Internal Audit Report

Social Care Direct (Adult Services)

06 September 2024

HSC2401

Overall Assessment	Reasonable Assurance

Contents

This Internal Audit review is conducted for the City of Edinburgh Council under the auspices of the 2024/25 internal audit plan approved by the Governance, Risk and Best Value Committee in March 2024. The review is designed to help the City of Edinburgh Council assess and refine its internal control environment. It is not designed or intended to be suitable for any other purpose and should not be relied upon for any other purpose. The City of Edinburgh Council accepts no responsibility for any such reliance and disclaims all liability in relation thereto.

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

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

Executive Summary

Overall Assessment	Reasonable Assurance

Overall opinion and summary of findings

Review of the design and operating effectiveness of the key processes, procedures and controls established to support delivery of Social Care Direct (Adult Services) has identified a number of issues, areas of non-compliance and scope for improvement.

The review recognises that the Social Care Direct Response Team (SCDRT) was established in April 2023 but expanded to all localities in January 2024. It is also noted, however, that several teams are involved in the delivery of Social Care Direct (Adult Services) and as a result some areas of service delivery and reporting are fragmented.

The following improvements have been raised to support development of key controls and to support mitigation of key risks to service and strategic objectives.

- policy & procedures should be updated to reflect current practice and ensure consistency in operations
- completion of officer training and continued professional learning should be monitored to ensure compliance with requirements
- a workforce plan should be developed for the SCDRT to ensure resources meet service needs and demands
- quality assurance processes should be strengthened to ensure actions are implemented following practice audits, to focus on operational QA including data quality and to share lessons learned
- an operational performance framework should be developed to monitor SCDRT performance
- risk registers should be reviewed regularly to ensure new, emerging and escalating risks are captured and mitigating actions taken

Areas of good practice identified

- the SCDRT welcomed audit findings to enhance their current practice and had begun addressing improvements prior to the report being issued
- communicating changes in both teams was effective
- an EHSCP Improvement plan is in place and monitored regularly
- the SCD (Corporate) training plan for new starts is comprehensive.

Audit Area	Control Design	Control Operation	Findings	Priority Rating
1. Policy and Procedures			Finding 1 – Policy, Procedures and Training	High Priority
2. Service Referrals and Screening Process				
3. Resource Management and Quality Assurance			Finding 2 – Workforce Planning and Quality Assurance	Medium Priority
4. Performance oversight and Governance			Finding 3 – Performance Monitoring and Data Quality	Medium Priority
5. Risk Management			Finding 4 – Risk Management	Low Priority

See Appendix 1 for Control Assessment and Assurance Definitions

Background and scope

The Adult Support and Protection (Scotland) Act 2007 is the legal framework for Adult Support and Protection (ASP) in Scotland. The Revised ASP Code of Practice provides guidance about the performance by Councils, public bodies, and other professionals under the Act. The Act defines an adult at risk, as a person aged 16 or over. Section 3(1) defines an 'adult at risk' as someone who meets all of the 3-point criteria (also known as the '3-point test).' Section 12A of the Social Work (Scotland) Act 1968 places a duty on the local authorities to assess need and then decide whether the assessed needs 'call for the provision' of services. The Eligibility Criteria Policy outlines the criteria to assess people's eligibility to receive care services and support.

In Edinburgh, ASP referrals come via the Customer Services Social Care Direct Corporate Team who take all calls for social care advice and then signpost or workflow referrals to the appropriate service required, including ASP concerns, which workflow to Social Care Direct Response Team (SCDRT) if there is no allocated worker. The SCDRT team focusses on prevention and early intervention. SCDRT Senior Social workers screen all incoming work and allocate work to a Social worker, Occupational Therapist or Community Care Assistant who have Conversation One (from the Three Conversations approach) with the service user with a view to maximising the existing assets the person has, sign posting or 'one and done' tasks such as urgent equipment or emergency (section 12) payments. Automated forms (those forms sent online) go to SCDRT, if not allocated, for screening and assessment. The teams are in different directorates and therefore have separate management, guidelines, training documents, policies and procedures.

Referrals, notes, and workflows are recorded on the Case Management Systems SWIFT/AIS. Where further assessment is required, the case is screened and work flowed to the relevant locality, and if appropriate, placed on their waiting list.

In February 2023, the Care Inspectorate published the Joint Inspection of Adult Support and Protection practice which identified areas of improvement for the Partnership including the management and oversight of screening and initial inquiries through Social Care Direct. The March 2023 inspection report Adult Social Work and Social Care in Edinburgh also identified significant weaknesses in the design, structure, implementation and oversight of key processes, including the assessment of people's needs and in their case management; approaches to early intervention and prevention were uncoordinated and inconsistent.

In June 2023, the Edinburgh Integration Joint Board approved a 3 year-Improvement plan in response to both Inspections. An update was provided to Policy and Sustainability Committee in March 2024. Monthly progress is also monitored through several governance forums and oversight groups.

Edinburgh Health and Social Care Partnership (EHSCP) are currently going through a restructure resulting in potential changes to services.

Scope

The objective of this review was to assess the adequacy of design and operating effectiveness of the key controls within the Social Care Direct Team with a specific focus on processes for screening referrals received, initial triage for adult concern and the response service for people to meet immediate needs.

Alignment to Risks and Business Plan Outcomes

The review also provided assurance in relation to the following Corporate Leadership Team (CLT) risks and EHSCP risks:

- Health and Safety
- Technology and Information
- Service Delivery
- People
- Regulatory and Legislative Compliance
- Reputational

Business Plan Outcomes:

Core services for people in need of care and support are improved.

Limitations of Scope

The following areas were excluded from scope:

- Children's Services and Criminal Justice (only Adult Services were reviewed)
- Out of Hours service – this service deals with emergencies and has separate processes
- Duty to Inquire – as there has recently been an audit carried out in this area by the Council's Quality Assurance and Compliance Team.

Reporting Date

- Testing was undertaken between 13 June 2024 and 1 July 2024.
- Audit work concluded on 1 July 2024 and audit findings and opinions are based on the conclusion of audit work as at that date.

Findings and Management Action Plan

Finding 1 – Policy, Procedures and Training

Finding Rating	High Priority

Policy and procedure documents require updating - the Eligibility Criteria Policy has not been updated since 2015. This a key policy which aims to ensure decisions about care and support are fair. Testing noted the policy is not used consistently, with decisions often based on the capacity of localities, rather than policy criteria resulting in potentially inconsistent decisions, which could put people at risk and have an impact on financial budgets.

There is no Service Level Agreement (SLA) between the Social Care Direct Response Team (SCDRT) and the Social Care Direct (SCD) Corporate team which sets out roles and responsibilities for each team. An SLA would set out a clear understanding of service expectations for both teams, promote accountability and provide a clear mechanism for measuring performance.

The roll out of the SCDRT has been phased by one locality at a time between January and May 2024. While it is recognised that the procedures are continually developing, they are not in line with how the team records information, resulting in inconsistent notes and recording. The procedures do not include timescales for responding to customers and there is no written process for managing priority cases. Management have advised that the job role is based around managing risk therefore Social Workers are aware of how to manage priority, however, SCD (corporate) are not trained on risk and do not having a clear process of managing and recording priority.

There is no written process for managing backlogs for assessments. Management advised they have daily oversight and can run a report, however, this was not provided to Internal Audit to verify. Management also advised there is no backlog in the workflow mailboxes as officers work until the mailbox is empty each day which could be over normal working hours, which relies on the good will of officers, and does not demonstrate robust resilience and business continuity controls.

Some customer records are 'locked' for confidential reasons; SCD (corporate) can identify these when searching but these cases would not be shown in the work flowed cases to SCDRT and could be missed by officers who cannot access locked records.

When a customer requires emergency assistance, they can request support from the local authority via a Section 12 payment. Whilst individual teams have their own process for recording information and processing payments, management advised the request goes through four teams (SCD, SCDRT, locality, then business support). It is unclear how long it takes for a customer to receive a payment.

Learning and development - role specific learning for Social Workers and Community Care Assistants is outlined in the Orb, however, as some officers are 'on loan' from localities, management do not have oversight of completed training.

An excel based training matrix has been introduced for officers to complete. Officers are required to complete continuous professional learning for SSSC registration, however, there was no record of officers confirming completion.

SCD (Corporate) do not receive training on adult protection as they are only required to record information and workflow, however, the Adult Social Work and Social Care in Edinburgh Inspection report 2023 identified that the opportunity for early intervention and prevention is missed as SCD are at the 'front door.'

Risks

- **Regulatory and Legislative compliance** – if policies and procedures are not reviewed regularly, they may no longer align with statutory requirements

Risks continued

- **Workforce** - officers may not complete all the required role specific learning for their role
- **Health and Safety** – failure to have clear processes for managing demand of assessments in line with current resources could impact the wellbeing of officers
- **Reputational Risk –** lack of consistent and up to date policy and procedures may result in customers receiving inconsistent services
- **Service Delivery –** if policy and procedures are not up to date, officers will not work consistently, and practice will vary which may put service users at risk
- **Financial and Budget Management** – budgets may be impacted if services are provided to service users who do not meet the appropriate eligibility criteria. Section 12 payments may not be paid in a timely manner.

Recommendations and Management Action Plan: Policy, Procedures and Training

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe
1.1	The Eligibility Criteria Policy should be reviewed and updated in line with current requirements. The policy should be approved by senior management and Committee where required. The policy should be communicated to all relevant colleagues and used consistently across relevant teams including SCDRT and localities.	The eligibility criteria will be reviewed, agreed through the appropriate governance route and communicated to staff and stakeholders.	Chief Officer, Health and Social Care Partnership	Head of Service, Assessment and Care Management	30/06/2025
1.2	A Service Level Agreement (SLA) between SCD Corporate and SCDRT should be developed outlining clear expectations on service standards, roles and responsibilities including updating procedures, undertaking quality assurance, performance monitoring and monitoring completion of training.	An SLA will be produced to ensure any immediate risks are mitigated. A review of SCDRT is due to be initiated and integral to that will be a requirement to ensure that there are clear expectations in relation to service standards, roles and responsibilities and joint procedures.			31/08/2025
1.3.1	SCDRT should update operational procedures to include: • timescales for responding to customers	The standard operating procedures and associated guidance will be reviewed and cover customer contact including urgent cases, KPI's, referrals section 12		Service Manager, SCDRT	31/12/2024

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe
	• a process for priority or urgent cases • whether contact and referral forms are used as outlined in Rec 3.3 • a process for access and sharing required information on 'locked' records • a process for processing and monitoring section 12 requests • guidance on consistent case note headlines and case notes as outlined in Finding 3 • a process for managing backlogs within required timescales and resources available with consideration of colleague wellbeing • guidance on daily monitoring of workflow boxes • a quality assurance process (including data quality issues) as outlined in Rec 2.4.	requests, backlogs, case notes, workflow, quality assurance. Due to limitations with the current system, there is no other alternative process for the accessing and sharing of locked records. This will be included in future iterations of the standing operating procedures once the new system is implemented.			
1.3.2	SCD Corporate should update procedures to include: • a process for priority or urgent cases • a process for access and sharing required information on 'locked' records • guidance on consistent case note headlines and case notes as outlined in Finding 3 • a quality assurance as outlined in Rec 2.4.	SCD (Customer Services) procedures to be reviewed and updated by SCD Team Leader. Existing call flow to be validated, including priority case and locked record processes and case note guidance. NB QA action addressed at 2.4.2 Contact Team Manager to sign off procedures by 31/12/2024	Executive Director, Corporate services	Customer Contact Team Manager	31/12/2024
1.4.1	Role specific learning and training for SCDRT should be monitored and held centrally to allow for management oversight of completed learning and compliance with SSSC requirements.	Role specific learning and training will be monitored centrally to ensure compliance with mandatory training which is integral to our responsibility as an employer in terms of the SSSC.	Chief Officer, Health and Social Care Partnership	Head of Service, Assessment and Care Management	28/02/2025

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe
		Meeting SSSC registration requirements is the professional responsibility of each individual registered social worker. Communications will be drafted to ensure that staff are aware of their responsibility in terms of registration requirements.			
1.4.2	SCD Corporate should consider whether Adult Protection Training for those answering calls, or closer working relations with SCDRT is required to ensure appropriate signposting and work flowing is completed.	Training to be requested from SCDRT and rolled out to all SCD Customer Services staff and added to new start induction process. Rollout to be completed by March 2025.	Executive Director, Corporate services	Customer Contact Team Manager	30/03/2025

Finding 2 – Workforce Planning and Quality Assurance

Finding Rating	Medium Priority

Workforce planning is essential to ensure there is a skilled and capable workforce to deliver strategic priorities and to meet changing needs. There is currently no workforce plan for SCDRT resources. Management have advised this will be developed following the Partnership restructure.

It was noted during fieldwork that when resources are low, continued service to customers is dependent on officers good will and senior management carrying out operational work. The SCDRT has been developed over the last 7 months with officers 'on loan' from localities. This means officers are balancing other priorities, such as a case load which could impact on the quality of services, they are able to provide within the SCDRT and, the service provided to customers. Loaned officers are also managed by localities, not the SCDRT which can present difficulties for competing priorities.

Quality Assurance (QA) provides a framework and guidance for continuous improvement. In May 2024, the Partnership approved the Clinical and Care Governance (CCG) QA framework. This high-level framework aims to provide a consistent approach to QA and practice audits across the Partnership. The SCDRT are included within the QA practice workplan, with two audits planned for 2024. The corporate SCD is however, not included in the workplan.

There are no action plans from practice audits and recommendations are not tracked, therefore it is unknown if recommendations have been taken on board. There is also no process to identify and address thematic issues or communicate lessons learned, to prevent repeat issues reoccurring.

Internal QA processes provide assurance that work is being carried out consistently and is good quality, errors can be rectified, and associated risks reduced. SCD (corporate) have an internal QA programme for new staff. Testing highlighted that there were incomplete notes on SWIFT and officers do not always complete the required fields. Incomplete SWIFT notes impact on the service provided to customers as they may have to duplicate the conversation with another colleague and may take longer to access a service required. There are also issues with work flowing to the wrong mailbox (team).

SCDRT do not carry out routine QA however, there is oversight by senior officers and management. Testing found that some required fields within the AIS system were not completed, and eligibility was being wrongly assigned.

Issues with data quality are captured in weekly reports issued to management, however, this does not include eligibility criteria, so management have no oversight of eligibility criteria being assigned or when it is not completed.

Management advised they check the data quality issues raised in reports and discuss these with officers, however, there is no written process to address issues raised and to prevent these from reoccurring.

There is also no mechanism for monitoring the time taken to issue a Section 12 payment, and there is a risk a customer may not receive urgent funds within a required timescale.

Risks

- **Governance and Decision Making – if** management are unaware of Quality Assurance and data quality issues, they could make uninformed decisions about resources, which could increase the risk on service delivery
- **Financial and Budget Management** – if eligibility criteria is not correctly assigned, management may not be able to effectively plan for resources to manage assessments, and more support may be provided to customers than required
- **Reputational Risk** – if errors are not identified and corrected, customers may not receive a quality or timely service
- **Strategic and Service Delivery** – if there are inadequate resources to meet demand strategic and service delivery objectives will not be achieved
- **Workforce** – inadequate resources will impact delivery of quality delivery services which meet customer needs.

Recommendations and Management Action Plan: Workforce Planning and Quality Assurance

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe
2.1	A workforce plan for Social Care Direct Response Team (SCDRT) should be developed. The workforce plan should be approved by senior management and a relevant governance forum with progress towards delivery of services within the resources set out in the plan monitored periodically and revised as required.	A workforce plan will be developed once the redesign of the front door is completed which is anticipated to extend over a 12-month period	Chief Officer, Health and Social Care Partnership	Head of Service, Assessment and Care Management	31/08/2025
2.2	Findings and recommendations from Quality Assurance (QA) practice audits should be tracked to confirm when they have been completed and where necessary progress reviewed. A relevant governance forum should also receive reporting on results of QA practice audit activity at an agreed, and regular frequency.	A quality assurance framework will be developed which will include practice audit activity.			28/02/2025
2.3	Thematic issues and lessons to be learned following practice audits should be shared with practice teams to enable changes to be actioned as required. This should include development of an email template or bulletin to ensure information and key messages are cascaded consistently.	A quality assurance framework will be developed which will incorporate thematic issues and lessons learnt from practice audits and clear communication approach to share learning.			28/02/2025
2.4.1	SCDRT should develop an internal Quality Assurance (QA) process which focuses on data quality issues to ensure work is streamlined and complete. The process should include the frequency of QA checks and an overview of what the checks will include and how this will be reported to management for oversight and assurance.	A quality assurance framework will be developed and will incorporate data quality issues and set out frequency of QA checks.			28/02/2025
2.4.2	Social Care Direct (corporate) should develop an ongoing internal Quality Assurance process to ensure work is streamlined and complete and data quality issues are identified. The process should include the frequency of QA checks and an	Existing Quality Assurance model (including frequency) to be assessed to ensure fit for purposes. Signed off by SCD Team Leader	Executive Director, Corporate Services	Customer Contact Team Manager	31/12/2024

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe
	overview of what the checks will include and how this will be reported to management for oversight and assurance.	Monthly updates, including any remedial actions/recommendations to be reported to SCD Team Manager Audit evidence will detail sample monthly updates			

Finding 3 – Performance Monitoring and Data Quality

Finding Rating	Medium Priority

A performance monitoring framework sets out the key measures to indicate whether a service is meeting required standards and outcomes and includes what information is reported where and at what frequency. An overarching performance framework is in place for the Partnership. This will be re-evaluated when the new strategic plan is confirmed, due later in 2024.

Review of the current framework presented to the Performance and Delivery committee of Edinburgh Integration Joint Board for approval in June 2024 notes that it is high level and does not detail operational level performance.

Weekly reporting is issued such as the Community Waits Summary, SCDRT Reporting and a 3 Conversations dashboard which include SCDRT data on how many cases have been work flowed to and from the team and how many conversations have been carried out and a monthly Departmental Management Team (DMT) report. However, there is no operational performance guidance to clearly set out performance reporting, including relevant officers responsible for reporting, who reports should be distributed to and what reports are priority.

Weekly reports issued outline the number of contacts within both SCD (Corporate) and SCDRT to other teams and the number of conversations completed. However, it was identified, that data in the reports may not be accurate due to the way information is recorded in SWIFT/AIS systems.

Data performance reports use manually input codes within case note headlines (e.g. NFA, (No further action), which leave room for error as if the code is not input correctly by the system user, the SWIFT reporting system will not pick it up. Also, parts of the system are not linked therefore performance data may be over or underinflated for some reporting. The system also does not track cases from logging, to screening, to assessment so dates input by SCD (corporate) are on a different system area (contact form) than dates input by SCDRT (assessment form). As parts of the system are not linked, dates may be recorded differently and the number of days between contacts reported will not be accurate, for example, if SCD (corporate) record contact on 02/02/24, the SCDRT target date on the assessment page should be the same date but testing highlighted that different dates had been used and this would not be picked up by data quality. As a result, when reporting, a customer may appear to have been contacted within 3 days when they have not, as reporting is based on the assessment dates, not the contact dates. It is acknowledged that a project to replace the SWIFT system is currently underway and due to go live in 2026. Workarounds to ensure data quality should be implemented in the interim to ensure timely and accurate reporting.

There is currently no formal governance structure for reporting on performance for the SCDRT, however, management have advised that when the re-structure is complete, it is expected performance will be reported to P&D committee.

Key Performance Indicators (KPIs) are measures used to evaluate performance. There are a number of Social Work governance KPIs which SCDRT base some of their performance on (KPI 1-conversation within 3 days, KPI 3-conversation about risk & KPI 6-AP referrals actioned within 48hrs), however, SCDRT are currently not reporting on all these KPIs and have not established their own KPIs for measuring team performance.

Risks

- **Strategic Delivery –** senior officers may not be aware of key performance issues and decisions required resulting in delays to service delivery
- **Regulatory and Legislative compliance** – senior officers may not get assurance that the service provided meets regulatory and legislative requirements
- **Service Delivery** – customers may not receive services within the required timescales

Recommendations and Management Action Plan: Performance Monitoring and Data Quality

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe
3.1	An operational performance reporting framework for SCDRT, should be developed which sets out what measures will be reported, to where and what frequency. The framework should be approved by a relevant governance forum who will be responsible for oversight of performance.	A performance reporting framework for SCDRT will be developed utilising existing data and reported through service oversight arrangements and the HSCP Quality and Assurance frameworks.	Chief Officer, Health and Social Care Partnership	Head of Service, Assessment and Care Management	28/02/2025
3.2	SCDRT should develop SMART (specific, measurable, achievable, relevant and timebound) Key Performance Indicators (KPIs) and outcomes to demonstrate progress achieving regulatory requirements, service standards and required timescales and to enable comparison against actual and target performance.	KPI's will be developed as part of the redesign of the front door / Social Care Direct.			31/08/2025
3.3	Recognising that the SWIFT replacement system project is underway, in the interim until the new system goes live in 2026, reporting to support collation of performance data should be reviewed to ensure systems queries include information from contact and assessment data. Guidance should be issued to colleagues to set out clear requirements for data input in required fields to limit data errors and improve data quality.	Guidance will be produced setting out expectations and requirements for data entry at key points.		Service Manager, SCDRT	31/12/2024
3.4	Management should also ensure that accurate data input, collation, extraction and reporting for this area is raised as a key requirement for the new social care operating system that will replace the SWIFT system.	The HSCP lead of the SWIFT replacement project will be provided with key requirements from the social care direct team in terms of data input, collation, extraction and reporting.		Head of Service, Assessment and Care Management	28/02/2025

Finding 4 – Risk Management

Finding Rating	Low Priority

Risk Management enables risks to the Edinburgh Health and Social Care Partnership's (EHSCP) or service objectives to be identified, recorded and managed. This provides greater assurance that objectives are achieved on an ongoing basis.

A risk register is in place for the EHSCP, the Southeast (SE) Locality (which SCDRT risks are escalated to and the SCDRT, it was noted that the SE locality and the SCDRT risk registers are incomplete and require updating.

Management have advised that further guidance for staff inputting to the risk registers would be beneficial.

Risks

- **Governance and Decision Making –** risks are not effectively identified, recorded, and managed which could affect achievement of objectives and ineffective oversight
- **Service Delivery** – colleagues are unaware of risks impacting service delivery, reducing the likelihood that service objectives are achieved.

Recommendations and Management Action Plan: Risk Management

Ref.	Recommendation	Agreed Management Action	Action Owner	Lead Officers	Timeframe
4.1	Risk registers should be agreed and reviewed at an agreed frequency to identify increasing, new or emerging risks. The review of the risk register should be clearly recorded with clear leads and timescales for mitigating actions documented and monitored. Risks out with the Council's or EHSCP risk appetite or risk tolerance should be escalated to the SE locality risk registers for support to initiate mitigating actions.	A risk register will be developed for this service which will include risk owners and mitigation controls	Chief Officer, EHSCP	Head of Service, Assessment and Care Management	31/12/2024
		Specific SCD risk register to be developed and reviewed by SCD Team Leader monthly. Appropriate escalations will be included in wider Customer and Digital Services risk activities. Audit evidence will detail sample risk registers.	Executive Director, Corporate Services	Customer Contact Team Manager	31/12/2024

Appendix 1 – Control Assessment and Assurance Definitions

Control Assessment Rating		Control Design Adequacy	Control Operation Effectiveness
Well managed		Well-structured design efficiently achieves fit-for purpose control objectives	Controls consistently applied and operating at optimum level of effectiveness.
Generally Satisfactory		Sound design achieves control objectives	Controls consistently applied
Some Improvement Opportunity		Design is generally sound, with some opportunity to introduce control improvements	Conformance generally sound, with some opportunity to enhance level of conformance
Major Improvement Opportunity		Design is not optimum and may put control objectives at risk	Non-conformance may put control objectives at risk
Control Not Tested	**N/A**	Not applicable for control design assessments	Control not tested, either due to ineffective design or due to design only audit

Overall Assurance Ratings	
Substantial Assurance	A sound system of governance, risk management and control exists, with internal controls operating effectively and being consistently applied to support the achievement of objectives in the area audited.
Reasonable Assurance	There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified which may put at risk the achievement of objectives in the area audited.
Limited Assurance	Significant gaps, weaknesses or non-compliance were identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the area audited.
No Assurance	Immediate action is required to address fundamental gaps, weaknesses or non-compliance identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the area audited.

Finding Priority Ratings	
Advisory	A finding that does not have a risk impact but has been raised to highlight areas of inefficiencies or good practice.
Low Priority	An issue that results in a small impact to the achievement of objectives in the area audited.
Medium Priority	An issue that results in a moderate impact to the achievement of objectives in the area audited.
High Priority	An issue that results in a severe impact to the achievement of objectives in the area audited.
Critical Priority	An issue that results in a critical impact to the achievement of objectives in the area audited. The issue needs to be resolved as a matter of urgency.

Appendix 2 – Areas of Audit Focus and Control Objectives

Audit Area	Control Objectives
Policy and Procedures	• Up to date policies and procedures are in place which clearly set out the end-to-end Social Care Direct processes for adults including the effective management of screening referrals, to ensure that referrals are completed in a timely manner and to the required standard. • Role specific learning and training needs have been established for adult social care direct staff supported by regular training to ensure compliance with regulatory requirements and new or updated processes. • An up-to-date Service Level Agreement is in place between the Social Care Direct Corporate Team (Contact Centre) and the Social Care Direct Response Team which adequately reflects the roles and responsibilities between the two services.
Service Referrals & Screening Process	• There are adequate controls over the screening process to ensure that all referral requests for adult social care including those which are 'locked records' are completed within appropriate timeframes, accurately recorded, and appropriately prioritised. • In addition, appropriate processes are in place to ensure that an effective 'Conversation One' has been completed with the service user and to support the transfer of referrals across to localities. • All adult social care screening assessments are performed in line with the Partnerships eligibility criteria policy. • Urgent adult social care screening assessments are completed and reviewed at an appropriate level and within appropriate timeframes. An effective escalation process exists for all complex or urgent cases identified. • Emergency (section 12) payments are appropriately approved and issued in a timely manner.

Resource Management and Quality Assurance	• Workforce planning processes for the adult social care direct team have been developed and provide assurance that:
	  ○ workforce requirements are assessed, regularly reviewed and action taken to ensure there is adequate capacity to meet demand across the short; medium; and long term to deliver an effective service
	  ○ appropriate solutions are developed to manage any gaps identified (for example staff sickness and annual leave)
	• Improvement plans for the Adult Social Care Direct service are in place with objectives regularly managed and monitored.
	• A quality assurance framework is in place to assess the screening and management of ASP referrals, which includes an embedded approach to lessons learned from both internal practice reviews and external inspections.
	• A complaints procedure is in place which is supported by a process to ensure learning from complaints and process improvements where necessary.

Performance Oversight and Governance	• A performance framework for adult social care direct is in place which includes key performance indicators, outcomes and agreed targets/timescales to measure success. • There is regular and accurate performance monitoring reporting of key processes to identify areas of good performance, and where improvement is required including ensuring backlogs are regularly reviewed and managed. • Governance and oversight arrangements are in place to ensure regular review and scrutiny of delivery adult social care direct services by an appropriate governance forum.
Risk Management	• Risks related to Adult Social Care Direct services are identified, recorded, and managed within a service risk register, and regularly reviewed to ensure appropriate mitigating actions are in place and remain effective, with escalation to divisional and directorate level risk committees where required.