REDACTED

INTERNAL AUDIT FINAL REPORT

PEOPLE

REFERRAL AND ASSESSMENT ASC

Issued to:
Assistant Director of Adult Services
Director of Adult Services
Principal OT and Service Lead
Operations Manager, Short Term Intervention
Operations Manager, Assessment and Care Management
Head of Service (LD)
Head of Mental Health
Head of Strategy and Performance ACS
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Prepared by: Principal Auditor
Reviewed by: Head of Audit and Assurance

Date of Issue: 25 May 2023

Report No.: PEO/03/2022

REFERRALS AND ASSESSMENT

INTRODUCTION

1. This report sets out the results of our audit of Adult Social Care Referral and Assessment. The audit was carried out as part of the work specified in the 2022/23 Internal Audit Plan agreed by Audit and Risk Management Committee. The controls we expect to see in place are designed to minimise the Council's exposure to a range of risks. Weaknesses in controls that have been highlighted will increase the associated risks and should therefore be addressed by management.

2. Referral and Assessment for Adult Social Care delivers Ambition 2 of our Making Bromley Even Better strategy, "*For adults and older people to enjoy fulfilled and successful lives in Bromley, ageing well, retaining independence and making choices".*

3. Under the Care Act 2014 and associated regulations the Council is required to provide information and advice (Sect 4), complete an assessment of an adults needs for care and support (Sect.9) and apply the eligibility criteria (Sect.13). We considered compliance to the Act with our review of the Initial Contact Team, referral to the locality and Learning Disability Teams and completion of the Full Care Act Assessment.

4. This audit has been included in the 2022/23 plan to review an element of Adult Social Care following the Strengths and Outcomes Based Practice launched in July 2021 and the migration from a care management system to a new case management system in November 2021. The audit review will also support the Department in their preparation for an external inspection due from 2023.

5. We would like to thank everyone contacted during this review for their help and co-operation.

AUDIT SCOPE

6. The original scope of the audit was outlined in the Terms of Reference issued on 10 October 2022.

7. We identified the following key risks:

- All referrals submitted are not captured, processed and passed to the appropriate team for action
- The care assessment does not meet the requirements set out in the Care Act 2014
- Delays in processing referrals and completing the assessment.
- ASC partners and providers charged with referral and assessment responsibilities do not meet the standards demanded.

REFERRALS AND ASSESSMENT

8. Our scope included:

- Review of Initial Contact Team (ICT) including the availability and quality of procedures; a walk through test with the Senior Initial Contact Officer (ICW) and sample testing for contacts received since April 2022.
- Review of the information available on the case management system (LAS) including the generation and distribution of reports specific to contacts, referrals and assessments
- Review of the Full Care Act Assessments (FCAA) undertaken by the five locality teams and the Learning Disabilities team to ensure accuracy, timeliness and compliance.

9. During fieldwork, we reduced the audit scope to exclude the hospital team and Mental Health. The processes and procedures used by the hospital team will be evaluated as part of the Discharge to Assess audit review, planned for March 2023. Mental Health assessments are completed by our Mental Health provider's care managers and held on their system. The Assistant Director ASC (Operations) (AD ASC Op) confirmed that the Council are looking at options to access client information held on this system or for client information to be uploaded directly to LAS.

10. We acknowledge that there has been a change in terminology between care management systems, referrals and assessment. For clarity we have reviewed and tested the initial contacts processed by the ICT and then once accepted by the service team and referred to an allocated case worker, the completion of the FCAA.

AUDIT OPINION

11. Our overall audit opinion, number and rating of recommendations are as follows.

AUDIT OPINION	
Reasonable	**(Definitions of the audit assurance level and recommendation ratings can be found in Appendix B)**

Number of recommendations by risk rating		
Priority 1	Priority 2	Priority 3
0	**7**	**0**

REFERRALS AND ASSESSMENT

SUMMARY OF FINDINGS

12. The audit has identified areas of good practice and sound controls as set out below:-

- There is a designated performance team to generate LAS reports for contacts, referrals and assessments. There is also a designated Practice Development and Systems Lead to link the LAS helpdesk/performance team and the practitioners/users
- Comprehensive weekly reports are distributed to managers to allow monitoring, oversight and planning. There is an ongoing dialogue with ASC colleagues to develop the reports available to the service to support effective delivery.
- Tracking of all data between reports to allow reconciliation of contacts, referrals and assessments to ensure all cases are accounted for.
- There are formalised working groups to receive, discuss and monitor the weekly performance reports and cascade information and actions back to the users. Membership of these groups is at an appropriate level and involves key officers, system (IT contractor's helpdesk and Project Officers) and practitioners.
- Comprehensive ACS Operating Procedure and Guidance were finalised in January 2023 and online practice guidance is available to all staff supported by a programme of LAS training and access to a help desk.

13. We acknowledge that ASC has experienced a period of significant change; a restructure of service teams as part of the Transformation programme, a relaunch of Social Worker practice in July 2021, migration to a new care management system in November 2021 and the challenges for a front line service during the COVID pandemic. We therefore took our testing sample from April 2022 to December 2022 to allow adequate time for new processes and procedures to be embedded.

14. Audit review, interview and testing has identified the following areas for ICW that require management attention:-

- Local procedure notes specific to the ICT were not available. The LAS procedures for ICW show that officers receive, create, triage and close a contact as "NFA", "Information Given" or "Signposted". This is not happening as in practice, ICWs refer to the service teams to complete and close.
- The ICWs close a contact with NFA if it becomes obvious during the initial contact that the service user does not require or qualify for Bromley services. Any advice or signposting that is imparted before a contact is opened is not captured as ICT activity or measured for performance.
- Forty eight hours is the accepted turnround time from initial contact to referral but this is not stipulated in the ACS Operating Procedures. There is no formal monitoring of contact processing time although LAS could be used to identify this information. There

is no escalation process if time thresholds are reached. There is no sample checking or quality assurance checks completed for the ICT's performance and output.

- The eligibility of any service user should start with their address confirming them to be an LBB resident. ICWs are prompted to check on Gov.UK address checker but LAS does not hold a LBB gazetteer of Bromley only addresses. The project Team have confirmed that there are plans to link to the Council's mapping system will improve this control.
- We asked the performance team to run a report on the LAS data held since April 2022 to identify temporary client information; estimated date of birth and unknown addresses shown as post code UK 99. As at 30.11.22, 5,437 records had the address as UK 99 and 8,066 records do not have the actual date of birth.

15. Audit review, interview and testing has identified the following areas for FCAA that require management attention:-

- There was no evidence that the FCAA had been sent to the service user for 16 out of our 20 FCAAs sampled. For two of these cases, the case notes on LAS show an "intention" to send but no evidence that this was completed.
- The date section on the FCAA template is confusing, there are system generated dates, requested and required and actual dates input by the user. This information is then pulled through to the digest reports. For the sample of 20, the reason for any delay over 28 days had not been consistently recorded by the user or prompted by the system.
- There is no specific target for the senior to sign off the FCAA or budget holder to authorise the funding. Authorisation and approval dates are not captured on the weekly digest report for assessments, timely authorisation is a control that should be monitored.
- The sample testing of 20 FCAA identified issues regarding entry of basic demographic information, incomplete and unsatisfactory entries identified by the Operations Manager at budget approval stage, chronology of approval, interpretation and representation of answers to ambiguous questions for direct payments and financial assessments.
- For 3 locality teams and Learning Disabilities a "pending" spreadsheet/document is maintained outside the system to record risk assessed FCAAs that need to be allocated.

DETAILED FINDINGS / MANAGEMENT ACTION PLAN

16. The findings of this report, together with an assessment of the risk associated with any control weaknesses identified, are detailed in Appendix A. Any recommendations to management are raised and prioritised, together with management's responses and time scales for implementation. Appendix B details the definition of the audit assurance and priority ratings.

REVIEW OF REFERRALS AND ASSESSMENT

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

1. Initial Contact Team (ICT) – Procedures

Finding

The ACS Operating Procedures and Guidance (ACS OP&G) finalised in January 2023 is a comprehensive document setting out how ASC operates in practice. The Initial Contact Team (ICT) procedures are set out in section 4. The LAS training guides are held on the IT Training SharePoint site and there are designated notes and workflow diagrams for ICT. We used both documents to measure against a "walk through" test with staff and further sample testing. The main issue arising were:-

- There were no locally agreed procedures held by the ICT to specify team tasks, target times or a "script" for ICW to follow
- The LAS process map for ICT sets out that ICW receive, triage, create and close a contact with an outcome of either No Further Action (NFA), signposting or advice given. In practice the ICT are only closing a contact if the outcome is NFA, advice and signposting is not being captured on LAS. This LAS process map does not agree to the ASC OP&G.
- There is a lack of clarity around the completion of the "Conversation" section of the contact form as ICWs are not completing the strength based conversations but leaving this to the duty teams.
- The ACS OP&G does not set out a target turnround time for ICT but does refer to "*all contacts must be worked on and finalised within **48 hours** of receipt"* in section 5, Community Locality Teams. It is not clear how the time is shared between the two teams, measured or recorded.
- For each month since April 2022, the number of contacts exceeds the number of people indicating possible duplication of contacts. The walk through test with ICT evidenced that our sample case was referred to the locality team duty and a new contact created.
- ACS OP &G state, "***most contacts***" come into ICT, LAS procedures state, "***All staff***, *not just ICT will create contacts*" The LAS Contacts report for September 2022 showed that 65% were received by the ICT team.

Risk

Inefficient use of resources and duplication of effort.

REVIEW OF REFERRALS AND ASSESSMENT

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

Recommendation	**Rating**
Local procedures should be developed to support the operational duties of the ICT. These procedures should agree to the LAS guidance notes and the ACS O P and &G to reflect actual service delivery. Clarify the role of the ICT to complete the LAS contact template specifically the conversation field. Clarify the need to create a new contact form when referred to the locality teams to avoid duplication.	**Priority 2**
Management Response and Accountable Manager	**Agreed timescale**
• Local Procedures to be developed setting out the operational duties of the Initial Contact Workers (ICW's) and clarifying their role alongside the role and functions of the Initial Contact Centre (ICC). Pathways to also be reviewed and updated. These are to include timescales for closing a contract. The responsible manager will be ensuring that these align with the Departmental Operational procedures and the LAS guidance. **Accountable Managers:** Initial Response Manager/Principal Occupational Therapist and Service Lead	31st August 2023
• Following feedback about the Contact form on LAS as part of this audit. The form has been reviewed with the ICW's input. The previous contact form in LAS was supposed to be the Initial Contact Workers 'Script' as it leads the workers through the questions that need to be asked when taking a phone call. However, this audit has highlighted that the ICW's were defaulting to note taking during phone calls rather than using the contact form in LAS as it was intended to be used. As a result of the review, we now have a shorter contact form that contacts the basic information required for the ICW's to pass to the Duty teams and also to enable Duty teams to risk assess and allocate work. The New Contact form in LAS went live May 2023. **Accountable Managers:** Practice Development and System Lead /HoS/AD Adult Services	12th May 2023
• Reminders were discussed with the Team Leads in JOT and in team meetings about the process around conversation and the duplication of Contact forms.	April 2023

2. ICT - Capturing activity and performance

Finding

We established from our interviews and the walk through test that ICW only complete the contact form if the outcome is NFA. Advice or signposting to other agencies issued to contacts **before** a LAS contact is created is not recorded and not reflected in ICT performance.

Similarly our sample testing for 10 ICT contacts with a NFA outcome, evidenced that 3/10 contacts were signposted to another agency and 3/10 were referred to Occupational Therapy or Assistive Technology (another process outside of LAS contacts and referrals).

There are no second checks or spot checks on completed contact forms to confirm performance, appropriateness of closure or compliance to agreed procedures.

The ICT Manager has used a turn round target of 24hours for staff appraisals but this has not been set down in locally agreed ICT procedures. There is no escalation process within the team for contacts open to ICW beyond an agreed threshold. There is no specific LAS reporting available to measure performance and to support the ICT manager.

Risk

All ICT service activity is not captured or measured to allow the team to assess and improve performance where required.
Delay in processing the contact and assessment

Recommendation	**Rating**
Consider a process to capture advice and signposting delivered by the ICT before a LAS contact is created. Remind all ICW that a referral to another agency is not a NFA outcome. Formalise a target turnround time for ICW and a LAS based report for ICT management to monitor and support an escalation process. Consider spot checks on ICW contacts for management to monitor quality, consistency and compliance to agreed procedures.	Prioritv 2

REVIEW OF REFERRALS AND ASSESSMENT

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

Management Response and Accountable Manager	**Agreed timescale**
• The new Contact form in LAS should enable the workers to capture advice and signposting as an outcome of a contact. **Accountable Manager:** Practice Development and System Lead /Initial Response Manager	August 2023
• Team Manager to advise ICW's that referral to another agency is not an NFA outcome. **Accountable Manager**: Initial Response Manager/ Principal Occupational Therapist and Service Lead	August 2023
• Team Manager will be developing policy and procedures and pathways for the end-to-end pathways in the Initial Contact Centre. **Accountable Manager:** Initial Response Manager/Principal Occupational Therapist and Service Lead	August 2023
• Team Manager with the support of the Head of Service and the quality assurance team will develop a quality assurance framework for the ICW's once the procedures are completed. **Accountable Manager:** Initial Response Manager/Principal Occupational Therapist and Service Lead/Quality Assurance Manager	September 2023

3. ICT – Address Checker, Basic Demographic Information and GDPR
Finding A primary requirement for ASC is that the service user resides in the Borough and as such a check on their address should be at the initial contact stage. The ICW is prompted to by a link to Gov.UK address checker but there is no system control. The gazetteer loaded onto LAS is not restricted to Bromley addresses, an example being BR1 which also includes Lewisham but will show as Bromley on LAS. We discussed the address issue with our IT contractor and suggest that a link to the Council's mapping system could be considered. If the address is unknown at the point of contact UK 99 is entered as the post code as a temporary measure. We asked the ACS performance team to run a LAS report to show all UK 99 addresses. As at 1/12/22 there were 5,437 records without a permanent address. We asked for similar exception reports to be run for Date of Birth that was **not** Actual and records that did not have a "Yes" in the consent field. As at 1/12/22 8,066 records did not have the actual DoB and 9,305 records showed either "no" or "not known" for the question relating to consent. These reports have been left with the service for filtering, review and investigation to cleanse this data and identify any current cases, receiving service on temporary or incomplete information. One of our samples tested related to a deceased client (2020) but the contact was created for a FOI received from a family member. The request for information should not have been linked to our service user's record. **Risk** Incomplete or inaccurate information is held for service users. Management decisions are based on incomplete or inaccurate data. Information Governance protocols are not met and service user information is inappropriately shared.

REVIEW OF REFERRALS AND ASSESSMENT

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

Recommendation	**Rating**
The three exception reports, UK 99 postcode, estimate DoB and affirmed consent should be added to the management suite of reports. Further filtering of these exception reports will improve data quality and identify any current service users with temporary demographic information. All LAS users to be reminded that any estimates and non-factual data must be updated at the earliest opportunity. Remind staff of their responsibility to comply to data handling protocols and information governance guidelines specifically when attaching documents to a client record.	Priority 2
Management Response and Accountable Manager	**Agreed timescale**
• Team Manager to liaise with Performance team. **Accountable Manager:** Initial Response Manager	August 2023
• HOSOM & JOT Team Meeting April 2023, **Accountable Manager:** Team Lead's & Heads of Service for all areas.	April 2023
• Operational Managers and Staff have been reminded about their duties around GDPR. We are also updating the departmental recording policy. **Accountable Manager:** Operations Manager, Short Term Intervention/Operations Manager, Assessment & Care Management and ASC Policy and Resource Development Officer	June 2023

4. Full Care Act Assessment (FCAA) - – Issue of Completed Assessments to the S/U

Finding

We selected a sample of 20 Full Care Act Assessments (FCAA) that had been completed between April 2022 and January 2023. Our sample was distributed across ASC, proportional to assessments completed by the 5 locality teams and Learning Disabilities.

The Care Act 2014 Section 12 states that *" The local authority must give a written record of a needs assessment to a) the adult whom the assessment relates".* The ACS OP&G section 5.1.2 states that "*once completed the practitioner/assessor should provide the adult and carer a copy of the assessment, either send via a secured e-mail or by mail/post. A case note should be made to evidence this.* The Operations Manager (Short Term Interventions) confirmed that the assessment should be evidenced in LAS Case Notes or Case Files – Documents.

For our sample of 20 FCAA:-

- 14/20 cases did not have supporting evidence in either Case Notes or Case Files on LAS that the FCAA was sent to the client
- 2/20 cases evidenced an "intention" to send the assessment but confirmation that it was sent was not seen
- 1/20 case related to a LB Sutton client and a FCAA should not have been completed by Bromley
- 2/20 the client died soon after FCAA completion and it is accepted that it may not have been appropriate to issue
- 1/20 the FCAA was cancelled at the initial assessment stage as the family withdrew.
- 2/20 cases had 4 and 2 FCAA's on LAS for the sample period

Risk

The care assessment does not meet the requirements of the Care Act 2014
The assessment does not accurately reflect the needs as the service user does not have the opportunity to review and challenge.

REVIEW OF REFERRALS AND ASSESSMENT

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

Recommendation	**Rating**
Remind all ASC assessors that the completed FCAA needs to be issued to either the service user, their carer or nominated adult. Consider adding a prompt to the Outcome section of the FCAA template to ensure this Care Act requirement is delivered. Alert LAS trainers to emphasise this requirement and agreed LAS location in future training sessions for assessments.	Priority 2
Management Response and Accountable Manager	**Agreed timescale**
• All staff have been reminded of the need to send a copy to the Care Act Assessment and Support Plan out to clients via HoSOM, JOT and Team Meetings. This is being routinely checked at the Practice Review Meetings by Heads of Service for their responsible areas. **Accountable Managers:** Head of ALD Service, Head of Mental Health, Operations Manager, Short Term Intervention/Operations Manager, Assessment & Care Management • A review of the modules within LAS is underway this year. We will add a prompt within the review and the assessment modules. **Accountable Managers**: Practice Development and System Lead, HoSOM, AD of Adult Services	April 2023 July 2023

5. FCAA – Dates and Authorisation

Finding

The date section of the FCAA template is confusing as there are system generated dates, requested and required and actual dates input by the user. These dates are then pulled through to the digest reports.

We acknowledge the assessment digest report to be a good control informing managers of elapsed time to monitor the 28 day target but we could not establish the source of this data to confirm which start and end date are used to populate the report.

The "completed" date in the FCAA template (date section) should represent the date that the allocated caseworker met with the service user and undertook the assessment. "Completed" also needs to represent the time span between the *initial contact* and *the assessment and any resulting service provision* (ACS OP&G section 3.3). Our interviews, observations and testing highlighted a lack of clarity around terminology, particularly "completion". The LAS "wiki" pages, accessed by the Practice Development and System Lead identified a number of "date" fields which, when populated, interlink with templates and reports.

Without clear definition and understanding of the "completion date", confirmation of the source data on the assessment digest monitoring of the 28 day target is limited.

For the sample period April 2022 to January 2023, 1,443 FCAA were completed, we randomly selected a sample of 20 service users, proportional to the assessments to each of the Locality and Learning Disabilities Teams. The two issues relating to dates are-

- The "date required" is system generated 28 days after the "date requested". There should be a drop down option to enter a reason for a completed date exceeding the target however this was not consistently applied. 10/20 had been completed in time but for 7/20 no reason had been prompted or entered for 1/20 the required date had been changed.
- There is no formal target for approval/sign off to end the FCAA. The date of the approval and authorisation is not captured and reported on the weekly assessment digest. 2/20 cases exceeded the 28 day target. For 1/20 the budget was approved before the senior had signed off the assessment.

REVIEW OF REFERRALS AND ASSESSMENT

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

Risk Completion of the FCAA does not meet the nationally and locally agreed target of 28 days for services to be arranged to meet service users assessed needs.	
Recommendation Include approver and authorising dates on the assessment report to identify "log jams" or pressure points in the assessment workflow. Consider a target for approval post assessor completion to ensure timely workflow for assessments. Clarify the source of dates in LAS to confirm the elapsed time as this is currently used to monitor against the 28 day target. Similarly confirm that there are LAS process maps, developed by the project implementation team, to track data input through the system.	**Rating** Priority 2
Management Response and Accountable Manager To be picked up at the LAS Operational group and project Lead for action. **Accountable Manager:** AD of Adult Services/ Practice Development and System Lead,	**Agreed timescale** June 2023

6. FCAA – Checks and Ambiguous Questions

Finding

- Our sample testing of 20 completed FCAAs highlighted that: 1/20 cases related to a FCAA completed on the 22/4/22 was for a LB Sutton client; this was not identified until the senior reviewed the assessment in June 2022.
- 2/20 cases were for clients now deceased so their address shows the Civic Centre, the historic address was not available and therefore not checked
- 1/20 case gave contradictory answers to closed questions in the communication section. This was also the case with Direct Payments questions before the template was changed in July 2022 and Financial Assessments.
- 1/20 case was cancelled at the initial assessment stage but was showing as a completed FCAA

Although the use of closed questions simplifies the assessment this does then rely on the assessor's correct interpretation. Text boxes have been used to give extended answers or explain "other" to drop down options but this relies on a specialist report to decode the data.

Risk

The care assessment does not meet the requirements set out in the Care Act 2014
The completed care assessment does not accurately or fully reflect the work that has been undertaken by the assessor.

Recommendation	**Rating**
Continue the work in progress by the ASC Performance Team and LAS Project officer to develop LAS to simplify the FCAA template and to deliver accurate complete and useful data including location and all attendees for the FCAA Liaise with the LAS trainer to ensure all changes to the assessment template are included in future training events and that the LAS training guides reflect current practices and requirements.	Priority 2

REVIEW OF REFERRALS AND ASSESSMENT

DETAILED FINDINGS AND ACTION PLAN

APPENDIX A

Management Response and Accountable Manager	**Agreed timescale**
• A review of LAS is underway. The contact form and Review form is complete. We will move onto the Assessment form next. The intention is to review all modules in LAS this financial year. All changes to the system are tested by staff and are picked up at the LAS Operational issues group attended by the internal trainer. (Organisational Development Officer) **Accountable Manager:** Practice Development and System Lead/Organisational Development Officer/AD Adult Services	July 2023

7. Allocations Pending and Reconciliation

Finding

The walk-through test for the assessment process was completed with a Locality Team Leader. The referrals to Duty are triaged, risk assessed and added to an excel spreadsheet as "pending". This document is then used at the weekly allocations meeting to match pending cases to resources. A check with the other Teams confirmed that three of the Locality Teams and the Learning Disabilities are using a spreadsheet or word document to record pending allocations. There were several reasons cited by Team Leaders for needing this record; that it gave a summary overview without having to go into the individual client record; it was easier to handle a high number of pending cases and as back up if LAS was not available.

Records maintained outside of the care management system must be regularly reconciled to LAS to ensure we are accounting for all cases. As at 13.2.23 Learning Disabilities had 19 cases (allocated and to be allocated) on their spreadsheet but the LAS showed 33. The maintenance of these records does represent duplication of effort and handling data on spreadsheets risks error and compromise.

Although the weekly digest reports track contacts, referrals and then assessments by source and destination as totals across the report tabulations, LAS cannot track an individual contact through the workflow to delivery of service. This functionality was anticipated when LAS was implemented but is not yet available. The ACS Performance Team Manager is currently working with the system provider and liaising with other Local Authorities to develop this client tracking. This would allow the service to identify "log jams" and pressure points.

Risk

Management decisions are based on LAS data not actual service activity.
All referrals submitted are not captured, processed and passed to the appropriate team for action.
Delays in processing referrals and completing the assessment.

Recommendation	**Rating**
If LAS does not currently meet the needs of the client teams to monitor assessments pending, development work should be requested to extract data and present in an acceptable format.	Priority 2

In the interim, all teams using a separate document to record pending allocations should be regularly reconciling to LAS. Any variance to be investigated and resolved to ensure all service users referred to assessment are accounted for and secondly to ensure LAS is current, complete and accurate. Continue the work of the ASC Performance Team to develop LAS to track a client from contact, referral, assessment and service.	
Management Response and Accountable Manager • All Team Leads have been asked to stop using spreadsheets to record incoming work to the team. The system is sufficient for Team Leads to manage the workflow and allocations. **Accountable Manager**: Head of ALD Service, Operations Manager Assessment & Care Management, Operations Manage Short Term Intervention.	**Agreed timescale** April 2023

OPINION DEFINITIONS

APPENDIX B

Assurance Level

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.

Recommendation 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.