Governance, Risk and Best Value Committee

10.00am, Tuesday, 01 August 2023

Annual Assurance Schedule – Edinburgh Health and Social Care Partnership

Executive/routine
Wards
Council Commitments

1. Recommendations

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

1.1.1 Note the Edinburgh Health and Social Care Partnership (the Partnership) annual assurance schedule for 2022-23

1.1.2 Note that the Partnership annual assurance schedule 2023-24 would be submitted for scrutiny to GRBV in 12 months (August 2024).

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Report

Annual Assurance Schedule – Edinburgh Health and Social Care Partnership

2. Executive Summary

2.1 The purpose of this report is to present the annual assurance schedule covering 2022-23 for the Edinburgh Health and Social Care Partnership (the Partnership) to Governance Risk and Best Value Committee (GRBV) for scrutiny.

3. Background

3.1 Every year, the Council requires all Executive Directors and the Chief Officer to review the effectiveness and appropriateness of 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).

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 £700 million and almost 6000 staff deliver the following services:

3.4.1 social work services for adults, including disabilities, mental health, older people, sensory impairment, and substance misuse.

3.4.2 support for carers.

3.4.3 primary care services including GPs and community nursing.

3.4.4 allied health professionals, such as occupational therapists, psychologists, and physiotherapists.

3.4.5 community dental, ophthalmic, and pharmaceutical services.

3.4.6 continence services.

3.4.7 unplanned admissions to hospitals.

4. Main report

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

4.1.1 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.

4.1.2 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

4.1.3 They have identified actions that will be taken to continue improvement.

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

4.3 This was then taken as the basis of the Chief Officer's assurance statement which is attached as appendix 1. The Chief Officer's assurance statement was returned to the Council's Governance Team 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 for 2023.

4.4 As part of the completion of the assurance statement for 2023, the Partnership felt that there was non-compliance / partial compliance in the following areas:

4.4.1 Point 6.2 - I have arrangements in place for the annual review of policies owned by my directorate, via the relevant executive committee, to ensure these comply with the Council's policy framework – non-compliance.

4.4.2 Point 2.1 - I have risk management arrangements in place to identify the key risks to my directorate (and the Council) – partial compliance.

4.5 To address these two areas of non-compliance / partial compliance work has started to address the issues and an update is undernoted:

4.5.1 **Risk Management** – the risk management approach needs to be strengthened in some areas of the Partnership. Alongside this, due to the configuration of the Partnership (i.e., managing across two organisations - CEC & NHS), risk management is not undertaken in a consistent manner. The rollout of the

Partnership risk framework (approximately 35% rolled out across the totality of the Partnership) ensures that risk registers will be reviewed and completed in a consistent way and support risk aggregation across all teams and work is ongoing to ensure alignment with the Council's risk management approach which is being refreshed as well as NHS Lothian which has also recently been refreshed.

4.5.2 **Policies and Procedures -** The co-ordination of policies going forward will be undertaken by the Operations Manager / Assurance Officer. The inspection into Adult Social Work and Social Care identified several outstanding policies, with 8 that are solely the responsibility of the Partnership to review, and work is progressing to review these within the next year. A process has now been put in place for the annual review of policies and procedures. Work has started with managers to ensure there is sufficient leadership and ownership for policies on and procedures, to ensure that policies and procedures are reviewed regularly.

4.6 There was recognition that across several areas that whilst the Partnership are compliant, there is further improvements that are required to enhance the controls in place:

4.6.1 Supervision meetings from staff in relation to social care services will be reviewed and enhanced and is a focussed piece of work within the Adult Social Care and Social Work Improvement plan.

4.6.2 Risk assessments in relation to social care services, will be reviewed and enhanced and is a focussed piece of work within the Adult Social Care and Social Work Improvement Plan.

4.7 It is also recognised that there have been views expressed regarding the lack of engagement in relation to the EIJB Bed Based Review. Work is underway in relation to the governance arrangements within the Partnership to ensure that the right people are engaged at the right time and informing decisions making and engagement following due process.

4.8 As part of the process an improvement plan has been developed and included as appendix 2 covering the areas identified as non-compliant and partially compliant with responsible officer and deadlines included.

5. Next Steps

5.1 The Partnership continues to work to deliver those actions identified in appendix 2 to strengthen controls in key areas.

5.2 The annual assurance process will continue to be reviewed in line with feedback to ensure that effective assurance is provided.

5.3 The 2023-2024 annual assurance schedule will be presented to Governance, Risk and Best Value Committee in 12 months for scrutiny.

6. Financial impact

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

6.2 An effective control framework is key in ensuring that the Council has appropriate governance in place.

7. Stakeholder/Community Impact

7.1 The assurance schedule exercise acts as a prompt for service areas to think about good governance and their internal control environment. Action plans support improvements in areas where weaknesses have been identified.

7.2 Completed schedules are reviewed by the Democracy, Governance and Resilience Senior Manager and are provided to the Chief Internal Auditor for comment.

7.3 The annual assurance schedule template has been drafted using input from the Council's subject matter experts and contributions from a range of specialist areas across the Council and Partnership including resilience, health and safety and internal audit.

8. Background reading/external references

None.

9. Appendices

Appendix 1 - Partnership Annual Assurance Statement 2022 - 23

Appendix 2 - Annual Assurance Action Plan

Appendix 1 – 2022 23 Partnership Annual Assurance Schedule

Ref	Statement	Response				
1	**Internal Control Environment**	**Assessment of Compliance**	**Did your directorate have any issues in this area during the reporting period? (Please reflect where open assurance actions mean that a control weakness exists)**	**Extract of Evidence from the Council's Corporate Governance Code. For information only.**	**Relevant service area controls**	**Improvement Actions (will auto-populate improvement plan tab where you should add action owner and deadline)**
1.1	I have internal controls and procedures in place throughout my directorate that are proportionate, robust, monitored and operate effectively.	Compliant		Annual Internal Audit Plan (based on most significant risks to the Council) CLT Change Board – programme/project management framework Council Companies/ALEOs – Governance Hub, Observers, annual reporting to Executive Committee and GRBV Community planning – Edinburgh Partnership, Community Plan Contingency planning and business continuity arrangements EIJB – scrutiny and accountability arrangements agreed through scheme Enterprise Risk Management Policy and Risk Management Procedure External validation/review e.g. external audit, independent assurance providers GRBV quarterly scrutiny of top risks GRBV scrutiny of CLT risk register, delivery of Internal Audit Plan and of all Internal Audit reports Health and safety audits Informal and formal reviews e.g. internal audit, quality assurance audits Overdue audit recommendations report monthly to CLT and quarterly to GRBV Policies that mitigate risks e.g. Anti-bribery,	EIJB and Partnership (via CEC) Internal Audit Plan. Regular monitoring of IA actions (9 outstanding, with 30 closed in the last year). EIJB Audit and Assurance Committee. EMT strategic risk management approach in place. Independent scrutiny from Care Inspectorate on service delivery. Health and safety assurance framework. Employment policies managing risk (including antibribery, fraud, code of conduct). Regular team huddles and staff 1:1's. All reports include section on risks. Regular performance reporting on key service areas. Scrutiny at Audit and Assurance Committee and GRBV. Resilience Arrangements in place. Quarterly Risk Committee in place, feeding into CLT risk committee and escalating risks accordingly.	
1.2	I have controls and procedures in place to manage the risks in delivering services through council companies, partners and third parties.	Compliant				

1.3	My internal controls and procedures and their effectiveness are regularly reviewed and the last review did not identify any weaknesses that could have an impact on the Annual Accounts.	Compliant		Fraud Prevention, Whistleblowing Quarterly corporate risks scrutinised at CLT Quarterly Risk and Assurance Committees Regular 121 meetings between the Council's Chief Executive and the Chief Executives of key ALEOs Report template and guidance – section on risks Reporting/review/monitoring at all levels – committee, CLT, SMTs, service level Risk Appetite Statement Risk Management Groups Risk management policies and strategies (e.g. procurement, standing orders, project management, health and safety, information governance) Risk Management Procedure Risk management tools Schools assurance programme Shareholder or service level agreements Team Central – monitoring implementation of audit recommendations Training, eLearning and workshops for staff and members Wide ranging internal and external counter fraud activity		
1.4	The monitoring process applied to funding/operating agreements has not identified any problems that could have a significant negative impact.	Compliant				

2	Risk and Resilience	Assessment of Compliance	Did your directorate have any issues in this area during the reporting period? (Please reflect where open assurance actions mean that a control weakness exists)	Extract of Evidence from the Council's Corporate Governance Code. For information only.	Relevant service area controls	Improvement Actions (will auto-populate improvement plan tab where you should add action owner and deadline)
2.1	I have risk management arrangements in place to identify the key risks to my directorate (and the Council).	Partially compliant		Budget Planning Business Impact Analysis CLT Change Board – programme/project management framework CLT scrutiny Contingency planning for major events Council Business Plan Enterprise Risk Management Policy GRBV quarterly scrutiny of top risks Health and safety audits Internal and external audits Internal Audit Plan development considers top risks Leader's induction includes Risk Management Quarterly corporate risks scrutinised at CLT Quarterly Risk and Assurance Committees Report template and guidance – section on risks Reporting/review/monitoring at all levels – committee, CLT, SMTs, service level Resilience Plans Resilience Protocols Risk Appetite Statement	Risk register is in place for the Partnership and key operational teams. Risk Registers are aligned to the EIJB risk register as well as the CEC and NHSL strategic risks where appropriate. Reports have sections specifically focused on risk. Partnership Risk Management approach agreed and being rolled out across the Partnership. Risk Committee now in place and specially focussed on managing risk across the Partnership and feeds into CLT in terms of escalation. Risk Escalation process in place from services to the Partnership Risk Committee. Risk register is in place for the Partnership and key operational teams. Risk Registers are aligned to the	The Partnership has a risk register alongside a range of service and project risk registers; however, these are not done in a consistent way (e.g. same templates / scoring) due to the configuration of the Partnership (i.e., managing across two organisations - CEC & NHS). The rollout of the Partnership risk framework (approximately 35% rolled out across the totality of the Partnership ensures that risk registers will be reviewed and completed in a consistent way and support risk aggregation across all teams and work is ongoing to ensure alignment with the Council's risk management approach which is being refreshed.

2.2	I have effective controls and procedures in place to record and manage the risks identified above to a tolerable level or actions are put in place to mitigate and manage the risk.	Compliant	The Partnership would recognise that further improvements are required in relation to risk assessment related to social care services and this will be reviewed and enhanced as part of the development of an action plan to address the findings of the two care inspection reports into adult social care and adult support and protection.	Risk Management Groups Risk management policies and strategies (e.g. procurement, standing orders, project management, health and safety, information governance) Risk Management Procedure Risk management tools Schools assurance programme Serious and Organised Crime policies and strategies Serious and Organised Crime plans, procedures and protocols Service Planning Training, eLearning and workshops for staff and members	EIJB risk register as well as the CEC and NHSL strategic risks where appropriate. Reports have sections specifically focused on risk. Partnership Risk Management approach agreed and being rolled out across the Partnership. Risk Committee now in place and specially focussed on managing risk across the Partnership and feeds into CLT in terms of escalation. Risk Escalation process in place from services to the Partnership Risk Committee.	The rollout of the Partnership risk framework (approximately 35% rolled out across the totality of the Partnership ensures that risk registers, including mitigating actions will be reviewed and completed in a consistent way and support risk aggregation across all teams and work is ongoing to ensure alignment with the Council's risk management approach which is being refreshed.
2.3	The robustness and effectiveness of my risk management arrangements is regularly reviewed and the last review did not identify any weaknesses that could have an impact on the Annual Accounts.	Compliant				
2.4	There is appropriate escalation/communication to the directorate Risk Committee and CLT Risk Committee (as appropriate) of significant issues, risks and weaknesses in risk management.	Compliant			Risk register is in place for the Partnership and key operational teams. Risk Registers are aligned to the EIJB risk register as well as the CEC and NHSL strategic risks where appropriate. Reports have sections specifically focused on risk. Partnership Risk Management approach agreed and being rolled out across the Partnership.	

2.5	I have arrangements in place to promote and support the Council's policies and procedures for staff to raise awareness of risk concerns, Council wrongdoing and officer's misconduct.	Compliant			Risk Committee now in place and specially focussed on managing risk across the Partnership and feeds into Corporate Leadership Team / NHS Corporate Management Team in terms of escalation. Risk Escalation process in place from services to the Partnership Risk Committee. Risk register is in place for the Partnership and key operational teams. Risk Registers are aligned to the EIJB risk register as well as the CEC and NHSL strategic risks where appropriate. Reports have sections specifically focused on risk. Partnership Risk Management approach agreed and being rolled out across the Partnership. Risk Committee now in place and specially focussed on managing risk across the Partnership and feeds into Corporate Leadership Team / NHS Corporate Management Team in terms of escalation. Risk Escalation process in place from services to the Partnership Risk Committee.	

2.6	My directorate has resilience and counter terrorism arrangements in place and my directorate's resilience data, plans, arrangements, protocols, and training mitigate the resilience risks that could impact on the delivery of our priority activities and ensure appropriate staff groups are adequately trained to respond to an incident affecting my directorate. All documentation is regularly reviewed and validated.	Compliant	We have one internal audit assurance action relating to testing of resilience plans and are currently developing a programme of scenario testing to support testing of resilience plans (56 plans in total).		Resilience Plans in place for all essential services and reviewed annually. Business continuity risks raised and discussed at a range of governance committees including the Partnership Risk Committee. Regular testing of call trees. Training and exercising undertaken alongside two resilience events which were led by the Partnership. NHS Resilience Committee in place. Participation in Lothian and Borders Resilience Partnership as well as participation in relevant exercises.	

2.7	I have policies, strategies, procedures and protocols as well as associated staff training in place to assess vulnerabilities and divert, deter, detect and disrupt activity related to serious and organised crime to protect the council, its clients and the wider community.	Compliant			eLearning in place for staff on fraud. Serious and Organised Crime policies and strategies. Serious and Organised Crime plans, procedures and protocols communicated to staff Service Planning. Segregation of duties in place.	
3	**Workforce Control**	**Assessment of Compliance**	**Did your directorate have any issues in this area during the reporting period? (Please reflect where open assurance actions mean that a control weakness exists)**	**Extract of Evidence from the Council's Corporate Governance Code. For information only.**	**Relevant service area controls**	**Improvement Actions (will auto-populate improvement plan tab where you should add action owner and deadline)**
3.1	I have arrangements in place to ensure compliance with payroll policies, overtime controls, absence management and performance e.g. home/remote working.	Compliant		360 reviews Annual Internal Audit Plan (based on most significant risks to the Council) Employee Assistance Programme Employee Engagement External validation/review e.g. external audit, independent assurance providers Financial benefits (credit union, season ticket loans, car benefit scheme, pension schemes) Funding scheme for professional qualifications HR Policies (Absence Management, Stress Management, Avoidance of Bullying and Harassment, Equal Treatment) Informal and formal reviews e.g. internal audit, quality assurance audits Inspiring Talent Programme	Compulsory training specific to role in place and monitored via supervisions. Online system for recording overtime, absence and performance. Induction process in place. Personal development in place and discussed as part of 1:1's / supervision. H&S report relating to staff accidents and incidents. Managing absence support for managers. WLT programme in place to share learning on a wide range of topics	

3.2	I have robust controls in place to ensure that statutory workforce requirements are met, including the management of 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.	Compliant		Internal and External training opportunities Leader Induction and Essential Learning Leadership Development Programme– Future, Engage, Deliver Managing Attendance Training for managers Occupational Health service Onboarding, induction essential learning and CPD for officers Open framework agreement for Learning and Development People Strategy Performance Management Framework (Performance Conversations) Policies that mitigate risks e.g. Anti-bribery, Fraud Prevention, Whistleblowing Regular reporting including Health & Safety Performance, absence levels Staff benefits (enhanced entitlements leave entitlement, flexible working options, childcare vouchers, ride to work scheme, premium benefits scheme) Wide ranging internal and external counter fraud activity Wider Leadership Team (incl. Learning Sets) Wider Leadership Team programme	which include workforce issues. Specific HR support for key areas where there are high sickness levels (e.g., Homecare) to support staff back to work.	
3.3	I ensure compliance with the Council's HR policies and procedures across all of my service areas, e.g. that recruitment and selection is only undertaken by appropriately trained individuals and is fully compliant with vacancy approvals and controls.	Compliant				

3.4	I 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.	Compliant		Compulsory training specific to role in place and monitored via supervisions. Online system for recording overtime, absence and performance. Induction process in place. Personal development in place and discussed as part of 1:1's / supervision. H&S report relating to staff accidents and incidents. Managing absence support for managers. WLT programme in place to share learning on a wide range of topics which include workforce issues. Specific HR support for key areas where there are high sickness levels (e.g., Homecare) to support staff back to work.	
3.5	I have arrangements in place to manage staff health and wellbeing; ensuring that sickness absence, referral to occupational health and stress risk assessments is managed in compliance with the Council's HR policies.	Compliant			
3.6	I ensure compliance with essential training requirements and support learning and development appropriately, including professional CPD requirements.	Compliant			

3.7	I have arrangements in place to support and manage staff performance e.g. regular 1:1/supervision meetings, performance/spotlight conversations.	Compliant	The Partnership would recognise that further improvements are required in relation to supervisions meetings in relation to social care services and this will be reviewed and enhanced as part of the development of an action plan to address the findings of the two care inspection reports into adult social care and adult support and protection.			
4	**Council Companies**	**Assessment of Compliance**	**Did your directorate have any issues in this area during the reporting period? (Please reflect where open assurance actions mean that a control weakness exists)**	**Extract of Evidence from the Council's Corporate Governance Code. For information only.**	**Relevant service area controls**	**Improvement Actions (will auto-populate improvement plan tab where you should add action owner and deadline)**
4.1	I have arrangements in place for the oversight and monitoring of the Council companies I am responsible for, that give me adequate assurance over their operation and delivery for the Council.			Annual Assurance Process (Directorates) Council Companies/ALEOs – Governance Hub, Observers, annual reporting to Executive Committee and GRBV Regular 121 meetings between the Council's Chief Executive and the Chief Executives of key ALEOs Service Level Agreement Register Shareholder or service level agreements		

4.2	I have an appropriate Service Level Agreement, or other appropriate legal agreement, in place for each Arm's Length External Organisation that I am responsible for.					
5	**Engagement and Consultation**	**Assessment of Compliance**	**Did your directorate have any issues in this area during the reporting period? (Please reflect where open assurance actions mean that a control weakness exists)**	**Extract of Evidence from the Council's Corporate Governance Code. For information only.**	**Relevant service area controls**	**Improvement Actions (will auto-populate improvement plan tab where you should add action owner and deadline)**
5.1	My directorate engages effectively with institutional stakeholders, service users and individual citizens, applying the council's consultation and engagement standards with evidence that the insights gathered are used to shape my directorates activities.	Compliant	Recognising there have been some views expressed regarding the lack of engagement around Drumbrae, work is developing in relation to a lesson learned / organisation redesign framework to ensure a clear pathway / approach in undertaking further organisations redesign to ensure that any consultation approach is clear.	Budget consultation Business sector forums Community engagement activity Community engagement strategy/policy Complaints Improvement Plan Consultation framework Consultation Hub Council Change Strategy Committee Papers Online Current partnerships e.g. Poverty Commission, Tourism Strategy, EIJB, City Deal Edinburgh Partnership (LCCPs, Neighbourhood Networks) Edinburgh People Survey Government partnership working Have Your Say webpage	Strategic plan consultation. Complaints improvement plans for all upheld complaints. EIJB meetings are public and webcast with papers available publicly. Petitions and deputations for EIJB and Council committees in place. Consultation protocol in place to standardise consultation approaches across the Partnership. Engagement included in report templates. Locality Improvement plans and operational plans are in development.	

5.2	I have arrangements in place throughout my directorate to ensure that there are effective communication methods that encourage, collect and evaluate views and experiences (while ensuring inclusivity e.g. customer surveys, consultation procedures, social media presence, etc.) and that these insights are used to inform the work of the directorate.	Compliant		Multi-agency partnerships Multi-channel methodology e.g. social media platform development Networks/user groups – e.g. Edinburgh Tenants' Federation Partnership agreements e.g. Police Scotland Partnership governance arrangements Partnership governance documentation Partnership plans e.g. Edinburgh Children's Partnership Petitions and Deputations Policies and procedures (consultation framework) Poverty Commission Public participation – deputations and petitions Public sector partnerships Publication of Council diary Report template – section on consultation Stakeholder group meetings Strategic documentation e.g. vision statements, aims, etc.	Engagement of Consultation Institute to develop consultation around the bed base in Edinburgh. Lay members (both citizen and user representatives) on the EIJB, to ensure their views are taking into account when making EIJB strategic decisions.	
5.3	I have appropriate arrangements in place throughout my directorate for recording, monitoring and managing customer service complaints and customer satisfaction.	Compliant		Strategic plans and agreements Strategy and Performance Hub Surveys e.g. Edinburgh People Survey, Annual Tenant Survey Third sector partnership working e.g. EVOC Webcasting of Council and major committees, including subtitles		

5.4	I regularly consult and engage with recognised trade unions.	Compliant				
6.1	**Policy**	**Assessment of Compliance**	**Did your directorate have any issues in this area during the reporting period? (Please reflect where open assurance actions mean that a control weakness exists)**	**Extract of Evidence from the Council's Corporate Governance Code. For information only.**	**Relevant service area controls**	**Improvement Actions (will auto-populate improvement plan tab where you should add action owner and deadline)**
6.1	I have arrangements in place to ensure all directorate staff are made aware of and fully understand the implications of all relevant existing and new council policies and procedures.	Compliant		Annual Assurance Exercise Annual Policy Assurance Statements Corporate Policy Framework and Toolkit, including consultation and engagement strategies Council Papers Online Employee policy refresher arrangements, process workshops and communications Information Governance framework Policy Register Report template and guidance (incorporating adherence to commitments and policy implications)	Annual Assurance exercise. Audit and Assurance Committee. Committee papers on line. Policy register. Regular 1:1's / team huddles to communicate any policies. Orb pages.	

6.2	I have arrangements in place for the annual review of policies owned by my directorate, via the relevant executive committee, to ensure these comply with the Council's policy framework.	Not compliant	The co-ordination of policies going forward will be undertaken by the Operations Manager / Assurance Officer. The inspection into Adult Social Care identified a number of outstanding policies, with 8 that are solely the responsibility of the Partnership to review, and work is progressing to review these within the next year. There are also a large number which sit within the responsibility of Corporate Services and the CSWO to review and update.			The co-ordination of policies going forward will be undertaken by the Operations Manager / Assurance Officer. The inspection into Adult Social Care identified a number of outstanding policies, with 8 that are solely the responsibility of the Partnership to review, and work is progressing to review these within the next year. There are also a large number which sit within the responsibility of Corporate Services and the CSWO to review and update.
7	**Governance and Compliance**	**Assessment of Compliance**	**Did your directorate have any issues in this area during the reporting period? (Please reflect where open assurance actions mean that a control weakness exists)**	**Extract of Evidence from the Council's Corporate Governance Code. For information only.**	**Relevant service area controls**	**Improvement Actions (will auto-populate improvement plan tab where you should add action owner and deadline)**

7.1	I ensure directorate staff are aware of their responsibilities in relation to the Council's governance framework and that the authority, responsibility and accountability levels within my directorate are clearly defined, with proper officer designation delegated, recorded, monitored, revoked and reviewed regularly to ensure ongoing compliance with the Scheme of Delegation.	Compliant		Codes of Conduct Committee Terms of Reference and Delegated Functions Council's Procedural Standing Orders Councillors' Code of Conduct Disclosure and PVG checks Employee Induction Employee Performance Framework Leadership Programme Legal Services provision of advice Member/Officer Protocol Policies and procedures Regulatory body reporting e.g. SSSC, GTCS Scheme of Delegation to Officers Statutory officer appointments and responsibilities Statutory/lead officers' independent reports to committee e.g. Monitoring Officer, Chief Social Work Officer, Chief Internal Auditor Whistleblowing Policy	Code of Conduct in place for all employees. Committee TOR's agree with annual review. Standing orders. Disclosure and PVG checks undertaken for some roles. Employee induction and partnership specific induction undertaken. Performance framework in place. Leadership / coaching programme offered to employees. Chief Social Work Officer provides an assurance role. Whistleblowing policy to support staff to raise any concerns. Scheme of Delegation in place for staff.	
7.2	I ensure my directorate's activities are fully compliant with relevant Scottish, UK and international legislation and regulations.	Compliant				

8	Responsibility and Accountability	Assessment of Compliance	Did your directorate have any issues in this area during the reporting period? (Please reflect where open assurance actions mean that a control weakness exists)	Extract of Evidence from the Council's Corporate Governance Code. For information only.	Relevant service area controls	Improvement Actions (will auto-populate improvement plan tab where you should add action owner and deadline)
8.1	My directorate ensures our officers are clear on their roles and responsibilities in terms of relationships and decision making.	Compliant		Annual Assurance Process (Council Companies and Joint Boards) Annual Assurance Process (Directorates) Codes of Conduct Commercial and Procurement Strategy Committee Terms of Reference and Delegated Functions Complaints Improvement Plan Consultation and engagement Contract Standing Orders Council Change Strategy Council company monitoring including Governance Hub, Council Observers on Boards, committee reporting Edinburgh People Survey Employee Code of Conduct Grant Standing Orders Member/Officer Protocol Monitoring/reporting on delivery of 52 coalition commitments Onboarding and induction for officers Performance Framework Policies and procedures Procurement framework	Code of Conduct in place for all employees. Committee TOR's agree with annual review. Standing orders, Disclosure and PVG checks undertaken for some roles. Employee induction and partnership specific induction undertaken. Performance framework in place. Leadership / coaching programme offered to employees. Chief Social Work Officer provides an assurance role. Whistleblowing policy to support staff to raise any concerns.	
8.2	I ensure that the Council's ethical standards are understood and embedded across my directorate and are upheld by external providers of services.	Compliant				

8.3	My directorate ensures that decisions are made on the basis of objective information, the consideration of best value, risk, stakeholder views, rigorous analysis, and consideration of future impacts. This is formalised through appropriate structures. (i.e. SMT reporting)	Compliant		Procurement Handbook Public participation – deputations and petitions Report template and guidance Scheme of Delegation to Officers Service Level Agreement template Standard Condition of Grant		
8.4	I consult with elected members as appropriate and as required under the Scheme of Delegation.	Compliant	It is also recognised that there have been views expressed regarding the lack of engagement in relation to the EIJB Bed Based Review. Work is underway in relation to the governance arrangements within the Partnership to ensure that the right people are engaged at the right time and informing decisions making and engagement following due process.			

9	Information Governance	Assessment of Compliance	Did your directorate have any issues in this area during the reporting period? (Please reflect where open assurance actions mean that a control weakness exists)	Extract of Evidence from the Council's Corporate Governance Code. For information only.	Relevant service area controls	Improvement Actions (will auto-populate improvement plan tab where you should add action owner and deadline)
9.1	I ensure directorate staff are made aware of their responsibilities in relation to the proper management of Council information, including the need to adhere to relevant legislation, Council policies, procedures and guidance around: information governance; records management; data quality; data breaches and privacy impact assessments; information rights; information compliance; information security; and ICT acceptable use.	Compliant		Annual communications plan, awareness raising initiatives and training events Centralised Information governance unit Council wide Record of Processing Data quality reviews and audits form part of statutory returns Established framework of management information and reporting to support operational decision making and trend analysis Information Board Information governance policies, framework, guidance, procedures and toolkit Information sharing agreements and data protection impact assessments Locking Client's Record Guidance Mandatory training for all employees Staff responsibilities outlined in relevant policies - Employee Code of Conduct, ICT Acceptable Use Policy, Policy on Fraud Prevention Standard data related terms and conditions in all new Council contracts	All FOI'S and DPA are co-ordinated centrally. Mandatory training in information governance for all staff undertaken every two years. Employee code of conduct. ICT acceptable use policy. data breaches process in place. PIA and information security. Reinforced via team meetings	

9.2	I ensure data sharing arrangements with third parties are recorded, followed and regularly reviewed throughout all service areas in my directorate.	Compliant				
10	**Health and Safety**	**Assessment of Compliance**	**Did your directorate have any issues in this area during the reporting period? (Please reflect where open assurance actions mean that a control weakness exists)**	**Extract of Evidence from the Council's Corporate Governance Code. For information only.**	**Relevant service area controls**	**Improvement Actions (will auto-populate improvement plan tab where you should add action owner and deadline)**
10.1	Directorate staff are made aware of their responsibilities under relevant Health & Safety policies and procedures, and I have appropriate arrangements in place for the identification and provision of Health & Safety training necessary for all job roles, including induction training.	Compliant		Contingency planning and business continuity arrangements Corporate Health and Safety Strategy and Plan Council Health and Safety Group Employee Code of Conduct Enterprise Risk Management Policy Enterprise Risk Management Policy and Risk Management Procedure External validation/review e.g. external audit, independent assurance providers Health and safety audits Health & Safety policies and procedures Institution of Occupational Safety and Health training Mandatory Health & Safety training for staff Reporting/review/monitoring at all levels – committee, CLT, SMTs, service level	Member of Council Health and Safety Group All staff undertake H&S training and agreed under code of conduct. Health and safety framework with HSC in place. H&SC E-learning (mandatory). Regular H&S reports to Executive Team meeting for scrutiny and review. Partnership Health and Safety governance arrangements in place.	

10.2	I have the necessary arrangements in place to establish, implement and maintain procedures for ongoing hazard identification, risk assessment and the determination of necessary controls to ensure all Health & Safety risks are adequately controlled.	Compliant	1 internal audit assurance action relates to lone working and options have been agreed by the Executive Team to strengthen lone working arrangements with work ongoing to implement those options.	Risk Management Groups Risk management policies and strategies (eg procurement, standing orders, project management, health and safety, information governance) Risk Management Procedure Risk management tools Scheme of Delegation Schools assurance programme Training, eLearning and workshops for staff and members		
10.3	I have competencies, processes and controls in place to ensure that all service areas in my directorate, and other areas of responsibility, operate in compliance with all applicable Health & Safety laws and regulations.	Compliant			Member of Council Health and Safety Group All staff undertake H&S training and agreed under code of conduct. Health and safety framework with HSC in place. H&SC E-learning (mandatory). Regular H&S reports to Executive Team meeting for scrutiny and review. Partnership Health and Safety governance arrangements in place.	
10.4	I have a robust governance and reporting structure for Health and Safety in my directorate.	Compliant				

11	Performance	Assessment of Compliance	Did your directorate have any issues in this area during the reporting period? (Please reflect where open assurance actions mean that a control weakness exists)	Extract of Evidence from the Council's Corporate Governance Code. For information only.	Relevant service area controls	Improvement Actions (will auto-populate improvement plan tab where you should add action owner and deadline)
11.1	I have arrangements in place for reporting to CLT, Committee and/or Council and, where performance monitoring identifies inadequate service delivery or poor value for money, ensure that improvement measures to address these issues are implemented and monitored.	Compliant		Annual external reporting e.g. Local Government Benchmarking Framework, Statutory reporting, Scottish Public Services Ombudsman, Scottish Government, etc Annual performance report to Council B agenda protocol Best Value reporting CLT Meeting - Performance Committee Terms of Reference and Delegated Functions Local Government Benchmarking Framework – Committee Report Monitoring/reporting on delivery of 52 coalition commitments – delete : no longer exists under new administration HR Performance Framework Planning & Performance Framework Strategy and Performance webpage	Annual performance report published. Performance and delivery committee remit is performance scrutiny / assurance. Regular performance reports submitted to ET and EIJB for assurance. Reporting via CLT performance meeting as well as joint Council and NHS performance meeting. B agenda arrangements in place for EIJB Whole system oversight board has a focus on performance. Performance and Delivery Committee focusses on performance and improvement.	
11.2	My directorate regularly works with relevant teams in Corporate Services to review and improve effectiveness by performance monitoring, benchmarking and other methods to achieve defined outcomes.	Compliant				

12	Commercial and Contract Management	Assessment of Compliance	Did your directorate have any issues in this area during the reporting period? (Please reflect where open assurance actions mean that a control weakness exists)	Extract of Evidence from the Council's Corporate Governance Code. For information only.	Relevant service area controls	Improvement Actions (will auto-populate improvement plan tab where you should add action owner and deadline)
12.1	I ensure all goods, services and works are procured and managed in compliance with the Contract Standing Orders.	Compliant		Annual Assurance Process (Directorates) Codes of Conduct Commercial and Procurement Strategy Committee Terms of Reference and Delegated Functions Contract and Grants Management team Contract Standing Orders Council company monitoring including Governance Hub, Council Observers on Boards, committee reporting Grant Standing Orders Legal Services provision of advice Policies and procedures Procurement Handbook Contract management manual Scheme of Delegation to Officers Service Level Agreement Register Standard Condition of Grant	Code of conduct. Compliance with procurement strategy and contract standing orders. Regular procurement board focusing on HSC contracts / contract monitoring arrangements in place. Scheme of delegation in place. Standardised HSC contract framework / documentation.	
13	Change and Project Management	Assessment of Compliance	Did your directorate have any issues in this area during the reporting period? (Please reflect where open assurance actions mean that a control weakness exists)	Extract of Evidence from the Council's Corporate Governance Code. For information only.	Relevant service area controls	Improvement Actions (will auto-populate improvement plan tab where you should add action owner and deadline)

13.1	All projects and programmes have a clear business justification, as a minimum this should articulate outcomes and benefits; have appropriate governance in place to support delivery; effective controls in place to track delivery progress and to take corrective action if required; have a robust benefits management framework in place; and ensure that a formal closure process is undertaken.	Compliant	4 internal audit actions requesting the reporting arrangements be strengthened for project and work is ongoing to close these actions. 5 actions have been closed / implemented.	2050 City Vision Budget Planning Capital Budget Strategy City Plan CLT Change Board Committee Terms of Reference and Delegated Functions Contract Standing Orders Council Business Plan Council Change Strategy Council's Risk Appetite Statement Enterprise Risk Management Policy External audits, reviews and validation Finance Rules Financial Regulations Procurement framework Report template and guidance Revenue Budget Framework Risk Registers Scheme of Delegation to Officers Service Planning Sustainability Strategy process Treasury Management Strategy	Innovation and Sustainability Programme now in place. Refined work programme now established, taking account of COVDI19. Programme Board and Portfolio Board established. Regular reporting to the EIJB on the transformation programme. Risk registers in place for projects and programmes.	
14.1	**Financial Control**	**Assessment of Compliance**	**Did your directorate have any issues in this area during the reporting period? (Please reflect where open assurance actions mean that a control weakness exists)**	**Extract of Evidence from the Council's Corporate Governance Code. For information only.**	**Relevant service area controls**	**Improvement Actions (will auto-populate improvement plan tab where you should add action owner and deadline)**

14.1	The operation of financial controls in my directorate is effective in ensuring the valid authorisation of financial transactions and maintenance of accurate accounting records.	Compliant		Budget Framework Comprehensive system of revenue and capital monitoring, with SMT and CLT oversight Contract Standing Orders Corporate Debt Policy Council Business Plan Council Change Strategy Elected Member training on financial statements, financial planning and treasury management Employee Training Finance & Resources Committee and Governance, Risk & Best Value Committee oversight/scrutiny Finance Rules Financial Regulations Internal control framework Medium-term Financial Strategy Professional officer representation/support/advice on major project boards, project assurance reviews, SMTs Tiered framework of financial planning and control Treasury Management Strategy	Budget setting protocol in place. Budget framework is in place. Contract standing orders in place. Strong links with Council and NHS Lothian finance team. Regular finance reports provided. Finance regular item on ET agenda. All reports have finance focused element. Medium term financial plan developed.	
14.2	I am confident that the arrangements in place to monitor expenditure/budget variances would identify control problems or variances that could have an effect on the Annual Accounts.	Compliant				

14.3	I 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.	Compliant				
14.4	I have arrangements in place to ensure that new and existing leases in the scope of IFRS16 are promptly identified and relevant details notified to Finance colleagues for incorporation in the Council's annual financial statements.	Compliant				

14.5	I have arrangements in place to review and protect assets against theft, loss and unauthorised use; identify any significant losses; and, ensure the adequacy of insurance provision in covering the risk of loss across my directorate.	Compliant				
14.6	I have arrangements in place for identifying any weaknesses in my directorate's compliance with Council financial policies or statutory/regulatory requirements.	Compliant				

14.7	I have arrangements in place for identifying any internal control, risk management or asset valuation problems within my directorate's service areas that could affect the Annual Accounts.	Compliant				
15	**Group Accounts (Corporate Services only)**	**Assessment of Compliance**	**Did your directorate have any issues in this area during the reporting period? (Please reflect where open assurance actions mean that a control weakness exists)**	**Extract of Evidence from the Council's Corporate Governance Code. For information only.**	**Relevant service area controls**	**Improvement Actions (will auto-populate improvement plan tab where you should add action owner and deadline)**
15.1	I have arrangements in place for identifying and reviewing any developments during the year that should lead to additions, deletions or amendments to the companies included in the Group Accounts.			Annual assurance exercise (internal audit input and oversight) Annual Corporate Governance Framework self-assessment (internal audit input) Annual Governance Statement – informed by the work of IA Annual Internal Audit Plan (based on most significant risks to the Council) Audit Charter Chief Internal Auditor's direct reporting line to GRBV Committee Terms of Reference and Delegated		

15.2	I have arrangements in place to identify and review any internal control, risk management or asset valuation problems with Council companies that could affect the Group Accounts.			Functions - GRBV Comprehensive system of revenue and capital monitoring, with SMT and CLT oversight Council Companies/ALEOs – Governance Hub, Observers, annual reporting to Executive Committee and GRBV External validation/review e.g. external audit, independent assurance providers Executive Committee and Governance, Risk & Best Value Committee oversight/scrutiny Regular 121 meetings between the Council's Chief Executive and the Chief Executives of key ALEOs Shareholder or service level agreements		
16	**National Agency & Regulatory Body Inspection Reports**	**Assessment of Compliance**	**Did your directorate have any issues in this area during the reporting period? (Please reflect where open assurance actions mean that a control weakness exists)**	**Extract of Evidence from the Council's Corporate Governance Code. For information only.**	**Relevant service area controls**	**Improvement Actions (will auto-populate improvement plan tab where you should add action owner and deadline)**
16.1	I have arrangements in place to identify any reports relating to my directorate and can confirm that there were no inspection reports that could impact on the signing of the Annual Governance Statement.	Compliant	Arrangements are in place to identify inspection reports that will impact on the Partnership and work is ongoing to develop an improvement programme for the recommendations arising from the two care inspections reports.	Committee Terms of Reference and Delegated Functions Governance, Risk and Best Value Committee – chaired by an opposition councillor and excluding executive committee conveners from its membership, with power to act on its own accord Executive Committee and GRBV oversight of external audit and inspection activity Scrutiny of directorate annual assurance schedules Regulatory Body inspection reports	Audit and Assurance and GRBV committee in place. Key national reports or those with an impact on the Partnership are discussed at a range of governance groups in terms of next steps. (e.g., Executive Team, Whole System Oversight Board, EAP oversight group, Social Care Improvement Plan Oversight Group).	

16.2	I have arrangements in place that adequately monitor and report on the implementation of recommendations.	Compliant	The Partnership has 9 Internal Audit outstanding management actions that are being addressed and work continues to implement a range of actions arising from the report from the Edinburgh Assistance Programme. Two inspections reports were published in Feb 2023 & March 2023 and identify a number of recommendations which are being taken and shaped into an improvement plan, which has its own reporting arrangements. A formal report will be presented to the May Policy and Sustainability Committee		Audit and Assurance and GRBV committee in place. Key national reports or those with a impact on the Partnership are discussed at a range of governance groups in terms of next steps.	
17	**Internal Audit, External Audit and Review Reports**	**Assessment of Compliance**	**Did your directorate have any issues in this area during the reporting period? (Please reflect where open assurance actions mean that a control weakness exists)**	**Extract of Evidence from the Council's Corporate Governance Code. For information only.**	**Relevant service area controls**	**Improvement Actions (will auto-populate improvement plan tab where you should add action owner and deadline)**

17.1	I have arrangements in place to ensure that all recommendations from any internal audit, external audit or review report published during the year, that have highlighted high, medium or significant control deficiencies, have been (or are being) implemented and that this is monitored effectively.	Compliant	The Partnership has 9 internal audit outstanding management actions that are being addressed and work continues to implement a range of actions arising from the report from the Edinburgh Assistance Programme. Two inspections reports were published in Feb 2023 & March 2023 and identify a number of recommendations which are being taken and shaped into an improvement plan, which has its own reporting arrangements. A formal report will be presented to the May Policy and Sustainability Committee	A validation audit of previously closed audit actions is included in the annual Internal Audit Plan Agreed management actions arising from internal audits are recorded and monitored through Team Central on ongoing basis. Overdue management actions are reported monthly to CLT and quarterly to GRBV Evidence above is for Internal Audit only - needs to link to external audit actions (Finance) and Best Value Actions (Governance). Also needs to consider improvement plans from regulator inspections such as Care Inspectorate and Education Scotland and other relevant review reports for the directorate which require monitoring, response and action plan. Integral part of Annual Assurance Schedule	Robust IA process in place to manage outstanding management actions (9 management actions outstanding with no historic ones remaining and 30 management actions closed in the last year). Regular scrutiny in place at ET on IA management actions. All IA actions have a lead officer as well as a lead officer to oversee IA implementation. Regular scrutiny at GRBV and Audit and Assurance Committee. Governance arrangements are in place for any national reports to ensure appropriate monitoring (e.g., Inspection improvement plan scrutiny.)	
18	**Progress**	**Assessment of Compliance**	**Did your directorate have any issues in this area during the reporting period? (Please reflect where open assurance actions mean that a control weakness exists)**	**Extract of Evidence from the Council's Corporate Governance Code. For information only.**	**Relevant service area controls**	**Improvement Actions (will auto-populate improvement plan tab where you should add action owner and deadline)**

18.1	All outstanding issues or recommendations arising from this exercise, commissioned reviews, committee reports and other initiatives in previous years have been addressed satisfactorily.	Compliant	The Partnership has 9 internal audit outstanding management actions that are being addressed and work continues to implement a range of actions arising from the report from the Edinburgh Assistance Programme. Two inspections reports were published in Feb 2023 & March 2023 and identify several recommendations which are being taken and shaped into an improvement plan, which has its own reporting arrangements. A formal report will be presented to the May Policy and Sustainability Committee.	Agreed management actions arising from internal audits are recorded and monitored through Team Central Overdue management actions are reported monthly to CLT and quarterly to GRBV A validation audit of previously closed audit actions is included in the annual Internal Audit Plan Integral part of Annual Assurance Schedule External Audit Report is scrutinised by GRBV and an improvement plan developed IA communicates regularly with Care Inspectorate, Audit Scotland, Scottish Housing Regulator and Education Scotland	Robust IA process in place to manage outstanding management actions. Regular scrutiny in place at ET on IA management actions and any other assurance actions. All IA actions have a lead officer as well as a lead officer to oversee IA implementation. Regular scrutiny at GRBV and Audit and Assurance Committee. Governance arrangements are in place for any national reports to ensure appropriate monitoring (e.g., Inspection improvement plan scrutiny.)	

Appendix 2 Improvement Plan

2	Assurance Statement Criteria	Improvement Actions	Action Owner	Planned Completion Date
2.1	I have risk management arrangements in place to identify the key risks to my directorate (and the Council).	The Partnership has a risk register alongside a range of project risk registers; however, these are not done in a consistent way (e.g., same templates / scoring) due to the configuration of the Partnership (i.e., managing across two organisations - CEC & NHS). The rollout of the Partnership risk framework (approximately 35% rolled out across the totality of the Partnership ensures that risk registers will be reviewed and completed in a consistent way and support risk aggregation across all teams and work is ongoing to ensure alignment with the Council's risk management approach which is being refreshed.	Executive Team	31 March 23
2.2	I have effective controls and procedures in place to record and manage the risks identified above to a tolerable level or actions are put in place to mitigate and manage the risk.			
2.3	The robustness and effectiveness of my risk management arrangements is regularly reviewed, and the last review did not identify any weaknesses that could have an impact on the Annual Accounts.			
2.4	There is appropriate escalation/communication to the directorate Risk Committee and CLT Risk Committee (as appropriate) of significant issues, risks and weaknesses in risk management.			
2.5	I have arrangements in place to promote and support the Council's policies and procedures for staff to raise awareness of risk concerns, Council wrongdoing and officer's misconduct.			
2.6	I have risk management arrangements in place to identify the key risks to my directorate (and the Council).			
6.2	I have arrangements in place for the annual review of policies owned by my directorate, via the relevant executive committee, to ensure these comply with the Council's policy framework.	The co-ordination of policies going forward will be undertaken by the Operations Manager / Assurance Officer. The inspection into Adult Social Care identified several outstanding policies, with 8 that are solely the responsibility of the Partnership to review, and work is progressing to review these within the next year. There are also a large number which sit within the responsibility of Corporate Services and the CSWO to review and update.	Operations Manager / Executive Team	31 Dec 23