NORTH YORKSHIRE COUNTY COUNCIL

AUDIT COMMITTEE

14 DECEMBER 2020

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 period from 1 September 2019 to 31 October 2020 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 14 months to 31 October 2020. The second part is presented by the Corporate Director and considers the risks relevant to the directorate and the actions being taken to manage those risks.

3.0 WORK DONE DURING THE 14 MONTH PERIOD ENDED 31 OCTOBER 2020

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.

(d) Discussing and offering feedback on ongoing risk areas such as the Transferring of Care Programme (TCP) and the Harrogate Adult Community Services Health and Social Care Integration.

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 RECOMMENDATION

4.1 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 November 2020

BACKGROUND DOCUMENTS

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

Report prepared by Stuart Cutts, Assistant Director – Audit Assurance, Veritau and presented by Max Thomas, Head of Internal Audit, Veritau

Appendix 1

FINAL AUDIT REPORTS ISSUED IN THE PERIOD ENDED 31 OCTOBER 2020

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
A	Visits to Care Providers: • Autism Plus (Larch Rise, Easingwold) • Wilf Ward (Palace Road, Ripon) • Independent Home Living (Scarborough)	No Opinion Given	A variety of audit testing was undertaken covering the key risks relating to each care provider. Work included: • Providing advice and guidance on financial procedures for residents' finances • Reviewing previous audit findings to establish whether agreed actions had been implemented • Reviewing arrangements for managing and safeguarding the financial affairs of service users • Reviewing the financial stability of a domiciliary care service.	January 2020 March 2020 July 2020	Two visits were made to Autism Plus in 2019 to assess and support improvements to the financial procedures used for residents' finances. Areas for improvement were highlighted covering financial procedure and contractual areas. At Wilf Ward, the management of service users' financial affairs was reviewed. Findings were raised regarding poor management of the joint household account, unauthorised expenditure on a resident's bank card, and expenditure which exceeded a resident's income. We reviewed the financial stability of Independent Home Living (IHL). Supporting information was provided to the Council. No significant issues were highlighted.	**Actions were agreed (Autism Plus).** **Responsible Officer: Assistant Director, Commissioning and Quality.** All seven actions raised in our visits at Autism Plus have been addressed. At Wilf Ward the provider has put in place improved arrangements which will be monitored by the council's Quality and Market Improvement Team. The Quality and Contracting Team has been working with the registered manager at IHL to monitor the service.
B	Payments for Residential Care	Reasonable Assurance	Notifications of the deaths of people in residential care should be communicated to, and within, the Council in a timely manner in order for systems to be updated and for payments to be stopped.	December 2019	We found that many residential care providers still do not comply with the requirement to notify the Council of a death within 48 hours. There was also no consistency regarding who within the Council the death was reported to.	**Four P2 and one P3 actions were agreed.** **Responsible Officer: Assistant Director, Strategic Services.** Regular reminders are now being included in the Provider Bulletins

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
			The audit reviewed whether the procedures and controls in place ensured that: • Information regarding deaths was promptly provided to the council and effectively processed • Information regarding bed returns was up-to-date and managed appropriately.		Each resident should receive an annual review by a member of the Social Care Operational Team. The annual review could highlight any changes in circumstances that have otherwise not been reported. Only 60% of resident annual reviews were completed during 2018/19. Client contributions should only be paid up until the date of death. The audit found out some providers were paid until the date the case was closed on the system and not the date of death. This resulted in overpayments to the providers. The escalation process for chasing bed returns was not always applied consistently across the council. Some care providers did not always supply the occupancy details which are requested on the bed returns.	about notifying the Council of deaths within 48 hours. Performance targets are now set for the completion of resident annual reviews. A provider portal has been implemented which will help remedy the issues on inputting dates into Council systems. The escalation process has been reviewed and information is now held in a central location. Reminders are sent out periodically and bed return reports can now be generated through the ContrOCC system.
C	Baseline Assessment of Care Providers	Reasonable Assurance	Baseline assessment visits review a number of areas to ensure that the care provider is following the contract provisions agreed with the Council. The audit reviewed whether • Visits were prioritised and scheduled appropriately	December 2019	It was found that the process for selecting providers to visit did not incorporate an assessment of key risks to the service. A contract and service specification is in place with each care provider. A scoring tool has been recently implemented to measure compliance with the service specification during	**2 P2 and 2 P3 actions were agreed.** **Responsible Officer: Assistant Director, Commissioning and Quality.** Findings raised in this work were considered and addressed in this review.

	System/Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
			• Appropriate contract management arrangements were in place • Visit information was reported correctly and promptly • Resulting actions were performed in a timely manner		baseline assessment visits. The scoring tools used for baseline assessment visits have been applied consistently. Visits are the primary contract management tool to ensure providers comply with their service specification. Section 12 outlines the quality control measures providers are expected to comply with. The council was not regularly gaining assurance that these measures were being carried out, and formal quality assurance was not taking place outside of the visits. Visit information was not adequately distributed within HAS. It was not used for managing risks, wider decision making or for prioritising further visits. There is no formal procedure in place to ensure recommended actions are followed up.	A baseline assessment review has been completed with new pathways developed for the improved baseline assessment processes. Additional Quality Improvement resources and a dedicated support team for care homes has also been provided.
D	Suspension Process	Substantial Assurance	The HAS Directorate maintains a list of approved providers. Where the quality of service provided is not in line with expectations, providers may be suspended from the list or framework agreement. The audit reviewed whether the: • Policies and procedures were fit for purpose	December 2019	Good procedures are in place for establishing the basis for suspensions and for monitoring progress against improvement action plans. Our review of three providers found there was appropriate grounds for the initial suspension and the providers were notified of their suspension in a timely manner.	**1 P3 action was agreed.** **Responsible Officer: Assistant Director, Commissioning and Quality.** The suspension process was due to be reviewed as part of the wider review of the Quality and Market Improvement Team and the Quality Pathway work. That

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			• Appropriate governance arrangements were in place to monitor and review suspensions.		Suspension reports were compiled and approved by the Assistant Director promptly. Once suspension had been agreed, all providers had action plans to implement to addresses weaknesses and these were monitored effectively by the Council. As part of the current suspension process, the Assistant Director - Commissioning & Quality makes all final decisions regarding suspension cases. This results in a lack of independence, particularly in appeal cases, as the Assistant Director is required to scrutinise their own decision making. Management are aware of this issue and highlighted it to us as a concern during the course of the audit.	work has been delayed as a result of Covid-19 pandemic. Interim measures have been implemented to ensure that any appeals to suspension are recorded through the governance team and reviewed independently. There is also now a template in place to standardise suspension reports and enable appropriate decision making.
E	Hardship Process	Reasonable Assurance	In some circumstances, care providers can submit a request to the Council for a financial hardship review. The audit reviewed the Financial Hardship process to assess whether: • The existing processes and procedures were appropriate and operating as expected • Sufficient information is obtained and considered during hardship case reviews.	December 2019	Guidance was available to providers requesting a hardship review however it did not stipulate the information required by the Council. The existing process for completing hardship reviews is not documented. Timescales and expectations for the reviews had also not been agreed by Quality & Market Improvement and Central Finance. The results of reviews are documented in a financial assessment report and sent to the Assistant Director of	**3 P2 actions were agreed.** **Responsible Officer: Assistant Director, Commissioning and Quality.** New process to include wider governance processes and decision making on hardship are expected to be fully completed by March 2022. Financial hardship matters linked to Covid 19 are being fully considered and assessed by the

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					Commissioning & Quality for review and to enable a decision to be made. However only financial information is included in these reports. Non-financial but potentially relevant information is not routinely provided.	Councils Supply Chain Resilience Board.
F	Public Health	High Assurance	The audit reviewed whether the procedures and controls in place ensured that: • Payments under public health contracts accurately reflected the costs paid by other public bodies • Contract management specialists are used to support public health staff in drafting contracts for service provision with third parties; • Suitable arrangements existed to ensure service continuity could be maintained once the ring-fence for the Public Health Grant ended on 1 April 2020.	March 2020	Payments were reviewed relating to three large Public Health contracts. Each payment had been correctly checked, authorised, and recorded in the Council's systems. A sample of additional, smaller payments were also reviewed. Each of these agreed with the terms of the contract, or the relevant national rates. For each contract reviewed, contract documents had been produced with support from the Council's Legal and Procurement Services. Performance is reviewed quarterly in accordance with the terms of the contract by the respective Contract Manager. From 2023/24, the Council has decided that only the government grant will be used to fund annual expenditure on Public Health services. Meetings have taken place during the past 12 months and plans are in place to agree how expenditure will be reduced over the coming three years and how suitable service levels will be maintained.	**No actions were agreed.** **Responsible Officer: Director of Public Health.**

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					It is expected that Public Health will be required to save around £3m over the three year period. This equates to approximately an eighth of the current budget, which could result in a reduction to some non-statutory services. Arrangements are being made to help manage these changes.	
G	Financial Assessments	Substantial Assurance	Approximately 6,000 financial assessments are completed in each year in respect of adult social care. It is important for assessments to be completed in a timely manner to prevent delayed invoices and customer complaints. The audit reviewed whether the procedures and controls in place ensured that: • Declarations had been signed and completed accurately; • Appropriate checks were performed and sufficient evidence was maintained; • Assessments were being completed in a timely manner.	July 2020	In the majority of cases we found case records in line with expectations. However declarations are not always signed or returned by clients, and some are not being uploaded onto the ContrOCC system. While guidance has been issued, there is no formal procedure in place to ensure that declarations left with, or posted to, clients, are pursued when they are not returned. Calculations and disregards were reviewed for accuracy. All of the cases where the confirmation letters could be seen appeared to have been correctly calculated. There was no internal timescale to guide how long assessments should take from referral to completion.	**1 P2 and 2 P3 actions were agreed.** **Responsible Officer: Assistant Director, Strategic Resources (HAS), Central Services.** Further reminders were sent to all Benefits, Assessment and Charging Service (BACS) officers outlining the actions to take to ensure that declarations are signed and returned where possible, and providing guidance as to what information should be recorded and where. A new alert system has been introduced into LLA to prompt operational teams to make referrals in a timely manner. The team are developing standards to identify agreed timescales in a more formal manner.

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 for audits completed in 2019/20 was 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.