NORTH YORKSHIRE COUNTY COUNCIL

AUDIT COMMITTEE

10 OCTOBER 2018

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 2018 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 2018

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 The programme of audit work is risk based. 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.

[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

26 September 2018

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 2018

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
A	Visits to care provider establishments: • The Lodge, (Scarborough) • Mencap (Scarborough) • Moorview (Whitby) • UBU Roche Avenue (Harrogate) • Avalon (Scarborough) • Eldercare • Foresight • Avalon Shared Lives • Financial Management review - Botton Village	Various: 1 x High Assurance 4 x Substantial Assurance 1x Reasonable Assurance 1 x Limited Assurance 2 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	Some providers did not have financial risk assessments on file for residents. There were no instructions available to staff on how to handle each resident's money. We also found several examples where providers were not fully complying with their own policies. This included instances 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. For those establishments given high and substantial assurance the arrangements were found to be generally working as expected with a small number of improvement points. The 'no opinion' audits were targeted 'follow up' reviews of specific issues. As such we did not evaluate the wider systems, processes and controls within theses establishments. Areas for improvement were however highlighted.	**Six P2 and twenty P3 actions were agreed** **Responsible Officer: Assistant Director – Quality and Engagement** The Quality and Engagement Team discussed the issues identified with the providers in question and worked as necessary to ensure any required improvements were made.

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
B	Direct Payments (2016/17)	Substantial Assurance	We reviewed the Direct Payment system to ensure: • The application process and initial assessment provided sufficient control and choice to the individual • There was effective monitoring of Direct Payment customers to ensure adequate care was provided and any misuse of Direct Payments was identified. • Performance management of Direct Payments (including management arrangements, policy, procedure, interaction with other areas of HAS and analysis of data) was effective.	October 2017	The control framework in place ensures Direct Payments are set up and used correctly in the majority of cases. The applications process and initial assessment of Direct Payment customers provided sufficient control and choice. There was potential for improving the integration and knowledge between some Direct Payment advisors and social care workers. The monitoring of Direct Payment accounts requires some improvement. Whilst effective monitoring was seen widely from the sample of cases we reviewed, some cases required more frequent monitoring than was taking place. Direct Payment clients were unable to employ personal assistants when they were the most appropriate and flexible option of care.	**One P2 and five P3 actions were agreed** **Responsible Officer: Direct Payment Team Leader** The DP procedure requires all reviews to be conducted jointly by DP Advisors and Social Care workers. Successful work has been completed in the Selby area focusing on realigning reviews to ensure they are conducted jointly. DPSS Team Leaders plan to ensure this practice is embedded countywide. Workshops were undertaken in September 2017 to review the monitoring process. A new process and plan was to be implemented. The level of frequency was also to be reviewed. The 'Make Care Matter' proposal aimed to raise awareness about adult social care, including a platform to advertise for personal assistants. We have also introduced a new Approaches - Pilot underway
C	Controls for Residential Care	Reasonable Assurance	The County Council pays towards the residential or nursing care of over 2,000 people at an annual cost of approximately £63 million. It is important that information about deaths is communicated to	October 2017	Providers were not routinely notifying the council of deaths within the 48 hour contractual period. Of the 51 deaths reviewed, only 16 had been notified within 48 hours. There was no consistency to how	**Five P2 and two P3 actions were agreed** **Responsible Officer: Benefits, Assessment and Charging Manager and Quality Assurance Manager**

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
			the Council and between departments, and that systems are updated accordingly. The audit reviewed the procedures and controls in place that ensure: • Information on residential care deaths was being promptly provided to the Council and effectively processed and updated through all relevant Council systems • Scrutiny of bed returns information was up to date, robust and issues of incomplete/out of date returns were being appropriately managed and escalated.		deaths are reported to the council. The wording of the contract means any contact with the council will mean the home has complied with its contractual obligations. Once the 'Tell Us Once' death notification is received by the council, the relevant details are not being processed onto Liquid Logic in a timely manner. Entering a date of death into Liquid Logic also does not stop payments being made. Providers were not always submitting the Bed Returns to the council. In addition, the council was not always processing the information contained within the Bed Returns submitted by the providers. The checking process before sending out the following four weekly Bed Returns was not always being completed effectively. One example was found where the council had failed to end payments to a home for a service user, despite being notified of the death on five Bed Returns.	The audit has raised awareness of the terms and conditions of the contract. A bulletin has been sent to providers to reinforce the message that providers must comply with the terms and conditions of the contract. The BACS Manager has reinforced the need for BACS staff to be notified of deaths so appropriate action can be taken. Work is ongoing with the General Manager, Registrars, Archives and Coroners to develop a process whereby registrars will notify NYCC of all deaths on regular basis. There is awareness of the weaknesses in the bed returns process. Some procedures have changed over the last year with a view to improving the situation. A lack of resources has contributed to some of the issues. The BACS manager is to work with other officers in the Council to help make further improvements in the sending of letters to providers.
D	HAS Debt Management	No opinion given	Senior HAS management requested a review in order to better understand the factors which have contributed to debts being written off or taking a	November 2017	A number of control weaknesses were identified. Financial assessments were not always being completed in a timely	**Six P2 actions were agreed** **Responsible Officer: Assistant Director Strategic Resources**

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			significant amount of time to collect. The review considered whether: • The processes in place for debt recovery were efficient • Invoices were being written off when appropriate and following the correct procedures • Credit Notes were being correctly raised. The review tested a sample of debts being dealt with in Credit Control and three specific cases requested by management. No opinion was given due to the targeted nature of the audit work.		manner resulting in clients accumulating a high value of backdated debt. Invoices were also not being issued in a timely manner from the date of the financial assessment. There are a number of cases where debt has been incurred through financial abuse. In one case a social care worker put the client's account on hold for a four month period so debt accumulated. This was due to some poor internal communication. One of the debts in the sample tested had numerous time delays between each part of the process until resolution. For the sample tested, debts had been written off at an appropriate level and credit notes had been used appropriately to correct errors in the issuing of invoices.	The findings helped support internal work on the corporate review of income and debt management which HAS Leadership Team were considering. Heads of Service have reminded staff of the need for timely referrals for financial assessments to be made. A reminder has been issued by Head of Quality and Monitoring to providers regarding their obligation to report changes including non-payment of contributions by the client. Credit Control now have 'read only' access to LLA and ContrOCC All staff have been reminded of the need to report suspected financial abuse, whether through Safeguarding or direct to the relevant manager.
E	Public Health	Substantial Assurance	The Public Health team have produced a new strategy to help reduce the rate of obesity in North Yorkshire. The Council also re-commissioned the smoking prevention service to help support	December 2017	We found the Public Health Team has plans were in place to respond to public health incidents. These have been co-ordinated with Emergency Planning and Public Health England.	**Three P3 actions were agreed** **Responsible Officer: Health Improvement Manager** Public Health and the Contracting

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			delivery of the Tobacco Control Strategy. The audit reviewed the procedures and controls in place to ensure: • The council has appropriate plans to prepare for and prevent public health incidents, which are co-ordinated with other agencies • Plans were in place to deliver and monitor the strategy for Healthy Weight, Healthy Lives: Tackling overweight and obesity in the North Yorkshire 2016-2026. • The new model for reducing the levels of smoking was effectively monitored and has appropriate performance mechanisms.		Progress has been made in delivering projects that contribute to the overall identified priority areas for the Healthy Weight, Healthy Lives Strategy. The strategy has a plan for clear governance arrangements. Solutions4Health (S4H) was awarded the contract for the new smoking prevention service. However, S4H had not been fully meeting the performance requirements set out in the contract. There was no control in place to validate S4H clients that receive remote support, to ensure the client and their details are genuine. The council has taken action to support and challenge S4H to address the poor performance. We also completed some additional audit checks which found errors with the payments by results claim form.	Team were working with S4H to identify additional controls to improve validation checking of performance data to help prevent a similar incident from occurring again. All S4H clients are now required to take a Carbon Monoxide meter reading. This test will help to support claims that the client has stopped smoking. Management were also considering carrying out spot checks to provide additional insight and/or assurance on the contract as/when required. Improvements to the claim form and process have been made.
F	Care Market Failure	Substantial Assurance	The Care Act requires a local authority to promote the efficient and effective operation of a market in services for meeting care and support needs. Failure of the care market is also on both the HAS and corporate risk register. The audit reviewed procedures	April 2018	Officers demonstrated a good understanding of the Care Act. Risk reduction actions appeared appropriate and were consistent with what the council must do to ensure compliance with the Act. The Quality and Monitoring team have developed an approach and system to react to any Market Failure.	**One P2 action was agreed** **Responsible Officer: Head of Quality Monitoring** The Market Position Statement will be updated.

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			and controls in place to ensure: • The council is complying with the statutory obligations of the Care Act 2014 in relation to the social care market • The authority has mitigating actions to effectively reduce the risk of market failures and these actions are being monitored sufficiently. • The risk management processes are then used to influence future planning.		The 2020 programme has implemented measures with a view to supporting people to remain within their own home and thereby staying out of care. There are initiatives in place to develop the resilience of the workforce and encourage recruitment in required areas; for example the developing of a 'heat map' and organised roadshows. The council is also developing methods of making recruitment easier and streamlined for providers. The Care Act 2014 requires local authorities to develop a Market Position Statement. Whilst the council had a written statement, it had not been updated since 2013.	
G	Learning Disability Accommodation	Substantial Assurance	NYCC are carrying out a full review of Learning Disability Accommodation and Care and Support with a view to ensuring the services provided are both compliant with the Care Act and meet the requirements of other legislation. The audit reviewed procedures and controls in place to ensure: • A robust plan was in place to	May 2018	Good progress has been made creating the Supported Living Pathway document and establishing appropriate governance arrangements. The Transformation Plan maps out the six work streams and logs the actions to be completed at each stage. Risks had been considered and an awareness of key risks has been demonstrated. However, at the time of audit the outcomes from this work had not been completely documented.	**Three P3 actions were agreed** **Responsible Officer: AD Commissioning and Quality & Head of Commissioning** A Risk log will be developed including mitigations. Risk and issue management is to be incorporated into formal project governance through the 2020 programme. Information requirements will be

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			achieve the new procurement arrangements for accommodation • The council was identifying and managing the key risks to the future ways of working for Learning Disability Accommodation and Care and Support		Data to help support decisions on the Learning Disability project has been a difficult to obtain. Further work will be required to analyse the data and to create meaningful information. The Council may require some additional skills and/or support to help progress the scheme.	prioritised. We will work on the basis of known current needs initially based on collated understanding of individual needs. We will work with Public Health to use the planned JSNA on Learning Disability to identify and analyse information. We will agree the scope of the next phase of Strength Based Assessments and establish appropriate project governance. We will consider if additional project resource is needed.
H	Financial Assessments	Substantial Assurance	The completion of a timely financial assessment is an important part of the care process. We reviewed the procedures and controls for financial assessments to assess whether: • Sufficient evidence was provided by the client to justify the outcome of the assessment • Assessments were being completed in a timely and efficient manner (subject to external influences) • Performance was monitored	June 2018	Charging policies cover all areas of social care. Detailed guidance is available for staff to assist with the completion of financial assessments. Assessments were up to date and there was no backlog An Assessment and Appointment module went live from February 2018. Appointment letters are now auto-generated by ContrOCC and additional information will be able to be extracted for reporting purposes. The annual uplift procedure has continued to improve over the last 5 years. Although the client uplift was applied in May 2018 this was earlier than in previous years.	**Three P2 actions were agreed** **Responsible Officer: BACs Manager** Those annual uplift proformas that have not been returned for 2 or more consecutive years will be chased up. We will then update the capital information. We will look at devising a performance measure which is produced directly from ContrOCC and which can record time taken for a financial assessment to be completed (whilst excluding any of the outside influences which are outside our control and which might skew the data). Declarations are already being reviewed as part of the GDPR

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					The capital elements of some financial assessments are not being updated regularly. A significant number of clients (20%) do not return their completed pro-forma and the council does not challenge these clients any further. Generally there was no undue delay to the completion of the assessments. Delays are sometimes inevitable depending on the availability of relatives and advocates. However, target times have not been set for the completion of financial assessments. Signed declarations are not always obtained from clients or their representatives.	compliance work. We will issue a reminder to staff to obtain a signed declaration and to enter a diary date to chase this up where a declaration has not been obtained.
I	Direct Payments (2017/18)	Reasonable Assurance	We reviewed the Direct Payment system to ensure: • The monitoring process for Direct Payments is consistent and sufficient for Direct Payment clients. • Support Plans are consistent and effective for Direct Payments clients. • The Direct Payment Support Service (DPSS) monitors and processes payments effectively	July 2018	The control framework helps to ensure Direct Payments are set up and used correctly, in the majority of instances. The majority of the issues found in the audit were linked to the one case referred by Veritau's Fraud team. We noted some cases did not have an immediate handover between Direct Payment Advisors (DPAs) Some DPAs are unable to effectively escalate their concerns with the administration or management of the Direct Payment.	**Three P2 actions and seven P3 actions were agreed** **Responsible Officer: Assistant Director, Inclusion (CYPS) and DPSS Manager** Improvements will be made to address the specific issues identified with the case in question. A change in process for managed accounts was implemented in October 2017. A formal transition process will be

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			The audit reviewed a sample of both Children's and Adults Direct Payments. One case was referred to the Veritau Fraud Team for further investigation.		There were inconsistent levels of documentation saved on Liquid Logic.	written and agreed between HAS & CYPS. Payments for all DPs to be made via ContrOCC. CYPS assessment staff will complete the HAS DP training package, with a focus on support plan completion.

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.