NORTH YORKSHIRE COUNTY COUNCIL

AUDIT COMMITTEE

25 OCTOBER 2019

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 2019 for the Health and Adult Services Directorate (HAS).

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 Health and Adult Services Directorate (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 work of internal audit is reported in accordance with an agreed programme of work with this report covering audits finalised in the year to 31 August 2019. 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 2019

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 a number of other areas of work in respect of the directorate. This work has included:

(a) Investigating cases that have either been communicated via the Whistleblowers' hotline or have arisen from issues and concerns referred to Veritau by HAS management.
(b) investigating data matches received from the National Fraud Initiative (NFI). These matches can indicate possible fraud or error.
(c) providing 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**. Where the audits undertaken focused on systems development, the review of specific risks as requested by management or value for money then no audit opinion has been given.

3.4 It is important that 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.

[1] For the County Council this is the Head of Internal Audit.
[1] For the County Council this is 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

10 October 2019

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 2019

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
A	Visits to care provider establishments: • Camphill Village Trust (Botton Village) • Stepping Stones (Skipton) • Avalon and Shared Lives (Botton Village) • Castle Grange (Scarborough)	Various: 1 x Substantial Assurance 3 x No opinion given	The audits were tailored to the risks highlighted in respect of each provider. A variety of work has been undertaken including the review of: • Previous findings to establish whether agreed improvements have been made • Arrangements for managing and safeguarding the financial affairs of service users • Financial controls to ensure they were in place and operating effectively. • Controls to ensure the property of service users is protected.	Various	At Camphill Village Trust there had been an improvement in the governance of residents' finances. There was now a suitable policy and scheme of delegation in place, which if enforced, will provide the necessary level of control. At Stepping Stones we helped to reconcile the financial accounts so these were accurate. We also highlighted weaknesses in the cash handling processes. At Avalon we found good progress had been made in the handover of all customer information and in the practical arrangements for managing and safeguarding the financial affairs of service users. At Castle Grange we found no issues.	**Two P3 actions were agreed - Stepping Stones (Skipton).** **Responsible Officer: Learning Disability Manager, Care and Support, Care and Support Provider Services.** The processes at Stepping Stones will be reviewed. This will include the possibility of transferring responsibility for invoicing to NYCC Finance and the closure of the community fund. The manager will implement the agreed improvements in cash handling.
B	Financial Safeguarding Procedures	No opinion given	We reviewed a specific financial safeguarding case to assess if internal procedures had been followed and whether there were any areas for improvement.	October 2018	We found officers had followed the correct internal policies and procedures. The complexities of the case has however helped to raise awareness of	**No actions for improvement were highlighted.**

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
					some of the potential risks in financial safeguarding cases.	
C	Scarborough Mencap	No opinion given	Scarborough Mencap deliver a range of services for the Council including day care, respite care and flex-support in homes and the community. Services are provided through Individual Service Contracts (ISC) or through Direct Payments. The audit reviewed the following areas: • Financial procedures and controls • Budget/cash flow projections/forecasting • Improvement plans / support for the financial and other changes required for the business • Governance arrangements The audit was a follow up visit following work completed in 2016/17.	November 2018	Some improvements had been made since the previous audit visit. An action plan had also been prepared by Mencap to help implement the agreed actions from the previous audit. Mencap had completed a review of financial procedures. Invoicing procedures now include the required controls. Security practices have also been updated to manage the risk of further financial abuse. However, key financial procedures and controls such as bank reconciliations, and a scheme of delegation were not in place. Management accounts and the annual financial statements were also not being completed promptly. An annual budget for 2018/19 had also not been prepared. A Business Improvement Plan for 2018-2020 had been prepared. However, it was not possible to assess whether the plan would deliver the required changes. There were clear governance challenges for the organisation with a small number of trustees and difficulties in attracting additional skills.	**Seven P2 and four P3 actions were agreed.** **Responsible Officer: Quality Assurance Manager** Progress on the actions was being considered by HAS officers, alongside their own improvement actions. Regular meetings are being held between representatives of NYCC and Scarborough Mencap. These meetings are focused on the steps being taken by the Provider. The SAGE System is now being used and financial arrangements are in place having been transferred to the Finance Administrator. The Scarborough Mencap Finance Administrator has since finalised the accounts.

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D	Deprivation of Assets	Substantial Assurance	Financial assessments are undertaken for service users to calculate their health and social care contributions. In some cases an individual may try to avoid paying for care and support costs by deliberately depriving themselves of assets. We reviewed the procedures and controls in place to ensure: • that where asset deprivation is detected it is investigated appropriately and consistently. • sufficient evidence is obtained to identify cases where there may be deprivation of assets. • decisions are recorded and evidenced.	December 2018	All cases reviewed were accurately identified by the BACS team and the correct capital analysis was performed. There was sufficient evidence obtained to identify and evidence cases of possible deprivation. In one case the council was not using the most cost-effective method to recover the funds. In another case there was no deprivation decision record, notice of deprivation decision, letter notification or financial assessment recorded.	**Three P3 actions were agreed.** **Responsible Officer: BACS Manager** Team managers were reminded to reflect the recovery method in the decision record. This includes recording whether they have applied Section 69 or Section 70 of the Care Act when making recovery decisions. Relevant officers were reminded to ensure that all relevant documents are saved into ContrOCC.
E	Public Health	High Assurance	We reviewed Public Health services to ensure: • Savings plans had been prepared, the plans were reasonable and monitoring arrangements were in place	May 2019	There was a comprehensive savings plan which had identified a list of savings options to help achieve a cumulative balanced budget by 2020/21 and an ongoing balanced budget from 2021/22.	**No actions identified.**

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
			to help ensure savings could be achieved. • Processes for requesting and completing public health data intelligence requests were robust. • Monitoring and reporting arrangements for training for a specific provider were effective.		This plan was being monitored on a regular basis by Finance. There are frequent progress meetings being held, including with the Corporate Director of Health and Adult Services and the Director of Public Health. We found the process for requesting and completing public health data intelligence requests was robust. We reviewed the monitoring and reporting arrangements for training delivered by Drugtrain for the North Yorkshire Alcohol Strategy. There were effective systems in place to monitor the delivery of training against outcomes.	
F	Deferred Payment Agreements	Substantial Assurance	A Deferred Payment Agreement (DPA) is an arrangement between the Council and a service user to use the value of their homes to offset the cost of care fees. The Care Act 2014 sets out the criteria a local authority must follow when setting up a deferred payment agreement with service users. A DPA provides service users with the option to not be forced to sell their home during their lifetime to pay care home bills.	May 2019	We found effective controls were in place to help ensure DPA's were completed in line with the Care Act and were being monitored. Before a service user enters into a DPA they are provided with guidance and advice about paying for care. The Council completes financial assessments to ensure service users have sufficient assets to fund the cost of their care. The Council does not always obtain evidence that the service user has an	**One P2 action and three P3 actions were agreed.** **Responsible Officer: Benefits, Assessments and Charging Manager** The client information pack will be updated to inform service users that they must send a valid insurance certificate for any asset used as security. The council will also request individuals with a DPA to send a valid insurance certificate on an annual basis.

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			The audit reviewed whether: • Deferred Payment Agreements were compliant with the Care Act. • There was an effective and efficient process in place for creating, monitoring and recovering deferred payments.		up to date insurance policy in place for the asset(s) they are using as security. Details for all DPA cases are manually recorded, managed and monitored using a spreadsheet. Information is also recorded in ContrOCC. However, ContrOCC is not able to be used to manage cases. The spreadsheet is also used and updated by a number of people, which increases the likelihood of inaccuracies and error.	There has been ongoing work to increase the functionality of ContrOCC. Once this work has been completed, the spreadsheets will no longer be required for monitoring purposes.
G	Direct Payments	High Assurance	We reviewed the Direct Payment system to ensure: • Payments were made accurately and in a timely manner. • Monitoring of direct payment accounts were performed appropriately. • Possible fraudulent use of direct payments was identified and reported to Veritau's fraud team. • Progress has been in implementing previously agreed actions	April 2019	In the majority of cases Direct Payments were processed in an accurate and timely manner. Monitoring had also been undertaken in a timely manner for most of the Direct Payments reviewed. We reviewed 20 cases where the service user was potentially in receipt of both Direct Payments and support for being in residential care. We found no significant issues. Good progress has been made in implementing previous audit actions. A new policy has been introduced to allow DPAs to escalate their concerns about the use of Direct Payments. A Disabled Children's Services policy is also due to be introduced in Autumn 2019.	**No actions identified.**

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H	Solutions4Health	No opinion given	Solutions4Health ran the North Yorkshire Smoke Free Service from December 2015. The Council decided to take the contract back 'in house' from 1 April 2019. As part of the transfer process, the Council reviewed all operational areas. As part of this process several discrepancies were noted the 2018/19 invoices. We therefore reviewed Solutions4Health 2018/19 invoices to ensure: • invoices being received from Solutions4Health were in accordance with the contract • the correct payments had been made to Solutions4Health	July 2019	Our review of Nicotine Replacement Therapy (NRT) invoices noted that Solutions4Health purchased NRT products at one rate and then uplifted the rate charged to the Council. The uplift percentage rate Solutions4Health used generally varied from 11% to 43% between the individual NRT products. The correct level of uplift was not specified in the contract. Payments made in 2018/19 matched the Solutions4Health invoices received. However, a full set of delivery notes was only available for two of the invoices.	**One P3 action was agreed.** **Responsible Officer: Senior Quality Assurance and Contracting Officer** The Senior Quality Assurance and Contracting Officer has been raising queries with the organisation and ensuring final payments take into account the issues raised by the audit. There is also future learning for contract management that goes wider than this service and the public health team. This will be picked up by contracting teams.
I	Liquid Logic – Access Controls and Data Reporting	No opinion given	The purpose of this audit was to review: • Access controls and security settings for both the Liquid Logic and ContrOCC systems, and to assess whether they complied with the Corporate IT Access Policy.	July 2019	No issues were found regarding access controls for Liquid Logic and ContrOCC. There was good awareness within the directorate about the importance of data quality. Internally a number of areas to improve data reporting had been identified. For example, the Liquid	**One P2 and four P3 actions were agreed.** **Responsible Officer: AD – Care and Support, ABC Project Sponsor, Head of Data and Intelligence, and HAS Data Governance Lead** The Data Quality Improvement Plan which has been commissioned will

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
			• Whether the management information reported from the Liquid Logic and ContrOCC systems to the HAS directorate was complete and accurate. The review also helped Veritau to gain a better understanding and knowledge in the reporting capabilities of both the systems to help inform future internal audit work.		Logic and ContrOCC Business Development Officers have produced a programme of work. The timescales to deliver these improvements however needed to be finalised. Both Liquid Logic and ContrOCC include a number of generic reports as well as the facility to produce tailored ad hoc reports. These reporting facilities were not regularly being used. A number of Liquid Logic performance dashboards have been made available. These are potentially beneficial as teams will have easy access to up to date information. However, some operational teams have a lack of understanding of the benefits of the performance dashboards that are being developed. It was noted that Deprivation of Liberty Safeguards (DoLS) and Livingwell cases are being managed using spreadsheets.	detail the approach, the required quality outputs, and review mechanisms to deliver improved data quality. We will look at which reports are required now and in the future. The audit work will also be used to inform future systems development. The use of the dashboards will be encouraged. For DoLS we will consider a 'portal' that will provide HAS with the functionality it needs to drive forward a) its digital ambitions, for example online self or supported assessments and b) enhance partnership working. The Living Well dashboard will be reviewed to help deliver improvements.

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.