding audit actions. All audit actions are managed within the Team Central system and tracked on a regular basis. An assurance oversight board has been set up with key action owners attending to update on outstanding actions.	Executive Team	July 2019
	2.10	Your business continuity plans, and arrangements should mitigate the business continuity risks facing the directorates essential activities.	Integrated Business continuity plans have now been developed and endorsed by the Edinburgh Integration Joint Board in December 18. Business Impact Assessments for all Partnership services are being progressed with support from the Council's business continuity teams. Specific business continuity plans are in place for key service	Chief Nurse	January 2019

			activities and these are reviewed on a regular basis		
Workforce Control	3.5	You must have robust controls in place to ensure that statutory workforce requirements are met e.g. PVG disclosure checks, statutory registration, qualification, European Working Time Directive, right to work in the EU	Processes have been put in place to ensure that recruiting managers are checking staff have the relevant workforce requirements prior to starting with the Partnership.	Executive Team	July 2019
Health and Safety Requirements	8.2	You must have appropriate arrangements are in place for establishing, implementing and maintaining procedures for the ongoing hazard identification, risk assessment and determination of necessary control to ensure Health and Safety risks are adequately controlled	An integrated approach to hazard identification, risk assessment and determination is now in place to ensure Health and Safety are adequately controlled. Integrated health and safety reports are now reported to the Executive team on a regular basis giving visibility of any emerging issues.	Executive Team	December 2019
	8.3	You must have competencies processes and controls in place to ensure that all service areas in your directorate and any other areas of responsibility	The Partnership Health and Safety group is now in place and has an escalation route to the Executive Team. The integrated reporting gives Executive Team oversight of health and safety audits, compliance issues, RIDDORS or any other exceptions.	Executive Team	December 2019
	8.4	Appropriate arrangements in place for the identification and provision of health and safety training necessary for all job roles including induction training	The Partnership health and safety group does monitor the uptake of health and safety training and this is subject to some further work on what is mandatory and where staff are “joint” posts, is it a requirement to do both Council and NHS policies if they cover similar topics.	Executive Team	December 2019
	8.5	Robust governance in place and reporting structure for	There is a Health and Safety Group for the Partnership that has a governance route to the Executive Team and	Executive Team	December 2019

		Health and Safety in place	includes representation from NHS Lothian and Council Health and Safety teams. There is also representation from Executive Team on the Council's Health and Safety Committee. An integrated reporting structure is in place for health and safety with regular reports to Executive Team.		
Commercial and Contract Management requirements	10.2	You have arrangements in place to ensure that there are named contract managers in place for every contract managed by the directorate and they are aware of their responsibilities	Contract monitoring is in place and the Partnership procurement board is in place to monitor contracts. A contract manager is now in place and contract managers are now in place.	Chief Finance Officer	March 2019
	10.4	You must have arrangements in place to ensure that changes in contracts or supplier details are recorded and communicated to relevant parties	Contracts and Supplier are managed via the Oracle process and contracts are managed in line with contract management guidance and documentation. The recruitment of a Partnership contract managers will help support to ensure that contract changes are managed accordingly.	Chief Finance Officer	March 2019
Change and Project Management requirement	11.1	All projects / programme must have a clear justification as a minimum, this should articulate outcomes and benefits, normally via a business case prior to commencing delivery.	Projects within the Partnership currently have a fragmented governance structure. The EIJB agreed to fund a change programme team which will be in place by July 19 and they will be responsible for reviewing and aligning current programmes / projects into a new programme structure. The change team will be responsible for managing all Partnership projects, ensuring any project aligns with the three conversations model. This team will also ensure any projects have a clear project mandate / justification as part of the business case process.	Head of Strategic Planning	July 2019
	11.2	Your project / programme management arrangements should have appropriate governance in place to support delivery. As part of governance, clear roles, responsibilities and	The change team will be responsible for managing all Partnership projects, with appropriate governance in place to support delivery. This will include developing terms of reference for project boards and teams.	Head of Strategic Planning	July 2019

		accountabilities are articulated and demonstrated by all members of the project / programme team			
	11.3	You must have effective controls in place to track delivery progress, take corrective action if required and ensure visibility of projects and programmes	The change team will have programme responsibility for all projects being delivered across the Partnership which will ensure visibility of all projects and programmes across the Partnership and ability to see the synergies between projects and programmes.	Head of Strategic Planning	July 2019
	11.4	You should have a robust benefits management framework in place, including clear benefit measures, owners and realisation plans	The change team will ensure that there will be robust benefits management frameworks in place for all projects that will be tracked as part of the project lifecycle.	Head of Strategic Planning	July 2019
	11.5	You must undertake end stage reviews and once the project has delivered the required outputs a formal closure process should be undertaken, including a final lessons learned exercise	The change team will ensure that there is a formal closure process in place for projects and programmes.	Head of Strategic Planning	July 2019
Internal Audit, External Audit and Review Report Requirements	15.2	You should have arrangements in place to ensure all recommendations from these reports have been (or are being) implemented and that this is monitored effectively.	The implementation of all internal audit actions is now being tracked through team central. All open actions are being managed and tracked by the Partnership Operations Manager. An assurance oversight group has been set up and chaired by the Chief Officer to focus on implementing outstanding actions.	Executive Team	July 2019
Progress	16.1	All outstanding issues or recommendations arising from this exercise, commissioned reviews, committee reports and other initiatives in previously years	All outstanding actions from Committee are tracked through action logs from Committees and regular updates are included in rolling action logs and / or contained within committee reports. Committee outstanding actions are viewed as part of the committee planning process and discussed fortnightly at the Executive Team meeting.	Chief Officer	July 2019

		should have been addressed satisfactorily.	Internal Audit actions are now being tracked through team central and will be monitored regularly.		