NORTH YORKSHIRE COUNTY COUNCIL

AUDIT COMMITTEE

30 NOVEMBER 2017

INTERNAL AUDIT WORK FOR THE HEALTH AND ADULT SERVICES DIRECTORATE

Report of the Head of Internal Audit

1.0 PURPOSE OF THE REPORT

1.1 To inform Members of the **internal audit work** performed during the year ended 31 August 2017 for the Health and Adult Services (HAS) directorate and to give an opinion on the systems of internal control in respect of this area.

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 HAS, the Committee receives assurance through the work of internal audit (as provided by Veritau), as well as receiving a copy of the latest directorate risk register.

2.2 This agenda item is considered in two parts. This first report considers the work carried out by Veritau and is presented by the Head of Internal Audit. The second part is presented by the Corporate Director – Health and Adult Services and considers the risks relevant to the directorate and the actions being taken to manage those risks.

3.0 WORK DONE DURING THE YEAR ENDED 31 AUGUST 2017

3.1 Details of the internal audit work undertaken for the directorate and the outcomes of these audits are provided in **Appendix 1.**

3.2 Veritau has also been involved in carrying out a number of assignments which have not resulted in the completion of an audit report. This work has included special investigations that have either been communicated via the Whistleblowers' hotline or have arisen from issues and concerns referred to Veritau by HAS management. We have also led on work involving data matches received from the National Fraud Initiative (NFI). Finally, we have provided support to directorate management in respect of a number of safeguarding alerts and other matters.

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. Where weaknesses are identified then remedial actions will be agreed with

management. Each agreed action has been given a priority ranking. The opinions and priority rankings used by Veritau are detailed in **Appendix 2**. Some of the audits undertaken in the period focused on value for money or the review of specific risks so did not have an audit opinion assigned to them.

3.4 It is important agreed actions are formally followed up to ensure that they have been implemented. Veritau follow up all agreed actions on a regular 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.**

3.5 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 with audit work instead focused on the areas of highest risk. Veritau's auditors work closely with directorate senior managers to address any areas of concern.

4.0 AUDIT OPINION

4.1 Veritau performs its work in accordance with the Public Sector Internal Audit Standards (PSIAS). In connection with reporting, the relevant standard (2450) states that the Chief Audit Executive (CAE)[1] should provide an annual report to the board[2]. The report should include:

(a) details of the scope of the work undertaken and the time period to which the opinion refers (together with disclosure of any restrictions in the scope of that work)

(b) a summary of the audit work from which the opinion is derived (including details of the reliance placed on the work of other assurance bodies)

(c) an opinion on the overall adequacy and effectiveness of the organisation's governance, risk and control framework (i.e. the control environment)

(d) disclosure of any qualifications to that opinion, together with the reasons for that qualification

(e) details of any issues which the CAE judges are of particular relevance to the preparation of the Annual Governance Statement

(f) a statement on conformance with the PSIAS and the results of the internal audit Quality Assurance and Improvement Programme.

4.2 The overall opinion of the Head of Internal Audit on the framework of governance, risk management and control operating in the Health and Adult Services directorate is that it provides **Substantial Assurance.** There are no qualifications to this opinion and no reliance was placed on the work of other assurance bodies in reaching that opinion.

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[1] The PSIAS refers to the Chief Audit Executive. This is taken to be the Head of Internal Audit.
[2] The PSIAS refers to the board. This is taken to be the Audit Committee.

5.0 **RECOMMENDATION**

5.1 That Members consider the information provided in this report and determine whether they are satisfied that the internal control environment operating in the Health and Adult Services Directorate is both adequate and effective.

Max Thomas
Head of Internal Audit

Veritau Ltd
County Hall
Northallerton

16 November 2017

BACKGROUND DOCUMENTS

Relevant audit reports kept by Veritau Ltd at 50 South Parade, Northallerton.

Report prepared by Stuart Cutts, Audit Manager, Veritau and presented by Max Thomas, Head of Internal Audit.

Appendix 1

FINAL AUDIT REPORTS ISSUED IN THE YEAR ENDED 31 AUGUST 2017

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
A	Visits to care provider establishments: • Henshaws, (Harrogate) • Wilf Ward (Winton Road and Newsham Way) • The Lodge, (Scarborough) • Mencap (Scarborough) • Moorview (Whitby) • UBU Roche Avenue (Harrogate)	Various: 4 x Substantial Assurance 1 x High Assurance 1 x Limited Assurance 1 x No opinion	We completed a programme of audit visits to care providers to ensure: • financial transactions relating to service users are recorded correctly and in accordance with the care provider's policies and procedures; • all expenditure relating to service users is appropriate and properly evidenced; • financial arrangements ensure that the property of service users is protected.	Various	Overall arrangements were found to be good with effective controls operating in most of the homes visited. We found one provider did not have financial risk assessments on file for residents. There were therefore no instructions available to staff on how to handle each customer's money. We also found several instances where providers were not fully complying with their own policies. This included where they were failing to carry out sufficient checks of the cash held by residents and were either not completing reconciliations of accounts or signing them off where receipts were missing or money did not balance.	**One P2 and four P3 actions were agreed** **Responsible Officer: Assistant Director – Quality and Engagement** The Quality and Engagement Team discussed the issues identified with the homes in question and worked as necessary to ensure any required improvements were made.
B	Court of Protection	Reasonable Assurance	The Court of Protection helps to support and protect individuals who lack mental capacity and cannot make their own decisions. The Council has a team which processes and manages Court of Protection and Appointeeship cases.	January 2017	All the files tested were up to date and contained the required information. The files were also stored in a secure environment. The specification for the new system was not fully developed and did not identify the required outcomes / outputs from the system.	**Two P2 findings and two P3 findings were agreed.** **Responsible Officer: Benefits, Assessments and Charging Officer** Management expected the new system would provide a number of key improvements so the weaknesses in

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			The team has recently procured a new financial system. The audit reviewed the extent to which: • effective procedures were in place for processing and managing Court of Protection and Appointeeship cases • appropriate plans are in place to ensure the successful implementation of the new financial system and to maximise the opportunities for process and case management improvement. • management arrangements ensure compliance to procedures and data quality standards.		There was no service level risk register in place for Court of Protection and/or Appointeeship cases. There were no procedure notes in place for the administrative functions of the service. There was no independent review of monthly reconciliations. There was also no separation of duties for setting up new payments and reconciling customer accounts.	the specification were not significant. Procedures will be put into place to ensure tasks are carried out regularly. Training on the new system will cover the change areas. The risks affecting the service will be explored to ensure appropriate controls are in place. This will be built into management arrangements. Spot checks will be carried out on a sample of new payments to ensure these are accurate and correct.
C	Continuing Healthcare	No Opinion Given	Continuing Healthcare (CHC) is a challenging area for the Council. The HAS directorate has recognised CHC as one of its key risks (a failure to establish and embed integrated systems for commissioning services that are jointly commissioned with Health). The directorate has also identified	January 2017	The audit work highlighted the significant nature of the challenges faced by the Council. There is scope for the NHS and NYCC to work together more effectively in this area. The National Framework states that the time between the checklist being received by the CCG and the funding decision should, in most cases, not	**Seven P2 findings and eleven P3 findings were agreed.** **Responsible officers: Head of Continued Healthcare, Corporate Director HAS and Assistant Director, Care and Support.** The Authority agreed a detailed plan

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			local issues with the operation of CHC. A National Framework for Continuing Healthcare is in place. However, interpretation of the Framework continues to be central to many issues with both the NHS and local government tending to interpret the framework differently. We reviewed the Council's current arrangements for effectively managing CHC. We included a sample review of a number of cases to help assess the extent to which appropriate arrangements were in place.		exceed 28 days. The actual time taken is currently between 4 and 7 months. The assessment process was not always fully quantifying the individuals care needs. As a result a majority of cases in North Yorkshire were funded on the basis of a 50/50 split between the NHS and NYCC. Such a split is however only likely in a minority of jointly funded cases. The Head of Continuing Healthcare identified errors in the process which may lead to over £2m in overpayments being recovered from the CCG's. There are no agreements with the NHS around standard ways of working. Reliance is placed on the National Framework and associated guidance. More work is also required to define data requirements (for both the NHS and NYCC.	with a variety of actions to help improve the current arrangements. A joint governance group has been set up to help oversee partnership working improvements. Governance arrangements have been defined and the group is to develop areas such as a data sharing agreement. Joint process improvement days have been held, and a provisional agreement to reinstate ratification panels has been made. Quality Assurance panels have been reintroduced. Organisational changes within the NHS have created additional challenges when developing future joint ways of working in respect of CHC. More robust processes for managing joint funding cases will be determined. A joint training package will also be put in place.
D	Public Health	Substantial Assurance	The audit reviewed procedures and controls in place to ensure: • a public health budget is produced in line with the	February 2017	Good controls were found to be in place. Public health budget setting was in line with council procedures. Budgets were being forecasted and monitored in an effective manner using	**Two P3 actions were agreed** **Responsible officer: Corporate Director/ AD Resources/ The Director of Public Health**

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			Council's finance manual, with clear links to each public health contract, and supported by sound and documented assumptions • Effective contract management is being undertaken • the Public Health Team has agreed clear outcomes with the Clinical Commissioning Groups (CCG's) operating within North Yorkshire.		the dashboard system. The dashboard has a built in authorisation system and forecasting was signed off by a senior member of the team. A Public Health Financial Planning report has been produced which is (in effect) a five year financial plan. However, future financial planning for Public Health needs to be further integrated into overall HAS strategic planning. Our review of a sample of Public Health contracts (with external partners that involve CYPS) saw an effective contract management process in place. There was supporting documentation to show contract mangers have regular communication with service providers. At the time of audit, the Council was agreeing memorandums of understanding with each of the CCGs. The memorandums stated each party will agree an annual written work programme. However, there were no details of how any actions in this work programme would be measured, reported and the memorandum's revisited.	The Public Health Financial Plan will be incorporated into HAS strategic planning to specify the recurrent funding to deliver commitments and the use of the public health reserve in keeping with grant conditions Memoranda of Understanding with CCGs will include agreed measures for monitoring progress and the timescale for review.

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E	Liquid Logic and ContrOCC	Reasonable Assurance	Liquid Logic is a fundamental system which holds and records information to support the care needs and support requirements of elderly persons. ContrOCC is an integrated finance module which incorporates contract management, provider payments, and client financial assessments and charging. The audit reviewed the processes and controls within the Liquid Logic system to ensure: • appropriate and effective controls were in place to safeguard the information being processed. • records were complete, accurate and up to date • the system for recording, administering and charging for residential care is working efficiently.	June 2017	The procedures for setting up new system users was working well. All new users had been appropriately authorised. Third party access to LLA and ContrOCC is also restricted and logged. There is a comprehensive Confidentiality Policy in place regarding access to sensitive records. All such access requests are appropriately authorised and a log is maintained. Our sample testing found Liquid Logic (and ContrOCC) was not always being updated in a timely manner to reflect client changes. We also highlighted a number of instances where the LLA and ContrOCC systems are not being used as efficiently as possible. The Council was not recovering the correct amount of charges from client contributions leading to a loss of revenue. Clients receive an annual increase in benefits (including pension) from April each year. Prior to the introduction of LLA and ContrOCC, uplift calculations were performed manually in time for the changes from April. However, since LLA and ContrOCC were introduced the annual uplift has not been applied until later in the year.	**Three P2 and one P3 finding were agreed as a result of the audit** **Responsible Officer: Assistant Director Strategic Resources HAS** A process between brokerage and operational staff is now in place which seeks to address some of the delays in updating Liquid Logic. Manual adjustments outside of the system will also be made. Future development of Liquid Logic and ContrOCC through the Assessments Billing and Contracts (ABC) project will help to improve efficiency and reduce workarounds. From 2018/19, the approval process for benefits uplift will be brought forward to December /January pre-ceding the financial year. This process will ensure there is sufficient time to process the uplift by 1 April and minimise the time / potential loss of income due to not having to retrospectively collect monies owed.

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F	HAS Assessment, Billing and Contracts Project (ABC)	No Opinion	Officers have recently undertaken a review of many of the financial and contracting processes within the directorate (Assessment, Billing and Contracts Project - ABC). It is currently envisaged the new processes and procedures will be introduced in 2018. Prior to introducing the new 'To-Be' processes Internal Audit were asked to review the changes and planned new processes in six areas (Baseline Assessments, Care Assessments and Brokerage, Contract Monitoring, Financial Assessments, Market Mapping and Provider Lists). We compared and contrasted key procedures and controls in the 'As-Is' Process Maps to the 'To-Be' Process Maps. We also considered the new 'To-Be' systems for under, over and inappropriate control.	July 2017	We provided a small number of comments and potential improvement points for officers to consider. We will continue to work with officers during 2017/18 to help support the development and implementation of the new processes.	Officers have agreed actions for all of the points raised which will be taken into account as the ABC project progresses.

Appendix 2

Audit Opinions and Priorities for Actions

Audit Opinions	
Audit work is based on sampling transactions to test the operation of systems. It cannot guarantee the elimination of fraud or error. Our opinion is based on the risks we identify at the time of the audit. Our overall audit opinion is based on 5 grades of opinion, as set out below.	
Opinion	**Assessment of internal control**
High Assurance	Overall, very good management of risk. An effective control environment appears to be in operation.
Substantial Assurance	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.
Reasonable assurance	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 Assurance	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.

Priorities for Actions	
Priority 1	A fundamental system weakness, which presents unacceptable risk to the system objectives and requires urgent attention by management.
Priority 2	A significant system weakness, whose impact or frequency presents risks to the system objectives, which needs to be addressed by management.
Priority 3	The system objectives are not exposed to significant risk, but the issue merits attention by management.