NORTH YORKSHIRE COUNTY COUNCIL

AUDIT COMMITTEE

27 SEPTEMBER 2012

INTERNAL AUDIT WORK AND RELATED INTERNAL CONTROL MATTERS FOR THE HEALTH AND ADULT SERVICES DIRECTORATE

Joint Report of the Head of Internal Audit, Veritau Ltd and the Corporate Director – Health and Adult Services

1.0 PURPOSE OF THE REPORT

1.1 To inform Members of the **internal audit work** performed during the year ended 31 August 2012 for the Health and Adult Services (HAS) Directorate and to give an opinion on the systems of internal control in respect of this area.

1.2 To consider the **Statement of Assurance** for 2011/12 signed by the Corporate Director – HAS.

1.3 To consider the **Risk Register** for the Directorate.

2.0 BACKGROUND

2.1 The Audit Committee is required to assess the quality and effectiveness of the corporate governance arrangements operating within the County Council. In relation to the HAS Directorate the Committee receives assurance through the work of the Internal Audit Service, as provided by Veritau Ltd, details of the annual Statement of Assurance provided by the Corporate Director, the Directorate Risk Register and the progress made to date by management to address the areas for improvement and the identified risks.

2.2 Accordingly there are three Appendices to this report:

Appendix 1

A summary of the **internal audit reports** issued in the year since the last full report, on the HAS Directorate (previously the Adult and Community Services Directorate), to the Audit Committee in September 2012. Specific attention is drawn to any Priority 1 recommendations that management have chosen not to implement.

Appendix 2

The relevant extract from the Statement of Assurance provided at the 2011/12 year end by the Corporate Director detailing the issues identified and the proposed actions to be undertaken during 2012/13.

Appendix 3

A copy of the current **Directorate Risk Register**.

2.3 The Risk Prioritisation System used to derive all Risk Registers across the County Council categorises risks as follows:-

- Categories 1 and 2 are high risk (RED)
- Categories 3 and 4 are medium risk (AMBER)
- Categories 5 and 6 are low risk (GREEN)

These categories are of course relative, not absolute assessments – equally the Risk Register at Directorate level is designed to identify the dozen or so principal risks that may impact on the achievement of performance targets etc for the Directorate as a whole in the year – it is not a full Register of all the Risks that are managed in the Directorate.

3.0 WORK DONE DURING THE YEAR ENDED 31 AUGUST 2012

3.1 Details of the work undertaken for the HAS Directorate and the outcomes of those audits are provided in **Appendix 1**. In addition, Veritau undertook a joint audit with the North Yorkshire NHS Audit Service to verify the public health return for North Yorkshire and York for 2010/11.

3.2 Veritau has also been involved in carrying out a number of special investigations that have either been communicated via the Whistleblowers' hotline or have arisen from issues and concerns raised with Veritau by HAS management. In addition, Veritau has provided support in respect of a number of safeguarding alerts.

3.3 As with previous audit reports an overall opinion has been given for each of the specific systems or areas under review. The opinion given has been based on an assessment of the risks associated with any weaknesses in control identified.

3.4 The opinions used by Veritau are provided for the benefit of Members below:

High Assurance	Overall, very good management of risk. An effective control environment appears to be in operation.
Substantial	Overall, good management of risk with few weaknesses identified. An effective control environment is in operation but there is scope for further improvement in the areas identified.
Moderate	Overall, satisfactory management of risk with a number of weaknesses identified. An acceptable control environment is in operation but there are a number of improvements that could be made.

Limited	Overall, poor management of risk with significant control weaknesses in key areas and major improvements required before an effective control environment will be in operation.
No Assurance	Overall, there is a fundamental failure in control and risks are not being effectively managed. A number of key areas require substantial improvement to protect the system from error and abuse.

3.5 The following categories of opinion are also applied to individual actions agreed with management:

Priority 1 (P1) – A fundamental system weakness, which presents unacceptable risk to the system objectives and requires urgent attention by management.

Priority 2 (P2) – A significant system weakness, whose impact or frequency presents risks to the system objectives, which needs to be addressed by management.

Priority 3 (P3) – The system objectives are not exposed to significant risk, but the issue merits attention by management.

3.6 It is important that agreed actions are followed up to ensure that they have been implemented. Veritau now formally follow up all agreed actions on a quarterly basis, taking account of the timescales previously agreed with management for implementation. **On the basis of the follow up work undertaken during the year, the Head of Internal Audit is satisfied with the progress that has been made by management to implement previously agreed actions necessary to address identified control weaknesses.**

3.7 All internal audit work undertaken by Veritau is based on an Audit Risk Assessment. Areas that are assessed as well controlled or low risk are reviewed less often and in our experience continue to be satisfactory between audits. Veritau's audit work is focused on the higher risk areas. Veritau officers work closely with the HAS senior managers to address any areas of concern. Veritau officers also meet with the Assistant Director – Resources on a quarterly basis in order to provide an update on progress against the HAS Audit Plan and to discuss audit related matters. The scope of many audits means that a large number of processes are reviewed with many of these being found to be satisfactory or better. In a number of the audits listed in **Appendix 1**, however, specific weaknesses were identified which need to be addressed. The main issues identified were:

- the lack of effective management of direct payments (**Appendix 1, E and F**); and
- poor systems for the recovery of debt for clients with power of attorney (**Appendix 1, L**)

4.0 AUDIT OPINION

4.1 Veritau works to the CIPFA Code of Practice for Internal Audit in Local Government in the United Kingdom. In connection with reporting to Audit Committees, that guidance states that:

"The Head of Internal Audit's formal annual report to the organisation should:

(a) include an opinion on the overall adequacy and effectiveness of the organisation's internal control environment

(b) disclose any qualifications to that opinion

(c) present a summary of the audit work undertaken to formulate the opinion, including reliance placed on work by other assurance bodies

(d) draw attention to any issues the Head of Internal Audit judges particularly relevant to the preparation of the Annual Governance Statement

(e) compare work actually undertaken with the work that was planned and summarise the performance of the Internal Audit function against its performance measures and criteria

(f) comment on compliance with these standards and communicate the results of the Internal Audit quality assurance programme".

4.2 The overall opinion of the Head of Internal Audit on the controls operated in the HAS Directorate is that they provide **moderate assurance**. There are no qualifications to this opinion and no reliance was placed on the work of other assurance bodies in reaching that opinion.

5.0 STATEMENT OF ASSURANCE AND DIRECTORATE RISK REGISTER

5.1 The Chief Executive and each Corporate Director provide a **Statement of Assurance** (SoA) at the end of each financial year. In this Statement the Corporate Director identifies those items that may give rise to internal control or performance risk issues for their Directorate in the forthcoming year. These issues feed into the process that enables the Annual Governance Statement (AGS) to be prepared for the County Council.

5.2 **Appendix 2** details the items identified by the Corporate Director in May 2012 (the first two columns of the Appendix). The *Progress to date* column has been added which records management action(s) to date in this financial year.

5.3 The **Directorate Risk Register** (DRR) is the end product of a systematic process that initially identifies risks at Service Unit level and then aggregates these via a sieving process to Directorate level. A similar process sieves Directorate level risks into the Corporate Risk Register.

5.4 **Appendix 3** summarises the current risks identified by the Directorate. As with the SoA a *Progress to date* column has been added to record management action(s) to date.

5.5 There is bound to be a degree of overlap between SoA issues and the Directorate Risk Register. Cross-referencing is therefore provided, where appropriate, between **Appendices 2 and 3** to assist Members consider the two documents.

6.0 **RECOMMENDATION**

6.1 That Members consider the information presented in this report and determine whether they are satisfied that the internal control environment operating in HAS is both adequate and effective.

MAX THOMAS
Head of Internal Audit
Veritau Ltd

HELEN TAYLOR
Corporate Director – Health and Adult Services

BACKGROUND DOCUMENTS

Relevant Audit Reports kept by Veritau Ltd at 50 South Parade
Contact Max Thomas on 01609 532143

Report prepared by Roman Pronyszyn and presented by Max Thomas, Head of Internal Audit.

County Hall
Northallerton

31 August 2012

APPENDIX 1

HEALTH AND ADULT SERVICES – FINAL AUDIT REPORTS ISSUED IN THE YEAR ENDED 31 AUGUST 2012

	System/Area	***Audit Opinion***	***Area Reviewed***	***Date Issued***	***Comments***	***Management Actions Agreed***
A	Provider List	High	The audit examined a sample of new clients for residential and domiciliary care to ensure that they had been allocated providers who had been approved by the Contracting Unit.	5/1/12	An effective control environment was in operation although the Adults Integrated Solution (AIS) system was not always being updated with details of the provider.	**One P2 action was identified** A report for all current services with no provider was requested. Brokers will check and amend records accordingly. Regular brokerage data quality reports to be produced to highlight issues on a monthly basis. Meetings have been held to agree parameters for data quality reports for Brokerage in all areas across the County. **Responsible Officer** Assistant Director (Commissioning, Contracting and Quality Assurance)
B	Establishment Financial Procedures (Wilf Ward Family Trust)	Moderate	The audit examined the procedures for handling tenants' monies at supported living establishments provided by the Wilf Ward Family Trust (a third party provider).	3/8/12	The audit found that the control environment was acceptable. A number of weaknesses were however identified including: • the ability of tenants to handle of their own money • access to tenants' bank PIN numbers • the allocation of shared costs, including food • the reimbursement of petrol costs to WWFT employees	**One P1, seven P2 and one P3 actions were identified** The Wilf Ward Family Trust has introduced new procedures to manage and control tenants' money. Where appropriate, this has included giving tenants greater responsibility for managing their own financial affairs.

	System/Area	Audit Opinion	Area Reviewed	Date Issued	Comments	Management Actions Agreed
C	Establishment Financial Procedures (UBU)	High	The audit examined the procedures for handling tenants' monies at supported living establishments provided by UBU (a third party provider).	4/4/12	The control environment was found to be effective although minor issues were found with a couple of tenants' financial arrangements.	**Two P2 actions were identified.** UBU has taken the appropriate action to deal with the identified issues.
D	Brokerage Home Care	Substantial	A review of compliance by the brokerage team of relevant Directorate procedures.	11/4/12	An effective control environment was found to be in operation although there was scope for improvement in a small number of areas. The following control weaknesses were identified: • there was often a delay in applying new rates for providers • in some cases, services were being operated without signed copies of the contact in place	**One P2 and two P3 actions were identified** Management are aware of the timing issues in relation to contracts. The only identified solution would be more staff resources however they are working on improving service delivery through automation **Responsible Officer:** Assistant Director (Commissioning, Contracting and Quality Assurance)
E	Direct Payments	Limited	The audit examined the following areas in relation to Direct Payments: • compliance with legislation • the adequacy of the policy framework • the application of policies and procedures to ensure consistency (two areas were tested	30/4/12	Control weaknesses were found in a number of key areas including: • the need for evidence to show that agents are made aware of their responsibilities. • the payment of Direct Payments to bank accounts not under the clients' control • under and overpayments of Direct Payments, and the failure to identify these in the	**Five P1 and nine P2 actions were identified** A number of the issues identified were addressed by means of refresher training and the issue of improved guidelines. Other actions taken include: • legal advice has been sought in respect of Direct Payments made into a bank account which is not in the clients'

	System/Area	Audit Opinion	Area Reviewed	Date Issued	Comments	Management Actions Agreed
			Hambleton and Richmondshire, and Harrogate and Craven) • the completeness of documentation on client files • the recording of payments		reconciliation process. • the need to make extra contingency payments when contracts are amended • the failure to record bank balances on the AIS system and the lack of monitoring of bank statements to ensure that payments are being used appropriately. • poor monitoring of the returns from clients because of system reporting problems • no evidence to show that new clients are subject to review after six weeks (for those clients tested) • no evidence to show that annual reviews are taking place (for those clients tested) • when Direct Payments cease, the appropriate documentation is not always being completed • the 3 forms on the Direct Payments database are not being fully completed in every instance. • discrepancies between the Direct Payments database and the Finance Audit Lists used by Finance.	name. • duplicate payments should now be identified through SWIFT financials. • the reporting functionality of the database has been improved. • a monitoring and review matrix has been issued to the DPSS Team. • all clients will have an annual review by March 2013. • a schedule for completing all current end of involvement forms will be issued to DPSS admin staff. • the forms on the DPSS database have been updated. • database training and guidance has been completed with the DPSS Team. • a full data cleanse of the database has been completed and records referenced against the payment lists. • Swift Financials has been used to pay all DP's from May 2012. **Responsible Officer** Service Development Manager - SDS and Direct Payments

	System/Area	*Audit Opinion*	*Area Reviewed*	*Date Issued*	*Comments*	*Management Actions Agreed*
F	Direct Payments – Operation Practice Issues	Limited	There was a separate report issued following the audit of Direct Payments (**see E above**).	30/4/12	A number of control weaknesses were found in key areas including: • the failure to follow Department of Health Guidance and hold Best Interest meetings. • six weekly reviews not being carried out	**Two P2 actions were identified** Refresher training to be provided and guidance on six weekly review and monitoring/recording given to the DPSS team **Responsible Officer** Service Development Manager - SDS and Direct Payments
G	Payment and Charges for Domiciliary Care	Moderate	The audit reviewed a number of areas including: • the raising of debtor invoices for client contributions • payments to providers • the recording of these transactions • reconciliations The scope of the audit was limited to sample testing invoices from Home Care Spot Contracts. Service users with Learning Disabilities were included in the sample.	8/06/12	The audit found a number of control weaknesses including: • client contributions which had not been collected from clients with Learning Disabilities in the Selby area • client contributions exceeding the actual costs of service provision in some instances • failing to reduce a client contribution after the client was re-assessed in 2006 • recording and checking errors There was also scope to make a number of efficiency improvements to payment processes.	**Seven P2 and two P3 actions were identified** Specialist brokerage officers are now in place to support clients with Learning Disabilities. The process of transferring to fairer charging will address the issues identified with client contributions. There is also a programme to transfer all invoices to electronic invoicing and away from paper records. The individual case identified has been corrected. **Responsible Officer** Assistant Director Resources

	System/Area	Audit Opinion	Area Reviewed	Date Issued	Comments	Management Actions Agreed
H	Charges for residential Care and Domiciliary Care Electronic Invoicing Follow Up	Moderate	The audit reviewed a number of areas including: • the raising of debtor invoices for client contributions • payments made to providers • the recording of these transactions • reconciliations The scope of the audit was limited to sample testing invoices from Home Care Spot Contracts for elderly people.	11/7/12	The audit found a number of control weaknesses including: • employee timesheets submitted by the providers which were not being checked in all areas and in some cases did not contain all the required information. • invoices from the providers which were not being checked in all areas and, in some cases, not being authorised correctly. • service users being charged in excess of the actual cost of care in some instances. • incorrect client contributions being requested in some instances • client contributions not being correctly recorded • inconsistent methods of checking and recording invoices across different areas	**Nine P2 and two P3 actions were identified** Providers to be requested to improve the quality of the timesheets and electronic invoices that they submit. Procedures to be improved in the individual areas where improvements to practice were identified. A review of authorised signatories will be carried out. Work is being carried out to improve the identification of errors in client contributions using technology solutions. The support manager (East) to review the ways of working to see if efficiency can be improved. **Responsible Officer** Assistant Director Resources
I	Personalisation	Moderate	The audit reviewed a number of areas, including: • compliance with legislation • the timeliness and completeness of assessments • the calculation of indicative budgets	5/07/12	The audit found a number of control weaknesses including: • support plans not being authorised by a manager. • in some cases, no evidence that Needs Assessment Questionnaires (NAQ) are being provided to service users • a lack of consistency in terms of	**Three P2 and four P3 actions were identified** There is a planned upgrade to the Adults Integrated Solution (AIS) that should prevent support plans being issued without authorisation. Work is also planned on AIS and case file data quality during

	System/Area	Audit Opinion	Area Reviewed	Date Issued	Comments	Management Actions Agreed
			• the timeliness and completeness of support plans • the arrangements for reviewing support plans • monitoring arrangements The audit also reviewed the progress made to address a number of control weaknesses identified in the 2010/11 audit report.		agreeing support plans.	2012/13. Staff will be reminded of the need to complete the AIS field with the date that the NAQ was given to the client. Reminders will be issued to staff to remind them that two copies of authorised support plans should be sent to the client asking for one to be returned. The return of these will not be monitored or chased. **Responsible Officer** Assistant Director Adult Social Care Operations
J	Data Quality AIS Issues	Substantial	As part of the HAS Brokerage Home Care Audit some issues were noted relating to the input of information on the AIS System. This area therefore formed a separate report to the Assistant Director Social Care operations	24/02/12	The control environment was found to be effective although a few issues needed to be addressed, including: • Needs Assessment Questionnaires (NAQ) not being completed in all cases. This was especially the case in relation to Learning Disability clients. • actual care packages did not always link to support plans The findings were relevant to a majority of the Learning Disability Clients and a minority of elderly person clients.	**Four P2 actions were identified** See the management response to the personalisation audit above. **Responsible Officer** Assistant Director Adult Social Care Operations

	System/Area	Audit Opinion	Area Reviewed	Date Issued	Comments	Management Actions Agreed
K	Continuing Health Care Reconciliations	Moderate	The audit examined the reconciliations performed for the financial year ending 31 March 2011.	8/12/11	A number of control weaknesses were identified in the following areas: • communications between departments throughout the process • monitoring of the CHC returns submitted.	**Three P2 actions were identified** A new manager has been employed by the PCT to oversee the CHC process. The PCT will now liaise directly with area finance officers to resolve claims. The principle finance officers will ensure identified issues are resolved in a timely manner. New procedures will be rolled out to the 3 areas for dealing with different funding scenarios. **Responsible Officer** Finance Manager (HAS)
L	Charges for Residential Care – Power of Attorney	Limited	The audit reviewed the arrangements for identifying and recording service users who have granted a Power of Attorney.	31/8/12	The audit found that records are not being retained to evidence the existence of Powers of Attorney. The information is also not being communicated to Credit Control in a timely manner.	**One P1 and two P2 actions were identified** Guidance has been issued to ensure that relevant information is recorded on AIS. The HAS procedures will also be amended. The Credit Control team (in Financial Services) now has 'read on' facility to AIS which should enable them to have the most up to date information.

	System/Area	*Audit Opinion*	*Area Reviewed*	*Date Issued*	*Comments*	*Management Actions Agreed*
						Responsible Officer Assistant Director Resources
M	Establishment Audit – Springhill Close	Substantial	An audit of the financial procedures operating at the establishment.	23/8/12	No significant issues were identified although there was scope for improvement in a small number of areas. The following control weaknesses were identified: • Bank reconciliations not being fully completed • Uncertainty over the insurance arrangements • Care plans not adequately reflecting the level of financial support required	**Five P1 and one P3 actions were identified** The majority of the agreed actions were implemented immediately. Assessments and support plans will be updated to reflect the level of financial support required. **Responsible Officer** Assistant Director Adult Social Care Operations

APPENDIX 2

EXTRACT FROM STATEMENT OF ASSURANCE PROVIDED BY THE CORPORATE DIRECTOR – HEALTH and ADULT SERVICES

AREAS FOR IMPROVEMENT IDENTIFIED BY HEALTH and ADULT SERVICES				
Areas for improvement		**Action proposed**	**DRR Ref**	**Progress to date (31 August 2012)**
A	**Demand outstrips budget provision for adult social care**	The Directorate has developed a resource predictive model based on nationally approved population, demographic trend analysis. These tools and techniques have been used to create a forecasting model to predict the pattern and anticipated cost which could occur within the County. Based on this model it is estimated that the incremental demand cost could be approx £3m per year for the foreseeable future; this equates to an additional 500 clients. In response to this pressure the County Council has provided, within the Medium Term Financial Strategy, incremental budget provision of £3m per annum. This provision will be regularly reviewed to ensure it is responsive to fluctuations of price and number of people being supported and this will in turn feed into the revised budget projections.	**C**	• The resource model is updated regularly and monthly activity data for residential and domiciliary services reviewed by HAS Management Board. • Monthly budget monitoring reports are considered by HAS Management Board and Operational Management Teams. These feed in to the Quarterly Performance Reports considered by Executive. • Information in relation to ordinary residence placements are collated on a monthly basis and this information is used to inform the budget monitoring position. • The revenue budget monitoring position is favourable with a current (managed) under spend of £2.8m being reported to Executive as part of Q1 monitoring for 2012/13. • Discussions have been undertaken with FE College for visually impaired people in Harrogate. As a result of our greater understanding of their long term business intentions there is no longer a significant financial risk for NYCC.

AREAS FOR IMPROVEMENT IDENTIFIED BY HEALTH and ADULT SERVICES				
Areas for improvement		**Action proposed**	**DRR Ref**	**Progress to date (31 August 2012)**
		There is also an emerging financial challenge relating to other authorities exercising ordinary residence rights of clients living within the North Yorkshire boundary which results in NYCC becoming responsible for the person's care and financial liability. This is a significant risk because of the 2 large Camphill Community villages within the County which provide accommodation for in excess of 150 people and the FE college for visually impaired people in Harrogate.		
B	**Implementation of the Change and Improvement Agenda**	The Directorate has an ambitious efficiency and transformational programme which seeks to make cost savings by improving service outcomes as well as disinvesting in traditional forms of service delivery. There has been investment in low level prevention services and supporting people at home through the use of preventative technology such as telecare. The priority is also to reduce reliance on residential care and support more people within their home as well as increase the range of supported accommodation through an Extra Care.	**C, D, H, I & L**	• Investment in preventative services such as reablement and telecare continues. • The Directorate has established performance targets for reducing the reliance on residential care. • The Directorate is committed to further expansion of Extra Care and the new scheme in Thirsk was approved by Executive on the 24 April 2012. • The personal care at home service has, in the main transformed into START (Short Term and Reablement Team). Given the significance of the change and financial pressures within the Directorate the HAS Management Board have commissioned a review of the service. The findings of this review will be reported in September. • The Directorate has also introduced additional resources to

AREAS FOR IMPROVEMENT IDENTIFIED BY HEALTH and ADULT SERVICES				
Areas for improvement		**Action proposed**	**DRR Ref**	**Progress to date (31 August 2012)**
		In addition the Directorate continues to transform its in house personal care service to provide a reablement service. For the majority of clients requiring support from the Directorate it is intended that this service will be the initial service offer undertaking the initial assessment to determine the individual life skills and developing a plan to improve these and level of independence. More recently the Directorate has introduced a programmed approach to monitoring the savings programme, regularising the frequency of review, the resources to monitor and support to deliver these projects.		monitor and support project delivery. In addition a more systematic approach to programme management has been introduced. As outlined earlier the Directorate's financial position is in good shape and most of the savings projects are on track to deliver within the year. Equally HAS are aware of the projects where there is slippage and are addressing these areas.

AREAS FOR IMPROVEMENT IDENTIFIED BY HEALTH and ADULT SERVICES				
Areas for improvement		**Action proposed**	**DRR Ref**	**Progress to date (31 August 2012)**
C	**Market forces lead to increases in the price of care that cannot be contained within budgets, or threaten market disruption, and service continuity**	The Directorate continues to undertake negotiations and dialogue with the independent sector through the Market Development Board. This is a forum comprising representatives from the independent sector, voluntary sector, health and NYCC. In the context of personalisation and transformational programme there is and will continue to be significant sharing of information to understand the market pressures within the County and take appropriate action as required. In addition there has been work with the independent sector to ensure business and service continuity. This should be viewed within the context of a national situation of increasing judicial challenge to those fees paid by Local Authorities. The Directorate is also working with the market to provide more creative solutions and services rather than relying on the traditional approaches to meeting people's support requirements.	**K**	• Regular meetings of the Market Development Board are ongoing. These are wide ranging discussions on contractual matters, market development and training issues affecting the residential, domiciliary and voluntary sector. • More recently the County Council has been served with Judicial Review proceedings by a range of complainants. The Judicial Review seeks to challenge the Residential and Nursing Home fees for 2012/13, the adequacy of consultation which led up to this decision and seeks to squash the fee decision for 2013/14. Mediation took place on the 15 August 2012 to agree a way forward and a Consent Order has now been agreed with the complainants.

AREAS FOR IMPROVEMENT IDENTIFIED BY HEALTH and ADULT SERVICES				
Areas for improvement		**Action proposed**	**DRR Ref**	**Progress to date (31 August 2012)**
D	**Realise value for money within existing and new service delivery**	In light of the challenges outlined above the Directorate has/will be - • invested in developing the contracting, procurement and quality assurance function • developing the quality assurance arrangements for residential care • undertaking value for money review of day provision and funding within the voluntary sector • making further investment within the brokerage function in light of the introduction of Adult Integrated Solutions (AIS) and an invest to save approach to provide challenge to high cost packages of care for people with learning disabilities • reviewing out of County placements • continue to invest in the transformation of the personal care at home service to provide reablement which is intended to help people regain the skills	**I**	• The contracting, procurement and quality assurance team are now established and attention is being given to rolling out the quality assurance arrangements. • A programme of value for money reviews for day provision is being undertaken and annual contract monitoring for other forms of service taking place. • As part of the organisational changes arising from many of the One Council work streams the brokerage staff are now managed by Procurement, Contracting and Quality Assurance Team. This change will enhance the resources available to this area and lead to improvements in the ways of working. • As part of the savings programme significant savings are envisaged from current learning disability arrangements. A programme board has been initiated to oversee these different strands of activity which include developing services within the County to enable people with significant needs to be supported at home and if not within close proximity of their families. • NYCC continues to work with North Yorkshire and York PCT and Clinical Commissioning Groups to ensure Health and Social Care Monies and Reablement funding are targeted to transform systems and deliver a better outcome for patients. Broad agreement has been reached on the approach to develop local services over the next 3 years and section 75 (Health Act 2006) agreements developed to govern these resources. The accompanying performance framework still has to be developed and agreed with our

AREAS FOR IMPROVEMENT IDENTIFIED BY HEALTH and ADULT SERVICES				
Areas for improvement		**Action proposed**	**DRR Ref**	**Progress to date (31 August 2012)**
		and confidence to live at home independently or with reduced level of ongoing support. Coupled with investment in home based technology (such as telecare) there is evidence that these have lead to improved outcomes for people		partners.
E	**Introduction of Adult Integrated System and SWIFT Financials**	The introduction of the client system has not been a smooth process as there have been significant problems with the functionality and reliability of the system. Some improvements have been made through the application of 'hot fixes' to the live system and more recently there has been an upgrade of the system. It is early days but the Directorate is optimistic this will result in improved user experience and increased functionality. During the financial year the functionality for paying residential homes and billing residential clients via the system went live. There were a number of months where there were teething problems from a system and resourcing perspective but this is now resolved. Indeed HAS is now looking to utilise the system to make direct payments from June 2012. This will		• The latest version release (v27.0.1) has been implemented and this is working effectively • Transactions in respect of residential care are now live within the AIS. In addition the interface from AIS to Accounts Payable is running smoothly. There are issues in relation to the speed of transactions and this is being investigated by both Northgate and NYCC. • Direct payments are now made using the system and HAS / FCS are currently testing the approach to making one off payments. This is a more automated way of working and will improve the accuracy and management information. • In terms of improving the quality of data this has been approached in 2 ways; providing operational staff with access to a data quality database to enable them to retrospectively check the accuracy of data recorded on the system as well as the production of an output report which will enable staff to validate the information prior in real time. The deployment of both of these approaches should result in improved data. In addition data quality is now part of the management, supervision and appraisal process

AREAS FOR IMPROVEMENT IDENTIFIED BY HEALTH and ADULT SERVICES				
Areas for improvement		**Action proposed**	**DRR Ref**	**Progress to date (31 August 2012)**
		streamline the systems being used and be a more efficient payment process. It also provides the Directorate with a resilient system to respond to the increasing numbers of direct payments recipients. Further attention is required to improve the reliability of the data within the system to enable progress to be made on automatic payment of non residential services and to remove unnecessary activities such as data cleansing routines required for statutory returns.		undertaken by team managers.
F	**Personalisation and Think Personal Act Local**	The Directorate has a made significant progress in this area in relation to the milestones required by the Department of Health. More recently plans are being drawn up to enable the Authority to signed up to the 'Making it Real programme' which is a public statement of actions required to develop the personalisation agenda. The progress against plan will be monitored and published on the website. This is a challenging agenda which will also be performance monitored	**A**	• An update report in relation the revised Fairer Contribution Policy is being presented to the Care and Independence Overview and Scrutiny Committee on the 30 August 2012. This demonstrates that of those people being eligible for community based services roughly less than 1% of them have declined services due to financial reasons. • Version 27.02 of the Adult Integrated System is currently in test system and HAS are optimistic it will be ready for release to full live production mid September. This will provide the functionality for automating the Needs Assessment Questionnaire; however there is significant testing and preparation prior to being able to go live. In addition HAS are at an early stage of exploring options for utilising a separately hosted assessment product and this will require a business case to justify the additional costs

AREAS FOR IMPROVEMENT IDENTIFIED BY HEALTH and ADULT SERVICES				
Areas for improvement		**Action proposed**	**DRR Ref**	**Progress to date (31 August 2012)**
		by the number of clients receiving a personal budget. The target is 100% by the end of 2013. The greater challenge then relates to increasing the number of people who take up a direct payment and decide to manage their own care. The administrative arrangements for direct payments are currently being reviewed in light of experience and to simplify the supporting paperwork. It is hoped that this will remove internal barriers which may have been a stumbling block for staff and lead to improved referral rate for clients choosing to take up a Direct Payment. In addition 6/8 week reviews are being introduced to ensure that Direct payment recipients are managing their personal care and financial arrangements more effectively. This check will provide an earlier warning of potential problems or where additional support is required. As part of the recent AIS updates the next phase of system development will be to utilise the needs assessment questionnaire. This will		relating to upfront licence, implementation costs and ongoing costs. • The Direct Payment administrative processes have been reviewed and simplified. Monitoring arrangements have been introduced to determine themes around non take-up of Direct Payments following initial referral. • Innovations funding was awarded to the North Yorkshire Centre for Independent Living in August 2012 to develop a peer support network, a Personal Assistant Register and to provide practical advice, support and training regarding the recruitment of Personal Assistants to Direct Payment recipients in Scarborough, Whitby and Ryedale. This will be extended to other areas of the County in 2013. • A Countywide Individual Service Fund (ISF) pilot is currently being procured with an implementation date hopefully in the autumn. An ISF is a money management option for personal budget holders who choose not to manage some or all of their support through a Direct Payment, but want more choice, control and flexibility than through a County Council managed personal budget. This will contribute positively to the target of 100% personal budgets by 2013. • A risk assessment framework is being developed to ensure there is consistency of decision making within the Directorate and ensure those support arrangements with more risk are appropriately signed off. This framework should provide increased governance and transparency of decision making. It should also support the personalisation agenda by focussing on personal outcomes, creative

AREAS FOR IMPROVEMENT IDENTIFIED BY HEALTH and ADULT SERVICES				
Areas for improvement		**Action proposed**	**DRR Ref**	**Progress to date (31 August 2012)**
		further simplify the processes within the Directorate and improve the speed at which people can be informed of their indicative personal budget. The charging policy was revised to bring this in line with personalisation guidelines issued by Dept of Health. This took place from May 2011. There has been a small increase in the number of complaints and some clients who have made choices about their care requirements once the financial assessment has been completed. These situations continue to be monitored and a report will be presented to Care and Independence Overview and Scrutiny in the Autumn 2012.		support planning and risk management.

APPENDIX 3

HEALTH AND ADULT SERVICES DIRECTORATE - RISK REGISTER

Risk Register					
		Current Risk Rating	**Post Risk Rating**	**SoA Ref**	**Progress to date (31 August 2012)**
A	**Partnership Working with the Health Environment** Failure to effectively transform services in order to manage collective budgets (intermediate care, continuing health care, reablement health monies) resulting in poor performance, ineffective use of resources, duplication of service &/or activity and external criticism	**1**	**1**	**F**	Joint work continues on the implementation of the local plans Regular dialogue with health senior management to contribute to and oversee the implement the NHS Review. Working together on joint agreed outcomes framework Create Health Co-Ordination Programme Manager and Health Coordinator posts to co-ordinate health interfaces Development of a new Adult Partnership Trust Health and Wellbeing board in shadow form Continue to work with the CCGs, Commissioning Support Unit and North Yorkshire and York PCT.
B	**Integration** Failure, in the context of the changing NHS landscape, to develop effective partnerships with the emerging NHS Commissioners and other NHS organisations to achieve the necessary changes to the North Yorkshire Health economy that will provide better outcomes for patients and local communities. This failure will have a negative impact on the development of	**1**	**1**		Develop Health & Social Care performance framework in line with national expectations for all Health partners Determine public partnership approach (Adult Partnership Trust or equivalent) Respond promptly to forthcoming DH Guidance on Joint Governance Framework and secure urgent local agreements. Continue to work with Commissioning Board local office and CCGs to develop robust change programmes for April 2013 onwards.

Risk Register					
		Current Risk Rating	**Post Risk Rating**	**SoA Ref**	**Progress to date (31 August 2012)**
	integrated services, delay the transformation of HAS services, give rise to increased costs to HAS and cause the loss of opportunities that joint provision may have.				Safeguarding Adults Board to consider the risk of new system for safeguarding. Independent Chair to meet CCGs to highlight importance of Safeguarding work.
C	**Service Transformation** Failure to carry out service transformation to mitigate unavoidable budget pressures arising for example, out of statutory responsibilities, demographic change and increased numbers with dementia, higher levels of need through transition, increased ordinary residence, changes to CHC process and framework and decrease in number of self funders resulting in unaffordable budget pressure, criticism and possible negative outcomes for people using the service.	**1**	**1**	**A & B**	Drive down the need for support by investment in reablement, telecare and equipment and shift away from a dependency culture to one of better outcomes and a focus on independence. Continue investment in earlier intervention and prevention through the commissioning processes. Progress the most cost effective form of service provision transferring towards 100% START and away from Personal Care at Home. Support the acceleration of extra care housing. Development of the Transitions Board. Introduction of the One Council Customer Access workstream including Care Directory. Further develop financial modelling for care and support of people with complex learning disabilities. Ensure quarterly monitoring of demographic modelling.
D	**Learning Disability Transformation** Failure to implement the Learning Disability Transformation and take the opportunity to modernise by 2013/14 resulting in budget pressure, loss of opportunities to modernise, political	**1**	**2**	**B**	Embed the staffing structures and promote the required culture change. Better ongoing communication with providers, users and family carers. Better understand the financial implications of the

Risk Register					
		Current Risk Rating	**Post Risk Rating**	**SoA Ref**	**Progress to date (31 August 2012)**
	concerns and reduced performance.				commissioning and decommissioning strategies. Better procurement of external services, particularly employment services and housing based options. Ensure link to HASMB programme board.
E	**Loss of Sensitive Data and Failure in Information Governance** Failure to ensure the service and the wider Directorate protects sensitive data (either electronic or hard copy) resulting in media attention, loss of reputation or prosecution.	**2**	**2**		Ongoing review of Caldicott implementation. Continue implementation of new Corporate Information Governance Standards. Monitor completion of mandatory e-learning courses. Review and implement revised Subject Access to Files procedure. Regular updates for staff.
F	**Public Health** Failure to be sufficiently prepared for Public Health responsibilities resulting in inability to protect the public adequately and not make sufficient progress in health improvement.	**2**	**2**		Transitional board in place, chaired by Corporate Director Health and Adult Services. Update Financial Information Return based on 2012/13 activity. Collate data on public health contracts. Develop Health & Wellbeing strategy. Arrange a workshop for appropriate people relating to health protection arrangements. Review and revise shadow arrangements to ensure effectiveness. Implementation arrangements for TUPE transfer of staff. Agree areas of joint/shared working with City of York Council.

Risk Register					
		Current Risk Rating	**Post Risk Rating**	**SoA Ref**	**Progress to date (31 August 2012)**
G	**Extra Care Housing & Regeneration Programme** Failure of the agreed procurement process to secure a partner to deliver the extra care housing and regeneration programme and to understand and mitigate the legal and financial risks arising from the procurement and EPH re-provision programme.	**2**	**2**		Use of flexible procurement process i.e. competitive dialogue to allow best outcome to be achieved. Secure resources to undertake procurement process. Engage external legal and procurement advice. Develop communications and consultation processes including Members.
H	**Cultural Change including One Council** Failure to effectively monitor and rectify where necessary, the combined effect of changes such as significantly reduced arrangements for management and supervision and strategic support, self service for managers, capacity for initiatives including One Council changes resulting in unacceptable deterioration in service levels	**2**	**3**	**B**	Establish a robust client role for HR, Workforce Development and admin support Monitor the impact of workforce development changes on front line service users such as deliver of statutory training. Also "self service" for managers in relation to HR issues. Continue to engage with and contribute to all One Council workstreams.
I	**Finance and Resources - Failure to manage and deliver the efficiency agenda** The budget is predicated on delivering a transformation agenda resulting in major financial efficiencies. Failure to achieve these efficiencies in a timely	**2**	**4**	**B & D**	Develop detailed delivery plans and programme management. Identify underperforming areas and take appropriate action. Appropriate engagement with staff and staff side in the transformational agenda including HR support.

Risk Register					
		Current Risk Rating	**Post Risk Rating**	**SoA Ref**	**Progress to date (31 August 2012)**
	manner would result in budget overspend, the need for urgent possibly inappropriate reduction in front line services, major cuts in senior management structures and financial risk to the Council's other Directorates.				Continue to report to Executive on a quarterly basis. Secure corporate commitment to flexible use of resources to enable HAS medium term service financial planning.
J	**Safeguarding Arrangements** Failure to have a robust Safeguarding regime in place results in risk to service users, failure to reach required standard on CQC and adverse effect on Directorate reputation.	**3**	**3**		Develop trend spotting methodology. Ensure partners are fully engaged with Safeguarding boards. Develop risk enablement panel. Work with Procurement, Partnerships and Quality Assurance team to improve quality assurance. Ensure lessons are learned through serious case reviews.
K	**Major Failure due to Quality and/or Economic Issues in the Care Market** Fundamental breach of contract by key provider(s) resulting in significant un-met service needs, loss of reputation, potential legal proceedings (e.g. failure of major provider) and long term impact on trust in the market to meet people's needs appropriately.	**3**	**3**	**C**	Ongoing Partnership and Partner Liaison meetings (market development board), market analysis and mapping and information sharing. Continue to monitor baseline assessments of providers. Engage in ADASS work to manage major problems occurring, such as financial issues in the care provider market and ensure robust contingency planning. Ongoing engagement meetings with CQC.
L	**Workforce Development** Failure to develop staff in line with transformation agenda resulting in reduction in quality of service and	**3**	**5**	**B**	Continue rollout of Community Care Pathway training and induction program. Complete reablement training program delivery.

Risk Register					
		Current Risk Rating	**Post Risk Rating**	**SoA Ref**	**Progress to date (31 August 2012)**
	transformation objectives not achieved				Provide support to the independent provider workforce. Monitor compliance with statutory mandatory training. Effective staff appraisal and training needs analysis. Contribute to Corporate Workforce Planning and Development Group.