PART 1

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DATE: 28 May 2024

AUDIT SUB-COMMITTEE INFORMATION BRIEFING

Meeting to be held on Tuesday 4 June 2024

This briefing will only be debated if a member of the Committee requests a discussion be held, in which case please inform the Clerk at least 24 hours in advance, indicating the aspects of the information item you wish to discuss.

1 INTERNAL AUDIT REDACTED REPORTS--JUNE 2024 (Pages 3 - 66)

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Printed copies of the briefing are available upon request by contacting Steve Wood on 020 8313 4316 or by e-mail at stephen.wood@bromley.gov.uk.

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THE LONDON BOROUGH
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REDACTED INTERNAL AUDIT REPORT

ADULT SAFEGUARDING

(Procedures and Quality Assurance Processes)

PEO/03/2023

21st May 2024

Auditor	Auditor, SWAP
Reviewer	Assistant Director, SWAP
	Head of Audit and Assurance

Distribution list

Job title
Director – Adult Social Care
Assistant Director for Safeguarding, Practice and Provider Relations
Assistant Director - Operations
Principal Social Worker

Executive Summary

Audit Objective	The objective of this audit was to provide assurance that the London Borough of Bromley (LBB) Adult Services are complying with their Adult Safeguarding duties and that controls are in place to ensure that referrals are dealt with effectively and within indicative timeframes.

Assurance Level		**Findings by Priority Rating**		
		Priority 1	**Priority 2**	**Priority 3**
Limited Assurance	There are significant control weaknesses which put the service or system objectives at risk. If unresolved these may result in error, abuse, loss or reputational damage and therefore require urgent management attention.	1	5	0

Key Findings

1. We found that areas reviewed were structurally sound, controls were clear and well formed, published and accessible, however, in practice results of internally performed case file audits indicate that controls were not being applied. During interactions with staff administering safeguarding, they expressed that they felt too stretched to access guidance and to take up training. Other controls have not been carried out in a timely manner including lessons learned exercises from case audits.
2. We found a comprehensive suite of policies, procedures, and guidance available to staff working in Adult Services, that this was easily available and embedded Safeguarding as a theme throughout. We found that these were consistent, cohesive, and up to date. This provides a clear structure within which safeguarding can operate within the Adult Services. There is a plan in place to streamline documents to make these more accessible to staff who are under time pressure to complete caseloads.
3. There are forums in place to allow staff at all levels of seniority to share information, concerns, and best practice with regard to Safeguarding and wider Adult Social Care provision.
4. Safeguarding Strategy and Performance meetings take place monthly and are attended by managers from across Adult Social Care as a whole. Review of recent minutes identified that there is a focus on improving practice within these meetings.
5. Case file audits were completed in 2023, through reperformance of a sample of safeguarding assessments, where strengths and weaknesses were identified.

6. A positive attitude of learning and development exists within a relatively new management team. There was a recognition that tasks remained incomplete and of further steps to be taken to maximise what is considered a strong foundation for the embedding of safeguarding into everyday Adult Services practice.
7. Membership of the Board provides additional oversight and strengthens multi-agency working across the borough.
8. **Lessons Learned and Defensible Decisions** (Priority 1) - the case file audits reported a significant proportion of cases in the sample that fell short of an acceptable level of detail of the rationale for deciding on cases that were deemed to be safeguarding. A challenge arose through an Enquiry that also found the quality of decision making was weak. No workshops or formal feedback to staff sessions have occurred to deliver the case file audits findings. An action plan for the first case file audit 2023 has been published but not actioned and no action plan has been written for the second review. ***See Recommendation 1.***
9. **Staff training** (Priority 2) – some staff that we interviewed reported feeling a lack of confidence in making safeguarding decisions and completing assessments. ***See Recommendation 2.***
10. **Data recording** (Priority 2) – some staff reported finding difficulties with the user accessibility of the data recording system. Weaknesses in the use of the Social Care case management system were reported in the 2023 case file audits. ***See Recommendation 3.***
11. **Supervisions** (Priority 2) - the importance and regularity of supervision is set out in policy, however, enquiry established that in practice this support was not consistently being made available as often as four weeks, and in one case had become a quarterly exercise. ***See Recommendation 4.***
12. **Indicative time targets** (Priority 2) – reports are produced detailing safeguarding cases exceeding an indicative target of 60-days. Enquiry Officers do not receive information directly and it was found that outstanding cases were not always being challenged to establish causes for delays. ***See Recommendation 5.***
13. **Quality Checks** (Priority 2) – responsibility for section 42 decisions is that of the Safeguarding Adults Managers (SAM), who must signoff enquiries performed by Enquiry Officers. In addition to this there are two annual case file audits performed in accordance with the Quality Assurance Framework. This review found the involvement of SAMs in quality checks insufficient and the learning from this has not been acted upon. ***See Recommendation 6.***

Management have agreed actions for all findings raised in this report. **Please see Appendix A**.

*Definitions of our assurance opinions and priority ratings are in **Appendix B**.*

*The scope of our audit is set out in **Appendix C**.*

Appendix A - Management Action Plan

1. Lessons Learned and Defensible Decisions
Finding **Lessons Learned** Policy and Procedures list the responsibilities of the Safeguarding Adults Manager (SAM) when closing a safeguarding referral. Amongst these steps is the requirement to take forward any lessons learned. Informal feedback from a SAM suggested that feedback is an ongoing dialogue between Enquiry Officers and SAMs throughout the process of safeguarding enquiries and that supervision is also an opportunity to address areas of improvement. Policy states that two casefile audits should happen each year, in 2023 two took place. Weaknesses and areas for improvement were identified in both. Findings were reported to the Operational Team in accordance with the Framework. However, workshops to educate staff and share lessons learned have not taken place. Action plans for the audits remain incomplete and uncompleted. The value of work such as this is limited if the findings are not utilised to inform change and improvement. There is a risk that unless findings highlighted in the case file audits are followed up, opportunities to promote good practice will be missed. Failure to prepare or to follow-up on action plans mean there is no accountability or plan to apply good quality intelligence identified through the audit. Delays between supervisions (see Recommendation 4) also pose a risk to complete a lessons learned exercise to be completed by SAMs as set out in the policy. **Defensible Decisions** We could not identify a published definition of 'defensible decision-making'; however, it is possible to summarise this as the necessary robustness of a decision, supported by appropriate evidence, in determining whether an adult is within or outside of the section 42 Care Act 2014 provision. Policy and Procedures demands clear, concise, and timely recording of information that preceded and ultimately influenced the final decision. The decision to conduct a section 42 enquiry rests with the SAM. The expectation is that all rationale of whether to proceed or discontinue an enquiry is recorded on the system. Procedures and Guidance sets out key principles of record-keeping and defines the senior's responsibility for recording. Case files audits completed in April 2023 reported that the quality of defensible decision evidence was lacking, "unclear or incomplete threshold decisions", and half were rated as in need of improvement. The second case file audit in November 2023, revealed an improvement, as 75% of those reviewed were deemed to meet the required standard. The report called for "clear and consistent recording of section 42(1) criteria, considering the balance between professional curiosity and person-centred outcomes". The Principal Social Worker (PSW) and the Consultant Lead Practitioner (CLP) confirmed there have been no follow

up workshops to deliver the findings of these two pieces of work, an informal notification was made to line managers, and as a result it would appear through sample testing that the quality of information improved by 25%.

The PSW offered an example, that during a recent Enquiry, the local authority fell short of the expected standard of case file recording to include analysis of information to arrive at a decision, because of this an investigation was launched and a suite of measures were drawn up. These include a planned learning event in May 2024, and a review of policy and a plan to embed this learning through the assessing teams.

Risk

If action is not taken to improve when weakness is identified, poor quality and insufficient collection and recording of information will continue unchecked. Service Users may be exposed to abuse or neglect and the Local Authority may be at risk of litigation and reputational damage.

Recommendation	**Rating**
Action plans for the November 2023 case file audit should be drafted and agreed, then actions combined with the Spring audit should be fulfilled, including workshops to deliver findings as set out in the performance framework. Specific lessons learned from internal case file audits and other feedback about defensible decisions should be communicated to staff through workshops and other training methods. This should highlight the consequences of failing to maintain evidence to support when challenged the defensible decision and support them to record appropriately. PSW to take forward their plans to complete lessons learned exercises and include this finding in training plans going forward.	Priority 1
Management Response and Accountable Manager	**Agreed timescale.**
November Action Plan to be completed by end of May 2024, capturing both safeguarding audits completed in 2023. Annual schedule of Workshops to deliver audit findings as set out in the performance framework. Annual schedule of specific lessons learned from internal case file audits and other feedback about defensible decisions will be communicated to staff through workshops and other training methods.	31 May 2024 June 2024 June 2024

The current Social Care case management system forms Review Group will strengthen defendable decision making by line manager (Safeguarding Adults Manager) e.g., as a mandatory text box. Safeguarding Policy 1 will be reviewed and updated to ensure the focus on defensible decision making. The recording policy is being reviewed; risk assessments and decision making will be captured. Lead Accountable Officer – Assistant Director for Safeguarding, Practice and Provider Relations	In place July 2024 Aug 2024

2. Staff training.

Finding

The Principal Social Worker (PSW) provided evidence that plans, and guidance are in place that address training and development. Each team member has a job description setting out the responsibilities and requirements of them and the role that they perform, qualifications and professional registration commensurate with that role. However, in practice, through interviews and observations it is possible to discern an underlying culture of caution and a pervasive lack of confidence in the delivery of decision making. Staff expressed that they felt ill equipped in the practical application of safeguarding information recording in the Social Care case management system, whilst case file audits demonstrated a lack of ownership of safeguarding as a function of Adult Services. The Consultant Lead Practitioner (CLP) reported concerns that the prevalent practice was to treat safeguarding as separate, rather than the embedded vision promoted through policy and procedures, and that a risk averse ethos has grown up in response to a fear that safeguarding is a complex and specialist area. The CLP reported that after a prolonged period where teams were automatically deferring all safeguarding decisions direct to the CLPs, that now enquiries were being made to support the decision ultimately made and the responsibility of the SAM. There may be a case for promoting soft skill training such as effective communication, advocacy, and risk awareness training.

The PSW has acknowledged that training in the use of the Social Care case management system to record safeguarding form process should be reviewed and made available to staff in response to concerns raised in a group discussion held during this review.

We received a spreadsheet from the Assistant Director for Safeguarding, Practice and Provider Relations, of concerns raised and whether the officer responsible for the referral had completed mandatory safeguarding training. Through review of this spreadsheet and underlying data we found two exceptions where there was no record of Level 4 training completed. The Principal Social Worker has however advised that one of these has been on maternity leave and the other is a locum who undertook the training at another Borough. We understand that both are booked onto the training in May 2024.

Risk

There is a risk that staff responsible for the identification and assessment of vulnerable adults are not confident in their ability to recognise the signs of abuse or neglect and may therefore miss vital opportunities to prevent serious harm. An unwillingness to engage with Safeguarding as part of the wider Adult Services role puts those experiencing or vulnerable to abuse and neglect at risk of prolonged or unchallenged exposure to mistreatment.

Recommendation	**Rating**
We recommend that a review of all staff training needs is conducted and appropriate remedy be sought as a matter of urgency. Training in areas such as advocacy, communication and risk awareness would complement technical knowledge and enhance service provision and competency.	Priority 2

Management Response and Accountable Manager	**Agreed timescale**
Staff Induction Protocol to outline mandatory safeguarding training and timescales.	June 2024
Newly appointed senior practitioners joining Bromley: our Consultant Lead Practitioners (CLPs) will give a view regarding the evidence of their safeguarding training that the person can produce to determine if they can act as a SAM or if they first need LBB refresher safeguarding training.	Ongoing
Team Leaders to monitor and update their team members' safeguarding training dates.	June 2024
Update Safeguarding Procedure 1 to include the mandatory frequency of refresher safeguarding training.	June 2024
Two additional safeguarding training sessions were arranged for May 2024 for level 3 (for safeguarding enquiry officers) and level 4 (safeguarding adult managers).	Completed
Managers were informed that team members cannot lead on a safeguarding enquiry or act as a safeguarding adult's manager until their refresher training was updated.	Completed
Time management, to attend relevant and mandatory training, to be discussed as part of supervision.	Ongoing
Lead Accountable Officer – Assistant Director for Safeguarding, Practice and Provider Relations	

3. Data recording.

Finding

We received copies of two casefile audits carried out by CLPs in 2023. Both identified weaknesses in the quality of information recorded in the Adult Social Care recording system. We received feedback from frontline staff and management that highlights several issues around the accessibility and use of the system. There was an overarching message that the confidence of those using the system was low, and the forms specifically used to record safeguarding assessments could be more accessible and staff could be better trained to use them. For example, we were told that forms can only be edited in order of workflow steps, this is to ensure proper oversight and authorisation, but also inhibits the assessor's ability to record emerging information as it becomes available. An Enquiry Officer reported that previous safeguarding reviews are not apparent when accessing the records of an existing Service User, and therefore relevant information is not included in the current assessment.

Enquiry Officer and SAMs who attended a meeting with us to discuss Safeguarding stated that there is no 'audit record' in the Social Care case management system contact form of which officers had completed work steps. From this exchange we conclude that either the system does not record this information or staff are unaware of how to access it.

There is a user guide that focuses on the safeguarding forms in the data recording system, multiple guidance documents for the Social Care case management system are available to all staff online. However, as per feedback from the Practitioners meeting and the issues recorded in the case reviews, there is grounds to remind staff of their existence and importance.

Risk

There is a risk that identified limitations of the data recording system and staff's lack of engagement with that system are preventing the proper process of making safeguarding assessments. Critical information may be lost, not recorded in a timely manner or recorded outside the system.

No system audit trail results in a risk that lack of accountability and recourse may damage reputation if a decision in the original assessment proves to be wrong. Missed opportunities for staff development if repeated errors or omissions cannot be attributed to an individual.

Recommendation	**Rating**
• A reminder should be sent to staff that Social Care case management system operational procedures are available • The Principal Social Worker said that reinstatement of training would be investigated with the trainers, this should be actioned. • A feedback exercise or a working group on the use and application of the Social Care case management system in delivering Adult Social Care services generally and safeguarding specifically would assist in educating staff on the capabilities of the system and identifying limitations that could be overcome through system development. • There have also previously been system champions in each team, and a desire for their reinstatement was made by members of Practitioners' Group.	**Priority 2**
Management Response and Accountable Manager	**Agreed timescale**
A reminder with the link will be sent to staff that Social Care case management system operational procedures are available. Reinstatement of Social Care case management system training: A cycle of safeguarding training after safeguarding forms were updated; and review if training can be offered periodically for new staff. A Safeguarding Adults Social Care case management system forms review group is already in place. This group includes safeguarding management and representative from operational teams. Lead Accountable Officer – Principal Social Worker	June 2024 September 2024 Completed

4. Supervision.

Finding

Adult Services and Safeguarding Policies states the importance of supervisions as a support and development tool, using regular 'face-to-face' contacts to build accountability, competence and confidence is set out clearly. They establish that Safeguarding Adult Managers are responsible for the overall coordination of the section 42 enquiry. The SAM will make decisions regarding the need to conduct a section 42 enquiry when abuse or neglect had occurred, all decisions will be recorded by them in the casefile, even if the decision is to take no further action.

Enquiry and feedback with officers established that supervisions were not consistently occurring at regular four-week intervals, as set out in the policy. That the availability of supervision, was between four and six-weeks in one case and three months in another. The ability to recall detailed information about cases that had occurred in the elapsed period was hard and meetings were felt to be stressful and unhelpful. The PSW provided us with the results of a supervision audit that was carried out in July 2023, results of a survey support the findings that not all supervisions are occurring at regular four weekly intervals. An action plan has been published in accordance with this audit and includes a recommendation to use reoccurring calendar bookings to promote this.

Oversight and accountability were raised in an open forum conducted for the purpose of this review, with opinions shared that accountability for safeguarding is lacking within the frontline teams, and that there is a 'cultural fear of safeguarding' within teams and by team leaders. Despite safeguarding being an all-pervasive theme running through adult social care guidance, CLPs believe that it is being treated as a separate and specialist area, that an assumption exists that because they are available to offer specialist support that Enquiry Officers and SAMs were relying on them too much to make section 42 decisions. More regular and effective supervisions would help to improve this.

We have also reviewed the supervision trackers for four teams and analysed the frequency of supervision between January and March 2024. We found that, on the basis of supervisions occurring monthly:

- 27% of supervisions that were due had not taken place and no reasonable explanation (for example annual leave or sickness) was recorded.
- A further 4% of supervisions had not taken place but reasonable explanations for these had been recorded.

We recognise that gaps may also be due to supervisors not recording when supervisions took place but alongside the interview findings as detailed above, failure to record will not be the reason for missed supervision in all instances.

Risk There is a risk that without regular and frequent supervision, issues that could be resolved quickly and simply in early stages are left until they become more complex and harder to rectify. Opportunities to offer support, receive feedback and convey messages are lost and become less relevant. Delays between supervisions often result in a larger volume of topics to consider, some of which can cause unnecessary anxiety as details may be less clear over time and multiple cases become overwhelming.	
Recommendation Supervisions should occur at four weekly intervals to provide staff and management with the opportunity to receive support in alignment with Policy. Supervisions should include support, coaching and guidance to staff.	**Rating** **Priority 2**
Management Response and Accountable Manager Line manager supervision tracker to be updated by line managers. Continue to promote the available supervision training: 1-day Professional supervision training offered by Learning & Development (2 sessions offered annually). Discuss supervision within Senior Practitioner forum and Operational Team Leaders forum. Consultant Lead Practitioners (CLPs) continue to have an open-door policy and regularly meet with Staff / teams for safeguarding support and advice. Guidance and advice provided must be recorded on the Social Care case management system. Update supervision policy to change minimum supervision frequency from 4 weeks to 4 to 6 weeks depending on the need of the staff member. Supervision Quality Assurance audit will be conducted by the end of this year following our supervision survey completed in 2023. All line managers to use reoccurring calendar bookings for supervision. When a Safeguarding Adults Manager is away from work due to sick leave or annual leave, then the Team Leader must identify a temporarily Safeguarding Adults Manager for the Enquiry Coordinator.	July 2024 Ongoing Aug 2024 Ongoing Aug 2024 Dec 2024 Ongoing Ongoing

When the Enquiry Officer is away from work due to sick leave or annual leave, then the Team Leader must identify a temporarily Enquiry Coordinator. Our PSW, who now supervise the CLPs, have send information to Team Leaders regarding the Consultant Lead Practitioner (CLP) role. CLPs continue to communicate this to teams. All operational Team Leaders to attend refresher Safeguarding Adults Manager (level 4) training at least once every 2 years. Lead Accountable Officer - Assistant Director for Safeguarding, Practice and Provider Relations	Ongoing Completed Ongoing

5. Indicative time targets.

Finding

An indicative timetable for the process of proceeding safeguarding referrals is published.

Policy and Procedures places the responsibility for managing the time frame of referrals on the SAM to work together with the Enquiry Officer administering the referral. Supervision is an appropriate opportunity to discuss problematic or delayed cases. A report is shared with officers detailing the length of time referrals have been open. Of 132 cases open as at 1 April 2024, 26 had been open for more than six months and a further 55 had been open for 2-6 months.

We received feedback at the Practitioners' Group that the complexity of a case often determined the speed with which it could be resolved, however, there was a reminder from within that group that all Safeguarding should be practiced with time being of the essence, and resolution being sought at pace was often in the best interests of the service user.

We were also informed that performance reports were directed to SAMs and line managers to follow up with front line staff to identify causes of delay and ensure that delays were genuine. We received feedback from frontline staff that suggest that cases that have exceeded this threshold have gone unchallenged. Observation from the CLP was that overwhelm in response to the volume of safeguarding referrals often culminated in avoidance and repetition of the process to delays. SAMs in attendance of this meeting expressed a desire to reinstate meetings with CLPs to regularly discuss the progress of such cases.

Risk

There is a risk that cases not prioritised may result in continued risk to the Service User, whilst failure to follow-up on outstanding workload may lead to continued avoidance and delays. Without review, lessons to be learned about genuine causes of delay may be lost, a person-centred approach may slow the closure of a Safeguarding case but be an acceptable compromise for the wellbeing of the Adult involved.

Recommendation	**Rating**
Staff should be made aware of cases exceeding the indicative time targets and explanation should be sought to understand the reasons for delays. Within the performance information dataset, further granularity should be provided for the 2-6 month bracket, so that managers can understand how far over 60 days cases have remained open.	Prioritv 2

Management Response and Accountable Manager	**Agreed timescale**
Reinforce that all enquiry officers and SAMs must complete the Social Care case management system case note to record rationale of reasons why the safeguarding is open for more than 60 days. This case notes must be updated bi-weekly.	June 2024
We have now implemented the bi-weekly Safeguarding Support and Performance Team Meeting in all operational teams.	Ongoing
A new EXCEL data report to be developed for current Social Care case management system to reflect what we had for the previous Social Care case management system:- all open safeguarding enquiries including the number of days open, as well as the case note setting out the reasons why the safeguarding is open for more than 60 days. Lead Accountable Officers – Head of Strategy and Performance, Principal Social Worker	July 2024

6. Quality checks.

Finding

Policy and Procedures states SAMs will quality-check all related mental capacity assessments and relevant best interest decisions on the file and authorise the forms for completion. Similarly, they will authorise all Safeguarding Adult forms and end the safeguarding workflow on the system when all forms are completed.

A lack of SAM involvement in safeguarding enquiries was reported in the April casefile audit, it was also observed that there was a correlation between reduced presence of the SAM in planning stages and throughout the workflow window, and quality of the case overall.

Enquiry with SAMs and Enquiry Officers established that a preference for a system of strategy meetings ahead of the enquiry and planning stages, reminiscent of a previous approach, would be considered helpful.

ASC assessments and support plans should be authorised in accordance with procedure, with good practice and experience shared. The Framework also includes a requirement to conduct case file audits in accordance with the audit programme. Two such investigations were conducted in 2023, and reports were produced. A sample of referrals were selected and reperformed, findings were noted, and weaknesses reported.

In 2023, four Safeguarding Adults Reviews were completed.

Risk

There is a risk that unless findings highlighted in the case file audits are followed up opportunities to promote good practice will be missed, the finding in both reports was that where SAM involvement was not evident the quality of the case file was insufficient.

Recommendation	**Rating**
Findings from the 2023 case file audits should be followed up and consideration should be given to consulting staff about the most effective approach to receiving SAM input to support ongoing quality.	**Priority 2**

Management Response and Accountable Manager	**Agreed timescale**
Reinforce that supervision / guidance to staff need to be recorded on the Social Care case management system.	June 2024
Reinforce that Team Leaders must be made aware by their team members of all complex and high-risk cases.	June 2024
SAM and Enquiry Officer forums facilitated by CLPs will commence in June 2024 and will support training needs and gaps in performance.	June 2024
Managers to be reminded of their duty and the minimum frequency of monitoring safeguarding timescales on open safeguarding enquiries that their team.	June 2024
Lead Accountable Officer - Assistant Director for Safeguarding, Practice and Provider Relations	

Appendix B - Assurance and Priority Ratings

Assurance Levels

Assurance Level	Definition
Substantial Assurance	There is a sound system of control in place to achieve the service or system objectives. Risks are being managed effectively and any issues identified are minor in nature.
Reasonable Assurance	There is generally a sound system of control in place but there are weaknesses which put some of the service or system objectives at risk. Management attention is required.
Limited Assurance	There are significant control weaknesses which put the service or system objectives at risk. If unresolved these may result in error, abuse, loss or reputational damage and therefore require urgent management attention.
No Assurance	There are major weaknesses in the control environment. The service or system is exposed to the risk of significant error, abuse, loss or reputational damage. Immediate action must be taken by management to resolve the issues identified.

Action Priority Ratings

Risk rating	Definition
Priority 1	A high priority finding which indicates a fundamental weakness or failure in control which could lead to service or system objectives not being achieved. The Council is exposed to significant risk and management should address the recommendation urgently.
Priority 2	A medium priority finding which indicates a weakness in control that could lead to service or system objectives not being achieved. Timely management action is required to address the recommendation and mitigate the risk.
Priority 3	A low priority finding which has identified that the efficiency or effectiveness of the control environment could be improved. Management action is suggested to enhance existing controls.

Appendix C – Audit Scope

Audit Scope
We reviewed the adequacy and effectiveness of controls over the following risks: The application of legislation is incorrect or inconsistent leading to failures of safeguarding duty resulting in real harm to service users. We reviewed the following controls; • Guidance and operational procedures are up to date and available to all officers making decisions about adult safeguarding within the service. • Staff are appropriately trained and qualified to apply statutory guidance on a case-by-case basis. • Consistent use of the data recording system ensures information is available and complete to evidence 'defensible decision-making', in accordance with s.42(1). • Regular review of targets against published and agreed timescales to ensure referrals are being addressed in a timely manner. • Adequate supervision and feedback is available to all staff engaged in adult safeguarding referrals to ensure support and continuous development of decision making skills. • Quality checks are made to ensure that referrals are processed in line with statute and guidance, and that lessons learned are used to improve the quality-of-service delivery. • Multi-agency working is used to ensure that referrals are not overlooked, and best use of resources is made to ensure vulnerable adults are protected. • Accountability and transparency are encouraged through senior management oversight and performance reporting.

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REDACTED INTERNAL AUDIT REPORT

CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH AND WELLBEING CONTRACT

AUDIT REFERENCE: PEO/06/2023

April 2024

Auditor	SWAP Principal Auditor
Reviewer	SWAP Assistant Director Head of Audit and Assurance

Distribution list

Assistant Director of Integrated Commissioning
Director of Children, Education and Families
Head of Service, Community Living Commissioning
Integrated Strategic Commissioner

Executive Summary

Audit Objective	The overall objective of the audit was to review the effectiveness of the controls in place to govern and monitor the Children and Young People's Mental Health and Wellbeing contract, to ensure the service is delivered to expected standard and at the agreed cost.

Assurance Level		**Findings by Priority Rating**		
		Priority 1	**Priority 2**	**Priority 3**
Limited Assurance	There are significant control weaknesses which put the service or system objectives at risk. If unresolved these may result in error, abuse, loss or reputational damage and therefore require urgent management attention.	1	1	0

Key Findings

We found that the following controls are in place and working well:

- There is an up to date, signed contract.
- Inflation pressures are effectively managed to minimise impact on the Council's budget and Medium Term Financial Strategy (MTFS) as far as possible. The contract does not allow for inflationary increases and as such the amounts payable remain fixed.
- No issues were noted with the budgets for the contract, and this is predicted to remain stable.
- Payments to the contractor had been appropriately approved.
- There are appropriate contract management and monitoring structures in place and contract management meetings are held regularly.

Management should consider the key findings summarised below:

1. **Performance Monitoring** (Priority 1) – Whilst there are mechanisms in place to manage the contract, the information reported and reviewed is not sufficient to ascertain how well the contract is performing and consequently we were unable to form a view on whether the contract is meeting outcomes and objectives or delivering value for money. The contractor's performance against the Key Performance Indicators (KPIs) in the contract specification are not monitored. The 2023 annual report was issued late and actions from the 2022 annual report were not monitored. ***See Recommendation 1.***

2. **Business Continuity Procedures (BCP)** (Priority 2) – We reviewed the contractor's BCP dated November 2023 and made some recommendations which have been redacted regarding level of detail and frequency of testing. ***See Recommendation 2.***

Management has agreed actions for all findings raised in this report. **Please see Appendix A.**

Definitions of our assurance opinions and priority ratings are in ***Appendix B****.*

The scope of our audit is set out in ***Appendix C****.*

Appendix A - Management Action Plan

1. Performance Monitoring	
Finding The contractor is required to produce and supply an annual performance report to the Council in May each year, however the report for 2023 was not published unti November 2023. As the annual report for 2023 had just been released at the time of our testing, we asked if the actions in the previous annual report from 2022 had been actioned and monitored by the Council. We were advised that they believed they were actioned, but could not confirm for sure, as they had not monitored them. We also reviewed the quarterly performance reports for Q1 and Q2 2023/24. We found that whilst the reports contained a lot of data and narrative, this did not link back to the KPIs in the service specification. The information also did not enable an assessment of how well the contract was performing, and if it was meeting outcomes and objectives and delivering value for money. This is because the information provided is primarily focused on activity numbers rather than outcomes and effectiveness. We asked if the KPIs were specifically monitored in any way, and we were advised that they were not. It was agreed that this was something that needed to be reviewed and improved. Whilst the service contract includes consequences for breach of KPIs, with the absence of effective performance monitoring, there is not a robust method to identify and escalate concerns. **Risk** Expected service levels are not achieved, and /or, issues are not identified and escalated for resolution. This contract is worth c.£4.5 million over the 5 year period (2021 to 2026), and whilst this is jointly funded by the Integrated Care Board, it still poses a high monetary risk to the Council if the contract terms are not properly fulfilled.	
Recommendation a) The KPIs in the service specification should be reviewed and appropriate monitoring and reporting put in place to assess the contractor's adherence to them. b) The actions raised in the annual report 2023 should be formally monitored throughout the year to ensure they are completed. c) The contractor should be reminded of the requirement to submit an annual report by May each year and consequences should be imposed if this is not delivered.	**Rating** Priority 1

Management Response and Accountable Manager

Agreed timescale

Area	Recommendation	Assurance Priority Rating	Action	Owner	Due by	Status
Performance Management	The KPIs in the service specification should be reviewed and appropriate monitoring and reporting put in place to assess the contractor's adherence to them.	Priority 1	Review KPIs in the Service Specification.	Contract Officer	May-24	In progress
			Work with contractor to review performance monitoring reporting template and develop structure to assist in monitoring key KPIs and evidencing impact/outcomes.	Contract Officer/ Contractor	Jun-24	In progress
			Develop and circulate contract monitoring schedule and issue calendar invites for the year ahead.	Contract Officer	May-24	In progress
	The actions raised in the annual report 2023 should be formally monitored throughout the year to ensure they are completed.	Priority 1	Monitor the annual report action plan at the contract management meetings.	Contract Officer	Quarterly	In progress
	The contractor should be reminded of the requirement to submit an annual report by May each year and	Priority 1	Develop a contract monitoring schedule and required reports and key deadlines for receipt of reports and issue to the contractor.	Contract Officer	May-24	In progress
			Send email reminders of upcoming deadlines for reports.	Contract Officer	Quarterly	In progress

	consequences should be imposed if this is not delivered.						

2. Business Continuity Procedures (BCP)

Finding

We reviewed the contractor's BCP dated November 2023 and made some recommendations which have been redacted regarding level of detail and frequency of testing.

Risk

There is a risk that the BCP does not reflect current processes and contact details, which could delay the response during an emergency.

Recommendation	**Rating**
Contract officers should ensure, via contract monitoring, that: a) The BCP plan is reviewed and further advice sought where necessary to ensure it contains sufficient detail. b) Once the BCP has been amended, a BCP test is completed on a regular basis.	Priority 2
Management Response and Accountable Manager	**Agreed timescale**
Agreed. Owner - Contract officer	April 2024

Appendix B - Assurance and Priority Ratings

Assurance Levels

Assurance Level	Definition
Substantial Assurance	There is a sound system of control in place to achieve the service or system objectives. Risks are being managed effectively and any issues identified are minor in nature.
Reasonable Assurance	There is generally a sound system of control in place but there are weaknesses which put some of the service or system objectives at risk. Management attention is required.
Limited Assurance	There are significant control weaknesses which put the service or system objectives at risk. If unresolved these may result in error, abuse, loss or reputational damage and therefore require urgent management attention.
No Assurance	There are major weaknesses in the control environment. The service or system is exposed to the risk of significant error, abuse, loss or reputational damage. Immediate action must be taken by management to resolve the issues identified.

Action Priority Ratings

Risk rating	Definition
Priority 1	A high priority finding which indicates a fundamental weakness or failure in control which could lead to service or system objectives not being achieved. The Council is exposed to significant risk and management should address the recommendation urgently.
Priority 2	A medium priority finding which indicates a weakness in control that could lead to service or system objectives not being achieved. Timely management action is required to address the recommendation and mitigate the risk.
Priority 3	A low priority finding which has identified that the efficiency or effectiveness of the control environment could be improved. Management action is suggested to enhance existing controls.

Appendix C – Audit Scope

Audit Scope
We reviewed the adequacy and effectiveness of controls over the following risks: • The contract is not well governed and as such there is a risk of poor service which could lead to reputational and financial damage to the Council. • Payments are made for services that have not been received, or that have not been received to a satisfactory standard. The review focussed on the following elements: • The contract includes details on performance monitoring arrangements and KPIs. • Monitoring of performance against the delivery targets set within the contract is carried out. • Processes are in place to identify, manage and escalate concerns. • There is a process for managing non-compliance with the contract and issues of supplier failure. • Lessons learned and areas for improvement are considered. • Contract costs are monitored in detail and any variance is identified and investigated. • Invoices are supported by evidence and appropriately approved. • Inflation pressures are effectively managed to minimise impact on the Council's budget and MTFS as far as possible. • Business continuity procedures are in place. Our audit included interviews with key officers who help manage the contract, a review of relevant reports and documentation as well as sample testing of related procedures and processes.

Redacted

REDACTED INTERNAL AUDIT REPORT

Health & Safety (Corporate) 2023/24

AW/01/2023

APRIL 2024

Auditor	Senior Consultant (Mazars LLP)
Reviewer	Assistant Manager (Mazars LLP) Manager (Mazars LLP)
	Partner (Mazars LLP)

Distribution list

Job Title
Head of Corporate Health and Safety
Director of HR, Customer Services and Public Affairs

Executive Summary

Audit Objective	The overall objective of the audit was to review the effectiveness of controls over the Council's compliance with Health and Safety (H&S) regulations, employment law and statutory reporting obligations.

Assurance Level		**Findings by Priority Rating**		
		Priority 1	**Priority 2**	**Priority 3**
Reasonable Assurance	There is generally a sound system of control in place but there are weaknesses which put some of the service or system objectives at risk. Management attention is required.	-	2	1

Key Findings

1. The Council has a Corporate Health & Safety (H&S) Policy in place that provides an overview of the scope and breadth of H&S arrangements across the Council. Once considered by the Corporate Leadership Team (CLT) this was signed and approved via email by the Chief Executive Officer (CEO) of the Council in June 2023.
2. The Corporate H&S Policy provides a breakdown of the roles and responsibilities within H&S at the Council. The H&S Policy is available to staff on the Council intranet, in a dedicated H&S section. Additionally, included in this section are other key policies and guidance. There is also a suite of mandatory H&S training for all staff as well as for particular roles at the Council such as housing and medical staff.
3. The Council display signage in line with H&S requirements such as fire exit signs, fire evacuation notices, physical and mental health first aider lists, as well as their locations, working at height, and manual handling posters. We were provided with photographs from the Council's Civic Centre in Bromley evidence the existence of these measures.
4. A review of the risk assessment tracking spreadsheet maintained by the H&S Team demonstrated that they are monitoring services to ensure that they are undertaking their duties. At the time of our fieldwork we noted a spreadsheet was shared with Council Directors in the week commencing (W/c) 06/11/2023 to inform them of any gaps in their areas and ensure these are addressed.
5. The Council requires staff to undertake a suite of mandatory training courses related to H&S. We reviewed examples of content for two of the mandatory training courses (Fire prevention and safety and Health and Safety inductions) and noted that the Council are actively tracking completion and both courses had been completed by all relevant staff at the time of our fieldwork.
6. There are a number of corporate bodies at the Council that oversee H&S, including the Corporate H&S Committee which is chaired by the Director of HR, Customer Services, and Public Affairs. The H&S Committee meets every two months and has a dedicated Terms of Reference (ToR); however, this has not been reviewed since January 2020.

7. In addition to the H&S Committee, the following groups also form part of the corporate health and safety governance framework at the Council:

   - The Environment and Public Protection H&S Committee; meets quarterly;
   - The Housing, Planning, & Regeneration Safety Meeting; meets quarterly;
   - Corporate Risk Management Group; meets three times a year;
   - Chief Executive's Department H&S Committee; meets every six months; and
   - Audit and Risk Committee; meets three times a year.

8. We reviewed the meeting minutes for the groups above and confirmed that between October 2022 and October 2023, in all cases, meetings were going ahead as scheduled.

9. The Council has started producing a bi-annual H&S Report which is presented to the Corporate H&S Committee. The report includes summaries of incidents broken down into categories, and Dangerous Occurrences Regulations (RIDDOR) reportable incidents, near misses, and total days lost due to incidents. The first report was published and completed in August 2023. Through review of meeting minutes we confirmed this was discussed by the Corporate H&S Committee in their October 2023 meeting.

10. Reports on the number of accidents and near miss statistics are produced periodically by the Council and include columns for each department, the number of accidents, the number of near misses, and the lessons learned for each of these two categories. It was confirmed that these statistics are also presented to the Corporate H&S Committee.

11. The Head of Corporate H&S distributes monthly H&S emails to managers at the Council that summarise issues or events relating to H&S from the previous month. We reviewed copies of these emails for June, July, and August 2023. The Council has deployed an employee feedback scheme called 'Ideas Aloud', which allows staff to provide feedback on the Council's services, including H&S matters.

12. The Council has emergency response plans, including procedures for evacuations and fire drills; for example, bomb threats, suspicious persons, and suspicious packages. Fire evacuation procedures are displayed physically near fire exits and on message boards at the Council's headquarters and fire drills are planned and recorded to identify any weaknesses. We obtained a fire drill log for listing the Council's corporate properties and selected the latest drill from the Bromley Civic Centre dated 30 August 2023. We confirmed that the drill took place to schedule across the building by reviewing reports detailing the performance of evacuations. These reports were analysed and discussed by the Corporate H&S Committee in their October 2023 meeting.

We have identified the following areas for management attention:

13. **Policies and Procedures** (Priority 2) – The policy and procedural guidance structure is not consistent across the suite of 28 H&S policies at the Council. Some are not version controlled at all and have not been reviewed in several years. ***Recommendation 1***

14. **Recording and investigation of accidents and near misses** (Priority 2) – The Accident - Incident Reporting Procedure states that all incidents should be reported to the Corporate H&S Team within five working days of occurrence. However, during out testing we noted that only two of the ten samples were reported to the Corporate H&S Team within this timeframe. ***Recommendation 2***

15. **Corporate H&S Committee Terms of Reference** (Priority 3) – We reviewed the Corporate H&S Committee ToR. The document was revised in January 2018 and last reviewed in January 2020 according to the document footer, so it appears to have a review cycle every two years. ***Recommendation 3***

Management has agreed to actions for all findings raised in this report. **Please see Appendix A**.

Definitions of assurance opinions and priority ratings are in ***Appendix B****.*

The scope of the internal audit is set out in ***Appendix C****.*

Appendix A - Management Action Plan

1. Periodic Review of Policies and Procedures

Finding

The Council has a Corporate H&S Policy in place and a suite of 27 specific policies that feed into it. We reviewed all 28 policies including the Corporate H&S Policy, to test whether they had been periodically updated in line with a defined review timescale. We noted the following issues:

- The 'Accident - Incident Reporting Procedure' that we received is dated June 2013 and there is no version control to suggest a more recent iteration;
- The 'Lone Working Policy, Procedure, and Guidance' is version controlled, but this iteration is dated April 2019;
- The 'Stress Policy' is dated June 2021, but it is not version controlled so we cannot ascertain the review cycle;
- The 'New and Expectant Mothers Policy and Procedure' has a version control and is dated April 2021, but it does not indicate what version this iteration is (left blank) and it does not indicate the review frequency with a date of future review;
- The 'Substance Misuse Policy' is dated April 2014 and there is no version control to suggest a more recent iteration;
- The 'Mental Health & Well-Being Policy' has a version control, but it does not indicate the review frequency with a date of future review. It is dated November 2019;
- The 'Mental Health First Aiders Policy' has a version control, but it does not indicate the review frequency with a date of future review. It is dated November 2019; and
- The 'Legionella Management Policy' has a version control, but it does not indicate the review frequency with a date of future review. It is dated April 2021.

The Council also indicated a number of the policies were currently under review, however, we noted some potential issues:

- The 'Risk Assessment Guidance' is dated September 2023, but there is no version control so we could not ascertain the review frequency or the date of next review;
- The 'Display Screen Equipment (DSE) Guidance' is not dated and not version controlled so we could not ascertain the date of the previous or the next review;
- The 'Driving and Mobile Phones Policy' is dated April 2014 and is no version control to suggest a more recent iteration;
- The 'Electrical Safety Policy' is dated April 2010, and there is no version control to suggest a more recent iteration;
- The 'Vaccination Policy' is dated April 2014, and there is no version control to suggest a more recent iteration. Considering the Covid-19 Pandemic that hit in 2020, this is potentially risky oversight;
- The 'Working at Height Policy' is dated April 2014, and there is no version control to suggest a more recent iteration;
- The 'Office Health and Safety Inspection Guidelines' is dated April 2010, and there is no version control to suggest a more recent iteration and;
- The 'Dealing with Work-Related Violence Policy and Procedure' is dated October 2023 and has a version control; however it does not include the frequency of review; the document was previously reviewed in April 2019.

The policy and procedural guidance structure is not consistent across the suite of H&S policies at the Council. Some are not version controlled at all and have not been reviewed in several years, whilst others are version controlled fully, with the date of review, the date of the next review, who reviewed it, and a summary of the changes made. A good example of this is the Fire Safety Policy which has a full page dedicated to Document Control and Distribution.

Risk

The H&S Policy Framework is not fit for purpose and appropriately endorsed to ensure tone from the top. Staff therefore do not take appropriate measures to safeguard their health and safety, and that of the Council's external visitors.

Recommendation	**Rating**
The Council should develop a consistent approach to reviewing and approving key H&S policies and procedures so that all documentation is subject to periodic review. This should include a version control that contains the following: • The frequency of review; • The date of previous review; • The officer that reviewed the policy/guidance; and • The date of the next scheduled review. The Council should also consider a policy and guidance review tracker that lists all H&S documentation that includes the frequency of review and the date the of the previous review to help ensure that policies and guidance are subject to periodic review.	Priority 2
Management Response and Accountable Manager The team have created a tracker for policies review/revision, which can be provided if useful. We regularly review our policies, though we appreciate this was not visually recorded on all of them, therefore we are in the process of updating all our policies so that the version control is recorded on them in a consistent way. This should be completed by the Corporate Health and Safety Team, which is led by the Head of Corporate Health and Safety, by the end of the month. Head of Corporate Health and Safety	**Agreed timescale** 30 April 2024

2. Recording and Investigation of Accidents and Near Misses

Finding

According to the 'Accident - Incident Reporting Procedure', accidents and near misses are recorded on forms that are available on the staff intranet page; the AR3 Form and the RIDDOR Form. The Procedure states that accidents and incidents need to be reported to the Corporate H&S team within five working days so that they can be reported on and followed up on if necessary. AR3 Forms have three sections; Section A which covers personal details of the injured or threatened person, Section B which covers the details of the incident, and Section C is management details, which covers whether an investigation was undertaken, what actions will be taken to stop re-occurrence, and whether it was a serious injury.

We selected a sample of ten accidents/near misses from a list of their reference numbers with a population of 259 dated between December 2022 and September 2023 to test whether a form had been completed, had been investigated and that documentation was retained. We noted the following:

- All ten samples had a completed AR3 form in place;
- Only two of the ten samples were reported to the Corporate H&S Team within five working days. The average number of days taken to report incidents from our samples was 15.5 days; and
- Sections A, B, and C were completed by the same officer for six of the AR3 Forms.

The Council has started reporting on corporate H&S bi-annually, with the first iteration being finalised in August 2023 and discussed by the Corporate H&S Committee in October 2023. The H&S Report includes a section dedicated to the '*Average number of days to report an incident'* and the findings reflect the findings we found in our testing; that the five day reporting window is not being met. The number of days taken to report incidents is also discussed at other Corporate H&S Committee meetings, however, the minutes do not detail whether the Council views this as an issue and how response times could be improved. The Head of Corporate H&S advised that currently KPIs and targets have not been established for this metric and improvements plans to better the number of accidents/near misses that are reported to this timescale have also not been discussed.

Risk

Where accidents and near misses are not reported to the Health & Safety Team in a timely manner, there is a risk that legislative timeframes are not met and issues remain unresolved.

Where accident and near miss forms are both completed and signed off by the same officer there is a risk that a lack of segregation of duties could affect the veracity of the incident, leading to inadequate reporting and investigation.

Recommendation	Rating
The Council should remind all corporate staff of the requirement to submit accident and near miss forms within five working days to help ensure that reporting timeframes are met and incidents can be investigated in a timely fashion. The Council should continue to track the average number of days to report an incident, but also establish performance targets to track against so that underperformance can be identified. The Council should follow-up with those departments that are submitting forms outside of the agreed timeframes to determine root causes of delays and determine if additional action is needed. The Council should also stress to staff the need to complete AR3 and RIDDOR forms whilst demonstrating segregation of duties between staff completing the different sections.	Priority 2
Management Response and Accountable Manager	**Agreed timescale**
We have been running reports on timeframe taken to report incidents and this has been discussed at Corporate Health and Safety Committee Meetings so services can pick issues up and address them. An email will be going out to managers this month to remind them of the need to report incidents in a timely manner – this email will be sent by Corporate Health and Safety. In this email, a reminder about ensuring different parts of the form are completed by the appropriate persons will be included. Head of Corporate Health and Safety	30 April 2024

3. Corporate Health & Safety Committee Terms of Reference	
Finding The Council's Corporate H&S Committee has a ToR which sets out the roles and responsibilities of the Committee including the frequency of meetings. However, it was noted that the document was revised in January 2018 and last reviewed in January 2020 according to the document footer, so it appears to have a review cycle every two years. Through a comparison of peer organisations, committee ToR are either reviewed annually or bi-annually. **Risk** Where a ToR is not reviewed periodically, there is a risk that it is outdated and does not reflect current practice.	
Recommendation The Council should ensure that the Corporate H&S Committee ToR is periodically reviewed either annually or every two years so that it reflects current practice.	**Rating** Priority 3
Management Response and Accountable Manager The TOR is going to the next Corporate Health and Safety Committee for review. This meeting was scheduled to take place on Tuesday 9th April Head of Corporate Health and Safety	**Agreed timescale** 30 April 2024

Appendix B - Assurance and Priority Ratings

Assurance Levels

Assurance Level	Definition
Substantial Assurance	There is a sound system of control in place to achieve the service or system objectives. Risks are being managed effectively and any issues identified are minor in nature.
Reasonable Assurance	There is generally a sound system of control in place but there are weaknesses which put some of the service or system objectives at risk. Management attention is required.
Limited Assurance	There are significant control weaknesses which put the service or system objectives at risk. If unresolved these may result in error, abuse, loss or reputational damage and therefore require urgent management attention.
No Assurance	There are major weaknesses in the control environment. The service or system is exposed to the risk of significant error, abuse, loss or reputational damage. Immediate action must be taken by management to resolve the issues identified.

Action Priority Ratings

Risk Rating	Definition
Priority 1	A high priority finding which indicates a fundamental weakness or failure in control which could lead to service or system objectives not being achieved. The Council is exposed to significant risk and management should address the recommendation urgently.
Priority 2	A medium priority finding which indicates a weakness in control that could lead to service or system objectives not being achieved. Timely management action is required to address the recommendation and mitigate the risk.
Priority 3	A low priority finding which has identified that the efficiency or effectiveness of the control environment could be improved. Management action is suggested to enhance existing controls.

Appendix C – Audit Scope

Audit Scope
We reviewed the adequacy and effectiveness of controls over the following risks: • The Health and Safety Policy Framework is not fit for purpose and appropriately endorsed to ensure tone from the top. Staff therefore do not take appropriate measures to safeguard their health and safety, and that of the Council's external visitors. • Staff and members are unaware of responsibilities and therefore do not comply with the Council's health and safety requirements, which puts individuals at risk. • Poor oversight and scrutiny of health and safety arrangements, resulting in key issues not being addressed in a timely manner due to unwieldy structures or a lack of authority, for example. • The Council is unaware of instances of non-compliance and/or does not address the root cause in a timely manner, which may result in repeated instances of non-compliance. The internal audit scope included the following: • **Compliance with Legislation, Regulations, Policies and Procedures** Health and Safety Policy and underlying policies and guidance are proportionate and up to date • **Roles and responsibilities** Responsibilities are clear and understood by all types of staff and associates (including first aiders and other staff at the Council for example); • **Risk Assessment and Management** Staff are made aware of Health and Safety risks and activities to mitigate these (e.g. manual handling, Display Screen Equipment (DSE), slips and falls, fire procedures etc); • **Health & Safety Training** Staff have received sufficient training to carry out Health & Safety responsibilities; • **Governance & Oversight** Proportionate governance framework to oversee and scrutinise Health and Safety; • **Recording and Investigation of Accidents** Accidents and near misses are comprehensively and consistently recorded; Accidents and near misses are investigated, and remedial actions made where necessary. • **Health and Safety's Role in the Combined Assurance Framework as the Second Line of Defence** The Council has clearly defined the roles and responsibilities of each assurance provider such as the health and safety department within the combined assurance framework. In addition, the audit will perform sample testing to verify the effectiveness of controls implemented by the health and safety department. This will include reviewing the reports produced and interviewing health and safety staff. By performing these tests, an internal audit will assess the reliability and accuracy of the health and safety department's work.

- **Safety Culture and Communication**

  The Council demonstrates commitment to promoting a positive safety culture and effective communication of health and safety information to employees. There are proper and effective communication channels, safety meetings, safety committees, and employee feedback mechanisms.

- **Emergency Preparedness**

  The Council has emergency response plans, including procedures for evacuations, fire safety, first aid, and communication during emergencies. The Council conducts drills and exercises to test emergency preparedness and these are effective.

SCOPE EXCLUSION

The following area will not form part of the current audit:

- **Health & Safety checks**

  Sample testing of key health & safety checks (e.g. Control of Substances Hazardous to Health (COSHH) assessments, Fire Risk assessments, asbestos surveys, electrical checks, gas servicing, legionella testing etc.), for example sites.

Redacted

REDACTED INTERNAL AUDIT REPORT

QUALITY OF CARE - ADULTS (RESIDENTIAL)

PEO / 04 / 2023

22 May 2024

Auditor	**TIAA Limited** Principal Auditor Director of Audit - TIAA
Reviewer	Director - TIAA Head of Audit and Assurance (Bromley Council)

Distribution list

Job title
Director of Adult Social Care
Assistant Director for Safeguarding, Practice and Provider Relations, Adult Services - People Directorate
Head of Service, Placements and Quality Assurance
Team Leader, Quality and Provider Relations Team, Safeguarding, Practice and Quality Improvement-Adult Services

Executive Summary

Audit Objective	The overall objective of the audit was to review how the Council receives assurance on the quality of its adult care placements (which are subject to the Council's Quality Assurance Review process) to ensure best outcomes for service users by assessing the quality of provision by the providers once placements have been made. The review also assessed the adequacy and effectiveness of the controls and processes in place for ensuring that, once placements are made, providers supply good quality care and continue to do so for the service users (focusing on adult placements).

Assurance Level		**Findings by Priority Rating**		
Substantial Assurance	There is a sound system of control in place to achieve the service or system objectives. Risks are being managed effectively and any issues identified are minor in nature.	**Priority 1**	**Priority 2**	**Priority 3**
		0	0	2

Key Findings

We noted the following areas of good practice and positive audit findings:

1. There is effective engagement and collaboration with the providers by the Quality and Provider Relations Team. The providers alert the team of any significant concerns and Care Quality Commission (CQC) inspections prior to formal assessment reports being published by CQC. The timely information received by the team is used to update the risk assessment and planning for visits for the providers. NB: There is good engagement with the CQC as evidenced by the CQC Operations manager also attending the Home Care Forum meetings.
2. A Quality Monitoring Feedback survey of the providers (dated February 2024) was undertaken by the team as part of the continuous improvement process for ensuring that the support and advice provided to providers is effective and the work undertaken improves services for the residents of Bromley. This sought feedback on each of the allocated Quality Monitoring Officers (QMO). Overall, the feedback was positive with very minor improvement matters noted.
3. There are up to date procedural and guidance documents which are current and were dated September 2023.
4. The Quality and Provider Relations Team have in place expected monitoring and tracking schedules for planning visits and recording when visits have been undertaken. There is a robust risk assessment process for each provider which takes into account various information including the outcome of CQC inspections and is used for planning monitoring visits.

5. There is a clear process for following up recommendations arising from monitoring visits and the outcome of the follow up of those actions is evidenced. The actions are included by the Quality Monitoring Officer in a table and progress also shown on a pie chart which shows the total number of actions, the number and % met / partially met / not met / in progress.
6. There is a programme of unannounced visits in addition to the full Quality Assurance Framework (QAF) monitoring visits to providers, and the dates of when these have been undertaken by the Quality Monitoring Officers are recorded with the CQC current scores as a Quality Assurance (QA) visit.
7. We shadowed a Quality Monitoring Officer on a monitoring visit to a provider. The assessment was undertaken thoroughly and conducted in a professional and collaborative manner with appropriate challenge and corroborating evidence reviewed.
8. For a sample of providers selected for testing we were provided with the detailed reports also showing the results of the follow up of the previous actions.

Our audit highlighted the following areas where controls and processes need to be improved:

1. **Timely completion of monitoring visits** (Priority 3). From a review of providers as recorded on the monitoring spreadsheets we found that for one provider a QAF had not been conducted for more than 24 months as the last QAF visit was carried out on 1st September 2019. ***See Recommendation 1.***

2. **Use of spreadsheets for tracking, planning and monitoring QAF visits** (Priority 3). The Quality and Provider Relations Team maintains several Excel spreadsheets for planning, risk assessing providers, recording monitoring visits, and recording the outcome of the QAF visits (including a recommendations tracker). There are opportunities to automate the process based on a cost vs benefit analysis or linking the spreadsheets for ease of updating in order to reduce the amount of time required to update each spreadsheet and also reduce the risk of errors including version control. ***See Recommendation 2.***

The Management Action Plan includes all findings raised in this report. **Please see Appendix A**.

*Definitions of our assurance opinions and priority ratings are in **Appendix B**.*

*The scope of our audit is set out in **Appendix C**.*

Appendix A - Management Action Plan

1. Timely completion of monitoring visits	
Finding The Quality and Provider Relations Team maintains a spreadsheet of providers which is used for tracking when each provider has had a monitoring visit using the Council's Quality Assurance Framework (QAF). The Council's processes for prioritising quality monitoring reviews as stated in the QAF monitoring guidance states that as a minimum for current providers one full QAF should be completed every 24 months. The QAF provider visits for all providers were noted to have been undertaken in line with the requirements of the guidance, except for one. For this provider a QAF had not been conducted for more than 24 months as the last QAF visit was carried out on 1st September 2019, with no subsequent QAF visit thereafter. We were informed by the Team Leader, Quality and Provider Relations Team that "*This provider is part of a Group of providers with 3 homes on the one site but the provider has registered them separately with CQC. The three homes have one main entrance, all adjoining, one kitchen, one laundry etc. and all use the same systems and one manager / administration staff across all 3 homes. Focus has been on one of the other homes as it was rated as Requires Improvement by CQC and the other two were rated as Good in April 2023. This home was not high on the Team's risk register, due to CQC rating, monitoring input to the other homes in the Group and with only a few concerns raise*d". At the time of concluding the audit the Team Leader, Quality and Provider Relations Team stated that the Quality Monitoring Officer was aware that the provider is due to have a QAF visit soon. Acknowledging the mitigations stated by the Team Leader, the provider should have had had at least 2 QAF visits since the last visit in September 2019 in compliance with the recommended timeframe for monitoring schedule within both the QAF Monitoring Guidance (September 2023) and the Guidance for Quality Monitoring (September 2023). **Risk** The officers may not be able to identify in a timely manner areas for improvement in relation to the quality of care provided for adult residential care placements.	
Recommendation A QAF visit for the outstanding provider be undertaken as soon as possible.	**Rating** Priority 3

Management Response and Accountable Manager	**Agreed timescale**
A visit has been booked for 31st May. Head of Service, Placements and Brokerage	May 2024

2. Use of spreadsheets for tracking, planning, and monitoring QAF visits

Finding

We noted that the Quality and Provider Relations Team maintains the following Excel spreadsheets:

- Provider Visits - Total and Type. This spreadsheet lists all the providers, and the number of QA Visits (including unannounced visits) Review Visits etc by month.
- Current CQC Scores: This spreadsheet contains details for each provider, previous and current CQC scores (overall rating and for each domain), dates for when QAF visits were undertaken etc.
- Contract monitoring risk and Planning - Care Homes. This spreadsheet is the visit planning tracker which is linked to each provider's risk assessment. This risk assessment determines the frequency of the visits and considers concerns raised and engagement and communication, CQC scores etc. to arrive at a risk score for each provider. The spreadsheet does not provide an alert system to show which provider is due for a visit and the process relies on the team regularly reviewing the spreadsheets as part of the visit planning process.

The spreadsheets are not interlinked but contain overlapping information which has to be regularly updated on each spreadsheet to ensure that it is accurate and reads across. Automating the process or linking the spreadsheets for ease of updating will reduce the amount of time required to update each spreadsheet and also reduces the risk of errors including version control.

Risk

Risk of errors and inaccuracies within the Excel spreadsheets maintained by the Quality and Provider Relations Team.

Recommendation	**Rating**
Opportunities to automate the process based on a cost vs benefit analysis or linking the spreadsheets for ease of updating be reviewed in order to reduce the amount of time required to update each spreadsheet and also reduce the risk of errors including version control.	Priority 3

Management Response and Accountable Manager	**Agreed timescale**
Will review the spreadsheets with the Quality and Provider Relations Team Leader & book a session with the Bromley Excel trainer to see if we can streamline further. Head of Service, Placements and Brokerage	6 months

Appendix B - Assurance and Priority Ratings

Assurance Levels

Assurance Level	Definition
Substantial Assurance	There is a sound system of control in place to achieve the service or system objectives. Risks are being managed effectively and any issues identified are minor in nature.
Reasonable Assurance	There is generally a sound system of control in place but there are weaknesses which put some of the service or system objectives at risk. Management attention is required.
Limited Assurance	There are significant control weaknesses which put the service or system objectives at risk. If unresolved these may result in error, abuse, loss or reputational damage and therefore require urgent management attention.
No Assurance	There are major weaknesses in the control environment. The service or system is exposed to the risk of significant error, abuse, loss or reputational damage. Immediate action must be taken by management to resolve the issues identified.

Action Priority Ratings

Risk rating	Definition
Priority 1	A high priority finding which indicates a fundamental weakness or failure in control which could lead to service or system objectives not being achieved. The Council is exposed to significant risk and management should address the recommendation urgently.
Priority 2	A medium priority finding which indicates a weakness in control that could lead to service or system objectives not being achieved. Timely management action is required to address the recommendation and mitigate the risk.
Priority 3	A low priority finding which has identified that the efficiency or effectiveness of the control environment could be improved. Management action is suggested to enhance existing controls.

Appendix C – Audit Scope

Audit Scope
We reviewed the adequacy and effectiveness of controls over the following risks: • The Council fails to ensure that providers provide good quality care for adult placements. • The Council is not able to identify in a timely manner those providers which provide inadequate/poor quality care for residential care placements. • There are inadequate and effective arrangements for quality assurance arrangements for contracts with providers and progress being made to raise standards in residential care placements. Our scope included the following: • Existence of adequate and approved policies and procedures which are complied with. • Compliance with the controls and processes as articulated in the Council's policies and procedures or quality assurance framework for monitoring provider contracts. • Assessment of the processes and controls in place for provider contract management / quality assurance to ensure that there is timely identification of inadequate/poor quality care for residential care placements. • Evidence of a process for following up corrective actions identified from the programme of quality visits to ensure that these are addressed by the providers in a timely manner. The review covered the financial year 2023/24 and assessed the evidence supporting the programme of quality visits undertaken by the Adult Services Team. Scope exclusions: The review does not provide assurance on the payments to providers, or safeguarding arrangements, and we did not undertake a quality review of a provider. We did not include within the scope the effectiveness of the controls in place over the placement of adults in residential care because as this was covered in the 2022/23 review of Adult Social Care Residential Placements.

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Redacted

REDACTED INTERNAL AUDIT REPORT

LEARNING DISABILITIES (Reviews and Budget Monitoring)

PEO/02/2023

15th May 2024

Auditor	Principal Auditor, Principal Auditor
Reviewer	Head of Audit and Assurance

Distribution list

Job title
Director of Adult Social Care
Assistant Director ASC, Operations
Head of Service, Learning Disabilities
Head of Finance, Adult Social Care, Health and Housing

Executive Summary

Audit Objective	This audit focused on the adequacy and effectiveness of review and budget monitoring processes, including high cost placements or services.

Assurance Level		**Findings by Priority Rating**		
		Priority 1	**Priority 2**	**Priority 3**
Reasonable Assurance	There is generally a sound system of control in place but there are weaknesses which put some of the service or system objectives at risk. Management attention is required.	-	3	2

Key Findings

This audit focused on the service user review and budget monitoring processes within the Learning Disability (LD) service. The service is currently facing some resource pressures caused by vacancies and long term sickness.

We identified areas of sound control and good practice including:

- The weekly distribution of overdue service reviews and the fortnightly Performance Review meetings gives senior management oversight and early alert of any issues with service reviews across the Department
- There are dedicated reviewing staff within LD which allows social workers to be task specific
- Budget monitoring information is produced and supplied to meet the budget setting and quarterly reporting timetable. Service area input to the process is evident.

We have identified the following areas for management attention:-

Procedures for LD Service Users (Priority 2) – There are no locally agreed procedures to support the LD review function. Our audit testing identified areas of social work practice, system input and Care Act compliance where further guidance would be beneficial. ***See Recommendation 1.***

Social Care case management system Review Tray and System Generated Reports (Priority 2) – The LD reviewing staff do not use the Social Care case management system LD Review Tray which has led to the data held being out of date, not reconciled to other Social Care case management system reports and limits our assurance that all LD clients are accounted for and are reviewed annually in line with the Care Act 2014. There is no active data

ownership, cleansing, utilisation and development of information available in Social Care case management system to support the LD review function. ***See Recommendation 2.***

Annual Reviews – Social Care case management system data input and record keeping (Priority 2) Audit testing on a sample of LD client reviews due in 2023/24 have identified some inconsistencies, anomalies and omissions with data input, dates and record keeping. ***See Recommendation 3***

We have made two additional Priority 3 recommendations for good practice.

As part of our review, we did also note that the projected outturn for the LD service changed from an anticipated £758K underspend presented in the Quarter 1 2023/24 budget monitoring report to a projected £155K overspend in the Quarter 3 budget monitoring report. At the time of the Quarter 1 report, there were vacancies and staff changes in key relevant posts. We are satisfied with the budget monitoring process as discussed with current officers and therefore have not made a further recommendation. Officers should however continue to monitor spend and projections closely to ensure that early remedial action can be taken if necessary.

Management has agreed actions for all findings raised in this report. **Please see Appendix A**.

Definitions of our assurance opinions and priority ratings are in ***Appendix B****.*

The scope of our audit is set out in ***Appendix C****.*

Appendix A – Management Action Plan

1. Procedures for LD Service User Reviews

Finding

The Adult Social Care (ASC) Practice guidance pages held on the ASC SharePoint site set out a guide to carrying out a review to comply with the Care Act 2014, specifically the duty to review, carrying out the review and revisions to a Support Plan. These comprehensive notes are available to all ASC officers to support the review process. The Standard Operating Procedures also set out the Council's approach to service reviews and contain links to template letters to issue the review to the Service User.

However there are no locally agreed, documented procedures specific to the LD review process. Our audit testing has identified areas that should be included in these procedures:

- Allocation of LD Reviews using the Social Care case management system (please see Recommendation 2)
- Clarification regarding the circumstances and the materiality of changes for which a Full Care Act Assessment should be completed rather than the review template (sample testing of 10 cases highlighted four where the officer had completed a FCAA rather than a review)
- Time targets to complete, authorise and follow up any actions arising
- Inclusion of all open tasks for that service user, specifically risk assessments to be updated or removed
- Upload supporting documentation to support the review for example pre review questionnaires
- Completion of all Social Care case management system fields to ensure compliance to the Care Act 2014 (please see Recommendation 3)

At the start of the audit the LD Management Team referenced procedures that had been drafted but not formalised. This document was not available for review.

Risk

Without procedures, there is an increased risk of non-compliance to the Care Act and of reviews not completed to an acceptable standard. This may in turn mean that clients do achieve desired outcomes. There is also a risk of inaccurate data on the social care case management system.

Recommendation	**Rating**
Develop locally agreed procedures to support the review function. These procedures should allow any officer assigned with a LD service review to complete the task end to end. (Please note that the list of areas set out above is indicative of issues identified in our testing, the team will need to identify key areas, themes and structure. Development of procedures will allow the LD Team to analyse their review process and identify areas that work well, need revision and gaps in workflow.)	**Priority 2**
Management Response and Accountable Manager 1. Review of the operational procedures to be carried out 2. Identify areas where an LD specific procedure is required, and develop such. 3. Write a local process for the LD team specifically and implement, where there are local targets and processes for allocation etc. Accountable Manager - Head of Service, Learning Disabilities	**Agreed timescale** 1. End June 2024 2. End June 2024 3. 14 June 2024

2. Social Care case management system Review Tray and System Generated Reports

Finding

LD officers utilise a standalone excel spreadsheet to track and allocate review cases, outside the social care case management system. This raises issues with duplication of effort together with risks of document corruption and loss of data. Although the officer completes a monthly reconciliation between the Social Care case management system Review Tray and the spreadsheet, this does not include an overall reconciliation to account for all clients or ensure that clients are successfully moved between monthly tabulations. For our sample testing of 10 clients, 4 had not been carried forward to the 2024 monthly tab and for 3 clients we were unable to find the case on the 2023 or 2024 tabs. The Social Care case management system is used to generate performance, monitoring and management reports to support service decisions and therefore any activity or data outside of the care management system may not be included.

The Social Care case management system LD Review Tray has some 1250 client records, compared to 770 current clients declared by the service in December 2023. The difference in numbers is due to the way that the Social Care case management system records "tasks". This means that there may be more than one task assigned against a single service user's name. Our own analysis identified 102 pre 2023 records, 702 "no due date" records, 51 risk assessments (reviews) and 626 tasks classified as "case". This indicates that the Review Tray is not managed and that there are some data quality issues.

The LD Overdue Reviews report generated from the Social Care case management system 12.12.23 contained 65 records with an overdue review of between 367 to 3,925 days. 14 records did not have a "latest review" date and narrative suggested these were 0-25 cases but had been included as LD data. The numbers of overdue reviews from this dataset was higher than the numbers on the dataset used by the service to scrutinise performance. The Performance Team Manager advised that this was due to the two datasets drawing information from different parts of the system and that going forwards, this would be rectified.

The "Reviews finalised in 2023/24" cumulative by month, shows a total of 961 LD reviews up to the end of February 2024. A difference here could be explained by Reviews started in 2022/23 completed in 2023/24 but there is a difference of some 200 clients.

During the audit our use of Social Care case management system generated reports has highlighted that the data is neither owned or scrutinised to remove anomalies and improve data quality.

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Risk

Service decisions are based on inaccurate and incomplete information. Key case management activities for individual clients are overlooked which may mean that provision no longer meets needs or that outcomes are not achieved.

Recommendation The Social Care case management system should deliver all data required and in a format to support the service. The service should: • Work with the Practice Development and System Team to identify and rectify the root cause that requires a stand alone spreadsheet to track and monitor review clients. • Offer training and support to LD officers to allow the team to own, use and have confidence in the data held in the Social Care case management system • Complete data cleansing of the Review Tray to remove obsolete records, review and update risk assessments and ensure reviewing officers are following Social Care case management system procedures so that duplicate tasks are not created. • Consider the need to data share risk assessments and contribute to the wider risk arrangements across the Council. • Assign ownership for data quality and data cleansing • Ensure that each system report used for performance monitoring and management is drawing complete and consistent information, in accordance with the purpose for which it is required	**Rating** Priority 2
Management Response and Accountable Manager 1. Data cleansing of Social Care case management system 2. Work with performance team to ensure data synergy when moving away from the current system of working 3. Develop a data quality assurance process Accountable Manager - Head of Service, Learning Disabilities	**Agreed timescale** 1. Sept 2024 2. Sept 2024 3. 14 June 2024

3. Annual Reviews – Social Care case management system data input and record keeping

Finding

Sample testing of ten client review records highlighted that:

- For 2 cases with multiple support plans and reviews we were unable to have assurance that the 12 months' review timeframe was achieved
- 1 case receiving a Direct Payment had not been reviewed since 2022, it was unclear how this had been overlooked.
- In 3 cases the completed review date did not agree to the Social Care case management system generated start date. We referred these to the Practice Development and System Lead to follow up and resolve

We checked the information available on the Social Care case management system to verify that the Review template had been completed in full, the review had been issued to the service user and/or family and that the review had been authorised and in a reasonable time frame. We found the following issues:

- For 6 cases there was no evidence that the review was issued to the service user or their representative. The LD Review Team Leader did raise a data protection concern if officers send the Review or FCAA to the Next of Kin
- For 2 cases it was not clear who had attended the review as involvement had not recorded on the review template or in the Full Care Act Assessment
- For 1 case a telephone review had been completed rather than a face to face review
- 1 Practice Review Group decision for an increase to service was not evidenced in case notes
- For 1 case the review start and end date exceeded 3 months

Our testing worksheet has been shared with the Head of Service to allow the team to review the sample cases.

Risk

Inconsistent working practices that may not fully comply to the Care Act 2014. Incomplete or inaccurate information may result in poorer outcomes for the client.

Recommendation	**Rating**
The LD Team should: • liaise with the Practice Development and System Team to investigate if the anomalies identified in our testing are system related or data input errors. • review the procedure issues raised by our audit testing and issue a reminder to all review officers of any social work practice or data input that requires remedy. • liaise with the Head of Security and Information Management to clarify the data protection position and protocols to follow with regard to the issue of Reviews to the next of kin.	**Priority 2**
Management Response and Accountable Manager 1. Review the operational process for quality checking of reviews 2. Work with the ASC Quality Assurance team to review progress 3. Work with staff to improve overall quality Accountable Manager - Head of Service, Learning Disabilities	**Agreed timescale** 1. 14 June 2024 2. Ongoing 3. 14 June 2024

4. Fraud Awareness	
Finding Review officers should have an awareness of overstatement of need by the service user and/or family and be mindful of any indication of care provider fraud whilst undertaking an assessment/review. Fraud Awareness training was delivered by the Fraud Service Provider in June 2023. This was mandatory training for all frontline ASC officers. We checked the training attendance records with HR colleagues and identified that of the 12 officers shown in the LD organisation chart, 7 had attended the training last year. Unfortunately the course was not recorded but the slides are still available from HR Learning and Development. **Risk** Over statement of need, misrepresentation, false declaration and misappropriation of Council funds is undetected. Review officers are not adequately equipped to complete a review mindful of any fraudulent activity.	
Recommendation All LD officers with a frontline, assessment or reviewing role should complete the fraud awareness training when next available. In the interim, all LD officers with a frontline, assessment or reviewing role should access the course slides. LD team members who did attend the course could enable induction to fraud awareness, cascade key themes and/or address in team meetings/supervision.	**Rating** **Priority 3**
Management Response and Accountable Manager 1. All staff to attend next available fraud training Accountable Manager - Head of Service, Learning Disabilities	**Agreed timescale** Next available session

5. New Budget Holder Training	
Finding The Budget Holder for the Learning Disabilities Care Management Service took up post in August 2023. We found that they had not received any formal Budget Monitoring Training or been invited to attend Budget Holders' financial awareness/planning and forecasting system training courses. **Risk** Budget Holders may not be maximising efficiency and effectiveness in the role. Duties may not be performed in a standardised manner.	
Recommendation The Budget Holder for the Learning Disabilities Care Management Service should attend the next available Budget Holders' financial awareness/planning and forecasting system training courses.	**Rating** Priority 3
Management Response and Accountable Manager 1. Budget holder to attend next training session Accountable Manager - Head of Service, Learning Disabilities	**Agreed timescale** Next available session

Appendix B - Assurance and Priority Ratings

Assurance Levels

Assurance Level	Definition
Substantial Assurance	There is a sound system of control in place to achieve the service or system objectives. Risks are being managed effectively and any issues identified are minor in nature.
Reasonable Assurance	There is generally a sound system of control in place but there are weaknesses which put some of the service or system objectives at risk. Management attention is required.
Limited Assurance	There are significant control weaknesses which put the service or system objectives at risk. If unresolved these may result in error, abuse, loss or reputational damage and therefore require urgent management attention.
No Assurance	There are major weaknesses in the control environment. The service or system is exposed to the risk of significant error, abuse, loss or reputational damage. Immediate action must be taken by management to resolve the issues identified.

Action Priority Ratings

Risk rating	Definition
Priority 1	A high priority finding which indicates a fundamental weakness or failure in control which could lead to service or system objectives not being achieved. The Council is exposed to significant risk and management should address the recommendation urgently.
Priority 2	A medium priority finding which indicates a weakness in control that could lead to service or system objectives not being achieved. Timely management action is required to address the recommendation and mitigate the risk.
Priority 3	A low priority finding which has identified that the efficiency or effectiveness of the control environment could be improved. Management action is suggested to enhance existing controls.

Appendix C – Audit Scope

Audit Scope
We reviewed the adequacy and effectiveness of controls over the following risks: • The Learning Disabilities review process does not fully meet the requirements set out in the Care Act 2014 • Inadequate review information is available to submit complete and accurate statutory returns • Decision making following review resulting in poorer outcomes for the client • Overspent budget requiring further efficiencies in order to balance the budget Our scope included:- • Procedures for the Learning Disabilities review process including time targets for annual reviews, interim reviews for new service users, authorisation and compliance with Care Act 2014. • Compliance to the agreed Standard Operating Procedures, Social Care case management system training guides and locally agreed procedures. • Review of the information uploaded to Social Care case management system, mandatory fields, templates accuracy and completeness of information. • Liaison and communication with care providers, LBB colleagues, Financial assessment contractor, the service user and family during the review process. • Review of the information available from Social Care case management system, ad hoc information and regular reporting, to support the review process, identify overdue reviews and measure performance. • Learning Disability expenditure across all service heads; support at home, access to community schemes/support, shared lives, supported living, residential/nursing placements and direct payments. • Review the budget monitoring for the Learning Disability service and any ad hoc financial reports that are available to the team to identify high costs services. • Review the controls in place to manage social care fraud risks, specifically overstatement of need.

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