Governance, Risk and Best Value Committee

10.00am, Tuesday, 23 August 2022

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 2021-22

1.1.2 Note that the Partnership annual assurance schedule 2022-23 would be submitted for scrutiny to GRBV in 12 months.

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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 2021-22 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 £600 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 GP's 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 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 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 for 2022.

4.4 As part of the completion of the assurance statement for 2022, the Partnership felt that there was partial compliance in the following areas:

4.4.1 Risk Management

4.5 As part of the process an improvement plan has been developed and included as appendix 2 covering the areas identified as partially compliant with responsible officer and deadlines included. Due to the significant impact of Covid19 and system pressures on Partnership services, it is likely that elements of the improvement plan may need to be reassessed and delivery deadlines reviewed.

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 2021-2022 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 2021 - 22

Appendix 2 - Annual Assurance Action Plan

Appendix 1 – 2021/22 Partnership Annual Assurance Schedule

1	Internal Control Environment	Assessment of Compliance	Did your service area 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
1.1	I have internal controls and procedures in place throughout my directorate that are proportionate, robust, monitored and operate effectively.	Compliant	No	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	EIJB and Partnership (via CEC) Internal Audit Plan, EIJB Audit and Assurance Committee, Internal Audit Oversight Group, EMT strategic risk management approach in place, independent scrutiny from Care Inspectorate on service delivery, health and safety assurance framework, employment policies managing risk, anti-bribery, fraud, code of conduct, Regular staff 1:1s. All reports include a section on risks, regular performance reporting on key service areas, training on risk in place. Focussed scrutiny on IA controls at ET, Audit and Assurance Committee and GRBV.	During the past year significant progress has been made to close outstanding IA management actions with a 70% reduction in outstanding management actions. For management actions arising out of more recent audits, there is a clear process that works well, and time made available for progress to be monitored. Timelines are met in the majority of cases and a clear route to escalate if issues arise.

1.2	I have controls and procedures in place to manage the risks in delivering services through council companies, partners and third parties.	Compliant	No	Policy and Risk Management Procedure External validation/review eg. 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 eg. internal audit, quality assurance audits Overdue audit recommendations report monthly to CLT and quarterly to GRBV, Policies that mitigate risks eg. Anti-bribery, 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 (eg procurement, standing orders,	EIJB and Partnership (via CEC) Internal Audit Plan, EIJB Audit and Assurance Committee, Internal Audit Oversight Group, EMT strategic risk management approach in place, independent scrutiny from Care Inspectorate on service delivery, health and safety assurance framework, employment policies managing risk, anti-bribery, fraud, code of conduct, Regular staff 1:1's. All reports include a section on risks, regular performance reporting on key service areas, training on risk in place. Focussed scrutiny on IA controls at ET, Audit and Assurance Committee and GRBV.	There is a continued focus on internal audit management actions to address issues raised through audits. Continuing regular monitoring and reporting progress of directions to partner agencies through Performance and Delivery Committee as well as an annual review.
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	No		EIJB and Partnership (via CEC) Internal Audit Plan, EIJB Audit and Assurance Committee, Internal Audit Oversight Group, EMT strategic risk management approach in place, independent scrutiny from Care Inspectorate on service delivery, health and safety assurance framework, employment policies managing risk, anti-bribery, fraud, code of conduct, Regular staff 1:1's. All reports include a section on risks, regular performance reporting on key service areas, training on risk in place. Focussed scrutiny on IA	We have made significant progress in closing outstanding IA management actions however do recognise that we still have more to do to close our remaining outstanding management actions and have a clear plan to achieve this.

				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	controls at ET, Audit and Assurance Committee and GRBV.	
1.4	The monitoring process applied to funding/operating agreements has not identified any problems that could have an impact on Annual or Group Accounts.	Compliant	No		EIJB and Partnership (via CEC) Internal Audit Plan, EIJB Audit and Assurance Committee, Internal Audit Oversight Group, EMT strategic risk management approach in place, independent scrutiny from Care Inspectorate on service delivery, health and safety assurance framework, employment policies managing risk, antibribery, fraud, code of conduct, Regular staff 1:1's. All reports include section on risks, regular performance reporting on key service areas, training on risk in place. Focussed scrutiny on IA controls at ET, Audit and Assurance Committee and GRBV.	There continues to be an increased focus on closing internal audit management actions relating to commissioning. Procurement board will continue to scrutinise commissioning activities and take action to mitigate risks. There is regular scrutiny and monitoring of budgets and funding arrangements through management teams and regular reports to the Executive Team.
2	**Risk and Resilience**	**Assessment of Compliance**	**Did your service area have any issues in this area during the reporting period? (Please reflect where open assurance**	**Extract of Evidence from the Council's Corporate Governance Code. For information only.**	**Relevant service area controls**	**Improvement Actions**

			actions mean that a control weakness exists)			
2.1	I have risk management arrangements in place to identify the key risks to my directorate (and the Council).	Partially compliant	No	Budget Planning, CLT Change Board – programme/project management framework, CLT scrutiny Contingency planning and business continuity arrangements 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, Risk Appetite Statement Risk Management Groups, Risk management policies and	Risk register is in place for the Partnership and the EIJB. Risk registers for service teams are being developed in a phased approach. Reports have sections specifically focused on risk. Risk Management approach has been agreed taking into account the way both NHSL and CEC manage risks . The Partnership Risk Committee is now established, focussing on new and emerging risks and horizon scanning.	Continue to work with teams to roll out service team risk registers and ensure there is a clear linkage from the top to the bottom of the organisation in relation to risk. As part of the Partnership's risk management approach, there is a defined and clear escalation route for risks.
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.	Partially compliant	No		Risk register is in place for the Partnership and the EIJB. Risk registers for service teams are being developed in a phased approach. Reports have sections specifically focused on risk. Risk Management approach has been agreed taking into account the way both NHSL and CEC manage risks . The Partnership Risk Committee is now established, focussing on new and emerging risks and horizon scanning.	Continue to work with teams to roll out service team risk registers and ensure there is a clear linkage from the top to the bottom of the organisation in relation to risk. As part of the Partnership's risk management approach, there is a defined and clear escalation route for risks.

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.	Partially compliant	No	strategies (eg procurement, standing orders, project management, health and safety, information governance) Risk Management Procedure, Risk management tools, Schools assurance programme, Service Planning Training, eLearning and workshops for staff and members.	Risk register is in place for the Partnership and the EIJB. Risk registers for service teams are being developed in a phased approach. Reports have sections specifically focused on risk. Risk Management approach has been agreed taking into account the way both NHSL and CEC manage risks . The Partnership Risk Committee is now established, focussing on new and emerging risks and horizon scanning.	Continue to work with teams to roll out service team risk registers and ensure there is a clear linkage from the top to the bottom of the organisation in relation to risk. As part of the Partnership's risk management approach, there is a defined and clear escalation route for risks.
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.	Partially compliant	No		Risk register is in place for the Partnership and the EIJB. Risk registers for service teams are being developed in a phased approach. Reports have sections specifically focused on risk. Risk Management approach has been agreed taking into account the way both NHSL and CEC manage risks . The Partnership Risk Committee is now established, focussing on new and emerging risks and horizon scanning.	Continue to work with teams to roll out service team risk registers and ensure there is a clear linkage from the top to the bottom of the organisation in relation to risk. As part of the Partnership's risk management approach, there is a defined and clear escalation route for risks.
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	Partially compliant	No		Risk register is in place for the Partnership and the EIJB. Risk registers for service teams are being developed in a phased approach. Reports have sections specifically focused on risk. Risk Management approach has been agreed taking into account the	Continue to work with teams to roll out service team risk registers and ensure there is a clear linkage from the top to the bottom of the organisation in relation to risk. As part of the Partnership's risk

	wrongdoing and officer's misconduct.				way both NHSL and CEC manage risks . The Partnership Risk Committee is now established, focussing on new and emerging risks and horizon scanning.	management approach, there is a defined and clear escalation route for risks.
2.6	My directorate has appropriate resilience arrangements in place and my directorate's business continuity plans and arrangements mitigate the business continuity risks facing our essential activities.	Compliant	No		Resilience Plans are 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.	Consideration to be given to the configuration of resilience plans for those areas not deemed to be essential.
3	**Workforce Control**	**Assessment of Compliance**	**Did your service area 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**
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	No	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	Staff should complete compulsory training specific to role, annual review of policies, online system for recording overtime, absence and performance, induction, personal development, H&S report relating to staff accidents and incidents, managing absence support for managers, WLT	

				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 eg. internal audit, quality assurance audits, Inspiring Talent Programme 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 eg. Anti-bribery, Fraud Prevention, Whistleblowing, Regular reporting including Health & Safety Performance, absence levels Staff benefits (enhanced	programme in place to share learning on a wide range of topics which include workforce issues.	
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	No		Staff should complete compulsory training specific to role, annual review of policies, online system for recording overtime, absence and performance, induction, personal development, 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.	
3.3	I ensure compliance with the Council's HR policies and procedures across all my service areas, eg. that recruitment and selection is only undertaken by	Compliant	No		Staff should complete compulsory training specific to role, annual review of policies, online system for recording overtime, absence and performance, induction, personal development, H&S report relating to staff accidents and incidents, managing absence	

	appropriately trained individuals and is fully compliant with vacancy approvals and controls.			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	support for managers, WLT programme in place to share learning on a wide range of topics which include workforce issues.	
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	No		Staff should complete compulsory training specific to role, annual review of policies, online system for recording overtime, absence and performance, induction, personal development, 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.	
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	No		Staff should complete compulsory training specific to role, annual review of policies, online system for recording overtime, absence and performance, induction, personal development, 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.	
3.6	I ensure compliance with essential training	Compliant	No		Staff should complete compulsory training specific to role, annual	

	requirements and support learning and development appropriately, including professional CPD requirements.				review of policies, online system for recording overtime, absence and performance, induction, personal development, 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.	
3.7	I have arrangements in place to support and manage staff performance e.g. regular 1:1/supervision meetings, performance/spotlight conversations.	Compliant	No		Staff should complete compulsory training specific to role, annual review of policies, online system for recording overtime, absence and performance, induction, personal development, 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.	
4	**Council Companies**	**Assessment of Compliance**	**Did your service area 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**
4.1	I have arrangements in place for the oversight and	Compliant	No	Annual Assurance Process (Directorates), Council Companies/ALEOs – Governance		

	monitoring of the Council companies I am responsible for, that give me adequate assurance over their operation and delivery for the Council.			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.	Compliant	No			
5	**Engagement and Consultation**	**Assessment of Compliance**	**Did your service area 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**
5.1	My directorate engages effectively with institutional stakeholders, service users and individual citizens, applying the council's consultation and engagement standards with	Compliant	No	Budget consultation, Business sector forums, Community engagement activity, Community engagement strategy/policy, Complaints Improvement Plan, Consultation framework, Consultation Hub Council Change Strategy: Planning for Change and	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	

	evidence that the insights gathered are used to shape my directorates activities.			Delivering Services Committee Papers Online, Current partnerships eg. Poverty Commission, Tourism Strategy, EIJB, City Deal, Edinburgh Partnership (LCCPs, Neighbourhood Networks), Edinburgh People Survey, Government partnership working , Have Your Say webpage, multi-agency partnerships multi-channel methodology eg. social media platform development, Networks/user groups – eg. Edinburgh Tenants' Federation, Partnership agreements eg. Police Scotland, Partnership governance arrangements Partnership governance, documentation, Partnership plans eg. 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,	approaches across the Partnership, engagement included in report templates, locality plans are in place.	
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	No		Communications team supports public engagement activity. Separate communications and engagement plans developed to support specific projects / work programmes. 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 plans are in place. Co-production principles embedded in planning and commissioning, with notable examples of good practice (e.g., Thrive). Carer representation on the EIJB.	

5.3	I have appropriate arrangements in place throughout my directorate for recording, monitoring and managing customer service complaints and customer satisfaction.	Compliant	No	Report template – section on consultation, Stakeholder group meetings, Strategic documentation eg. vision statements, aims, etc, Strategic plans and agreements, Strategy and Performance Hub, Surveys eg. Edinburgh People Survey, Annual Tenant Survey, Third sector partnership working eg. EVOC, Webcasting of Council and major committees, including subtitles	Complaint 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 plans are in place	
5.4	I regularly consult and engage with recognised trade unions.	Compliant	No		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 plans are in place. Staff side representatives from NHS Lothian and CEC sit on the EIJB and participate in Committees.	Ensuring engagement with Trades Unions is embedded into specific engagement plans for major service re-designs.
6.1	**Policy**	**Assessment of Compliance**	**Did your service area have any issues in this area during the reporting period? (Please reflect where open assurance**	**Extract of Evidence from the Council's Corporate Governance Code. For information only.**	**Relevant service area controls**	**Improvement Actions**

			actions mean that a control weakness exists)			
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	No	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)	CEC Annual Assurance Exercise, Audit and Assurance Committee, Committee papers on line, policy register. Regular management teams held which discussion any new or amended policies. Regular sessions with HR to discuss HR led policies. Managers also undertake regular 1:1s with staff to ensure policies are discussed and disseminated accordingly.	
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.	Compliant	No		Annual Assurance exercise, Audit and Assurance Committee, Committee papers on line, policy register. Forward planning (annual cycle of business) identifies areas and timescale/s for policy review etc.	
7	**Governance and Compliance**	**Assessment of Compliance**	**Did your service area have any issues in this area during the reporting period? (Please reflect where open assurance actions mean that a**	**Extract of Evidence from the Council's Corporate Governance Code. For information only.**	**Relevant service area controls**	**Improvement Actions**

			control weakness exists)			
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	No	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 eg. SSSC, GTCS, Scheme of Delegation to Officers, Statutory officer appointments and responsibilities, Statutory/lead officers' independent reports to committee eg. Monitoring Officer, Chief Social Work Officer, Chief, Internal Auditor, Whistleblowing Policy	Code of Conduct in place for all employees, committee terms of reference agreed 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.	
7.2	I ensure my directorate's activities are fully compliant with relevant Scottish, UK and international legislation and regulations.	Compliant	No		Code of Conduct in place for all employees, committee terms of reference agreed 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	**Responsibility and Accountability**	**Assessment of Compliance**	**Did your service area 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**
8.1	My directorate ensures our officers are clear on their roles and responsibilities in terms of relationships and decision making.	Compliant	No	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: Planning for Change and Delivering Services , Council company monitoring including, Governance Hub, Council Observers on Boards, committee reporting Edinburgh People Survey, Employee Code of Conduct, Grant	Code of Conduct in place for all employees, committee terms of reference agreed 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. Fortnightly 1 to 1s offer an opportunity to explore and resolve any specific issues; weekly management huddles and away	

				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, Procurement Handbook, Public participation – deputations and petitions, Report template and guidance, Scheme of Delegation to Officers, Service Level Agreement template, Standard Condition of Grant	days also utilised to explore governance issues.	
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	No		Code of Conduct in place for all employees, committee terms of reference agreed 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.	
8.3	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	Compliant	No		Code of Conduct in place for all employees, committee terms of reference agreed 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	

	structures. (i.e SMT reporting)				role, whistleblowing policy to support staff to raise any concerns. Templates in place and embedded to aid with decision making. Established procurement processes followed and scrutinised by the Procurement Board.	
8.4	I consult with elected members as appropriate and as required under the Scheme of Delegation.	Compliant	No		Code of Conduct in place for all employees, committee terms of reference agreed 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. Established APM and briefing processes for committee business.	
9	**Information Governance**	**Assessment of Compliance**	**Did your service area have any issues in this area during the reporting period? (Please reflect where open assurance actions mean that a**	**Extract of Evidence from the Council's Corporate Governance Code. For information only.**	**Relevant service area controls**	**Improvement Actions**

			control weakness exists)			
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	No	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 FOIs 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, Privacy Impact Assessment (PIA) and information security. Reinforced via team meetings.	
9.2	I ensure data sharing arrangements with third parties are recorded, followed and regularly reviewed	Compliant	No		All FOIs and DPA are co-ordinated centrally. Mandatory training in information governance for all staff undertaken every two years. Employee code of conduct, ICT	

	throughout all service areas in my directorate.				acceptable use policy, data breaches, privacy impact assessment and information security. Reinforced via team meetings	
10	**Health and Safety**	**Assessment of Compliance**	**Did your service area 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**
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	No	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 eg. external audit, independent assurance providers, Health and safety audits Health &	Member of Council Health and Safety Group, all staff undertake H&S training and agreed under code of conduct. Health and safety framework within the Partnership embedded. 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	No	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, 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	Member of Council Health and Safety Group, all staff undertake H&S training and agreed under code of conduct. Health and safety framework within the Partnership embedded. 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.	
10.3	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	No		Member of Council Health and Safety Group, all staff undertake H&S training and agreed under code of conduct. Health and safety framework within the Partnership embedded. 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	No		Member of Council Health and Safety Group, all staff undertake H&S training and agreed under code of conduct. Health and safety framework within the Partnership embedded. 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.	
11	**Performance**	**Assessment of Compliance**	**Did your service area 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**
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	No	Annual external reporting eg. Local Government Benchmarking Framework, Scottish Public Services Ombudsman, Scottish Government, etc, Annual performance report to Council, B agenda protocol Best Value reporting, CLT Quarterly performance meeting, Committee Terms of Reference and Delegated Functions, Local Government Benchmarking Framework Monitoring/reporting on delivery of 52 coalition commitments Performance Framework Strategy and Performance Hub	Annual performance report published, the remit of performance and delivery committee covers 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.	
11.2	My directorate regularly works with relevant teams in Corporate Services to review and improve effectiveness by performance monitoring,	Compliant	No		Annual performance report published, the remit of performance and delivery committee covers performance scrutiny / assurance. Regular performance reports submitted to ET and EIJB for assurance. Reporting via CLT performance	

	benchmarking and other methods to achieve defined outcomes.				meeting as well as joint Council and NHS performance meeting.	
12	**Commercial and Contract Management**	**Assessment of Compliance**	**Did your service area 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**
12.1	I ensure all goods, services and works are procured and managed in compliance with the Contract Standing Orders.	Compliant	No	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 Scheme of Delegation to Officers Service Level Agreement Register Standard Condition of Grant	Code of conduct, and the Partnership comply with procurement strategy and contract standing orders. Regular procurement board focusing on Partnership contracts in place, contract monitoring arrangements embedded, scheme of delegation in place. Standardised Partnership contract framework / documentation. Any Shadow IT has been compliant with the Shadow IT Framework.	

13	Change and Project Management	Assessment of Compliance	Did your service area 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
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	No	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: Planning for Change and Delivering Services 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	Transformation team 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. Governance processes in place for the formulation, approval, monitoring and annual review of directions associated with EIJB decisions. Clear governance process in place for progressing service redesigns, business cases through the Strategic Planning Group. Strategic Planning Framework agreed by the Executive Team in February 2022.	Transformation programme to transition to a strategic programme focused on innovation and sustainability.

14.1	Financial Control	Assessment of Compliance	Did your service area 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
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	No	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: Planning for Change and Delivering Services , 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	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 Executive Team agenda. All reports have finance focused element.	
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	No		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 Executive Team agenda. All reports have finance focused element.	

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	No	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.	
14.4	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	No		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.	
14.5	I have arrangements in place for identifying any weaknesses in my directorate's compliance with Council financial policies or statutory/regulatory requirements.	Compliant	No		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.	

14.6	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	No		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	
15	**Group Accounts (Corporate Services only)**	**Assessment of Compliance**	**Did your service area 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**
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.	Compliant	No	Annual assurance exercise (internal audit input and oversight),Annual Corporate Governance Code 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		

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.	Compliant	No	Internal Auditor's direct reporting line to GRBV, Committee Terms of Reference and Delegated 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 eg. 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 Inspection Reports**	**Assessment of Compliance**	**Did your service area 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**

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	No	Committee Terms of Reference and Delegated Function, 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	Audit and Assurance and GRBV committee in place, key national reports or those with an impact on the Partnership are discussed at Executive Team in terms of next steps.	
16.2	I have arrangements in place that adequately monitor and report on the implementation of recommendations.	Compliant	No		Audit and Assurance and GRBV committee in place, key national reports or those with an impact on the Partnership are discussed at Executive Team in terms of next steps.	
17	**Internal Audit, External Audit and Review Reports**	**Assessment of Compliance**	**Did your service area 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**
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	Compliant	No	A validation audit is included in the annual Internal Audit Plan. Agreed management actions arising from internal audits are recorded and monitored through Team Central. Integral part of Annual Assurance Schedule Overdue management actions are	Robust IA process in place to manage outstanding management actions. Regular scrutiny in place at the Executive Team on IA management actions. All IA actions have a lead officer as well as a lead officer to oversee IA implementation. Regular	

	highlighted high, medium or significant control deficiencies, have been (or are being) implemented and that this is monitored effectively.			reported monthly to CLT and quarterly to GRBV	scrutiny at GRBV and Audit and Assurance Committee.	
18	**Progress**	**Assessment of Compliance**	**Did your service area 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**
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	No	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 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 Council participates in LAN (council scrutiny bodies) whose activity is based on shared risk assessment.	Robust Internal Audit and External Audit process in place to manage outstanding management actions. Regular scrutiny in place at Executive Team 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.	

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).	Continue to rollout the guidance to the Partnership which includes establishment of a Partnership Risk Committee and Risk Forum, guidance on developing risk registers and escalation process for risks which tie into the risk and resilience IA management actions.	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.		Executive Team	31 March 23
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.		Executive Team	31 March 23
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.		Executive Team	31 March 23
2.5	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.		Executive Team	31 March 23
2.6	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.		Executive Team	31 March 23
2.7	My directorate has appropriate resilience arrangements in place and my directorate's business continuity plans and arrangements mitigate the business continuity risks facing our essential activities.	Consideration to be given to the need for an over-arching resilience plan for those areas of strategic planning not currently covered.	Executive Team	31 March 23