NORTH YORKSHIRE COUNTY COUNCIL

AUDIT COMMITTEE

13 DECEMBER 2021

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 October 2021 for the Health and Adult Services (HAS) 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 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 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 YEAR ENDED 31 OCTOBER 2021

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:

- Investigating cases that have either been communicated via the Whistleblowers' hotline or have arisen from issues and concerns referred to Veritau by HAS management.
- Meeting with HAS management and maintaining ongoing awareness and understanding of key risk areas such as the Approved Provider Lists, Public Health, Partnerships and integration with Health bodies, and Market Failure in the Care Market
- Investigating data matches received from the National Fraud Initiative (NFI). These matches can indicate possible fraud or error.

- Completed a review of Henshaws (a charity supporting people with sight loss and a range of other disabilities) which was requested by the Director of Health and Adult Services.
- Providing support to directorate management in respect of a number of safeguarding alerts, provider 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. The work completed for the directorate and the opinions given following each audit contribute to the annual report and opinion of the Head of Internal Audit.

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 note the results of internal audit work performed in the period for the Health and Adult Services directorate.

Max Thomas
Head of Internal Audit

Veritau Ltd
County Hall
Northallerton

25 November 2021

BACKGROUND DOCUMENTS

Relevant audit reports kept by Veritau.

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 YEAR ENDED 31 OCTOBER 2021

	System/ Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
A	Extra Care Housing	Reasonable Assurance	We reviewed the Extra Care Housing processes and controls to ensure: • Robust and transparent governance arrangements are in place for managing Extra Care allocations. • Appropriate processes for scoring and allocating individuals are in place, and these are operating effectively and consistently.	February 2021	Appropriate governance arrangements for overseeing Extra Care allocations were found to be in place. Relevant information is communicated regularly to Senior Management and Members. Strategic matters are routinely discussed. Data on each schemes dependency levels are collated and reviewed annually. Appropriate processes were in place for allocating high needs individuals to Extra Care schemes and these were being followed. At the time of audit there was a lack of clear and comprehensive guidance for providers on how to store and maintain information. There was also no retention policy clarifying how providers should maintain and store documents. Our review of specific cases also found inconsistencies related to the	**1 P2 action was agreed.** **Responsible Officer(s):** Specialist Housing Development Manager Appropriate guidance covering storing and maintaining documents has been introduced which covers the areas raised in the audit.

	System/ Area	Audit Opinion	Areas Reviewed	Date Issued	Comments	Action Taken
					storing and maintaining of information.	
B	Mental Health Aftercare (s117)	Limited Assurance	Section 117 of the Mental Health Act 1983 (MHA) requires Local Authorities (LA) and Clinical Commissioning Groups (CCG) to provide or arrange for the provision of aftercare services for individuals who have been discharged, from having been detained under, qualifying sections of the Mental Health Act. The s117 process was reviewed to ensure: • Adequate management and governance arrangements were in place. • Only patients who were eligible received non-chargeable aftercare services under s117. • Aftercare plans were completed and properly	June 2021	We found that there was no central register or list of people flagged as being eligible for free s117 aftercare. The lack of a central register or list meant the service was unaware of how many people were eligible for, or receiving, s117 aftercare. A number of people marked as being eligible for free aftercare were found to have not been detained under a relevant section of the Mental Health Act. Some reviews of aftercare packages and s117 eligibility were not being carried out regularly and some reviews had not been appropriately documented. Aftercare plans were not always being completed correctly, in a timely manner, or at all in some cases. Some people were also not being discharged in line with the correct procedures, and some	**7 P2 and 1 P3 actions were agreed.** **Responsible Officer:** Assistant Director Care and Support, Health and Adult Services. A number of actions were agreed relating to each of the findings. They included a review of all cases identified during the audit and the development of a dashboard to assist with the management of s117. Work is ongoing with the Data and Intelligence Team and Business Support to develop the system and to review the financial claims process. Current guidance and practices are being reviewed and amended as

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			maintained for each person. • Aftercare provided was reviewed on a regular basis and ended where appropriate. In 2018 the council updated the expected management arrangements for s117 cases. Guidance was further developed and all relevant staff received updated s117 case training.		decisions were not always documented. Some people eligible for free aftercare were being charged to receive these services, and some were not being charged when it appeared they should have been. Instances of poor record keeping and a lack of use of the system were seen. We also saw cases of ineffective joint-working between the council and the Health Service. We tested a significant number of cases in detail. There was an improvement in the quality of the more recent (post-2018) cases, compared to those before the updated management arrangements were put in place. The council is part way through revisiting the older cases and our detailed review was designed to help support and accelerate that work.	needed. A process will also be agreed with the Engagement and Governance Team to ensure complaints are passed to relevant people. The review process is being evaluated and work with operational teams is in progress to ensure outstanding reviews are completed in a timely manner. A data cleanse of the system is being performed, to be supported by quarterly review and ongoing dip sampling to be completed moving forward. All actions have an implementation date of 31 March 2022. Work is well underway to help ensure the areas for improvement highlighted in the audit are fully addressed.

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C	Adult Safeguarding	Reasonable Assurance	A revised four stage model for responding to safeguarding concerns was introduced in October 2019. We reviewed the council's arrangements for Adult Safeguarding to ensure: • The new four stage model for responding to safeguarding concerns has been successfully introduced into practice and is being followed consistently. • A person focused approach is evidenced throughout the process. • Statutory reports are produced that comply with established criteria and are submitted within the required timescales. • Improvements are considered through monitoring of cases and	July 2021	All of the cases we reviewed that had either a formal meeting or informal discussion had been handled appropriately in line with the new model. There was a clear, documented rationale for closing the enquiry, on either the enquiry or closure form. Safeguarding enquiries are categorised under four different 'enquiry types'. Enquiry types are reported internally at board meetings and as part of the statutory Safeguarding Adults Collection (SAC) returns. However, we found a significant number and percentage of some enquiry types were not being accurately recorded. A key aspect of the new safeguarding process is a person focused approach. No significant issues were found in the cases we reviewed, with the voice and wishes of the individual or representative being considered and documented.	**1 P2 action was agreed.** **Responsible Officer:** Adult Safeguarding Manager Guidance on the 4 different enquiry types was to be: • Re-issued in the System Communication Bulletin and Safeguarding Newsletter • Incorporated into the level 3 and level 4 Safeguarding Training for officers and Safeguarding Co-ordinators. • Presented at the Care and Support Forum where Safeguarding Co-ordinators attend and a summary of the findings of this audit will be shared.

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			post-implementation review.		To facilitate collection of the SAC return there is a dashboard which helps collate the necessary information. A Performance and Quality Improvement (PQI) group meets regularly to monitor compliance with the new process and legislation. The PQI group routinely review and validate safeguarding data and provide assurance to the North Yorkshire Safeguarding Adult Board At the time of the audit a post implementation review of the new process was ongoing, facilitated by Transformation & Change. Objectives of the review had been agreed with management.	• Discussed at the Enquiry Officer's Safeguarding Peer Support Sessions that are facilitated by Safeguarding Officers.
D	Domiciliary Care Payments and Contract Management - Royal Mencap Society	Limited Assurance	Mencap provides care in a number of supported living accommodation premises in Hambleton, Richmondshire, Selby and Harrogate. Expenditure by NYCC on	October 2021	Improvements in contract management and controls were found to be needed to help identify and manage delays in the process of agreeing Individual Service Contracts. To support this, better use of the	**3 P2 and 3 P3 actions was agreed.** **Responsible Officer:** Business Support Manager HAS

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			these contracts in 2019/2020 was £3.42m. We reviewed the systems in place to ensure: • The care in support plans was agreed, authorised, and delivered in line with the Individual Service Contracts (ISCs) • Individual Service Contracts, both new and amended, were issued to Mencap, signed and returned in a timely manner. • Efficient communication channels were in place between the various departments of the council and the provider • Mencap had controls in place to ensure that the specified services were being delivered as expected		Liquid Logic case management system was recommended. The date provided for the initiation of services on the Individual Service Contract (ISC) is set at the start of the process but not implemented until the ISC had been signed by the provider. We identified some significant delays in ISC's being signed. In one case, where there was a delay of 18 months before the ISC was signed, we found the agreed level of care had not been provided in the period. No single person at the Council or Mencap has responsibility for operational management of the contract or consulting/liaising with the other body. Nominating a single point of contact, particularly at the council, would help to improve information management and standards. There were instances where Mencap was not making amendments to e-invoices to	A 'Management Action Plan Summary' has been produced by HAS. This plan covers both the interim and long term actions, and seeks to address all of the findings raised during the audit. The council has set a deadline of 31 March 2022 to complete these actions.

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			The audit was requested by the council because there were some known issues with the existing arrangements.		reflect the actual care being provided. Council monitoring arrangements were not always highlighting or challenging these cases.	
E	Continuing Healthcare	Reasonable Assurance	NHS Continuing Healthcare (CHC) is a package of ongoing care arranged and funded by the NHS for adults who have been assessed as having a 'primary heath need' as set out in the National Framework. Eligibility is determined following the completion of the Checklist and Decision Support Tool (DST). We reviewed the council's arrangements on Continuing Healthcare to ensure: • The council was following the correct process between the referral for CHC eligibility and the completion of the DST,	October 2021	We found the council was supporting the CCG timescale of 28 days. Any delays were due to the Covid 19 pandemic, the individual being assessed being unwell or internal CCG delays. A sample review of current cases (when the centralised CHC team was in place) found more detailed system case notes, and more of the expected supporting documentation, compared to a review of cases before the establishment of the CHC centralised team. Up to date Care Act assessments were generally in place. However, there were various financial issues relating to joint funded claims, back dated claims, back dating CHC funding	**2 P2 and 4 P3 actions were agreed.** **Responsible Officer:** Service Manager – Continuing Healthcare and Section 117 Aftercare All cases highlighted by the audit will be reviewed. Joint reviews will be supported by the CHC Team and will pick up actions required to address missing information. Monitoring forms to track the process have been updated. A case file audit tool has been piloted and is to be introduced to help ensure all cases are appropriately supported.

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			and the process was completed within the Clinical Commissioning Group's (CCG) required timescales. • Where a client became eligible for full CHC status, a process was in place to ensure that any financial contribution by the client to the council ceased. • A joint review between the council and the CCG was undertaken within the necessary timescales for joint funded care packages. • Adequate management and governance arrangements were in place.		and the accuracy of notifications/case notes. For the majority of the sample joint reviews with the CCG were not taking place. There were also no written agreements between the council and CCG for the claiming of CHC funding. Other than this, adequate management and governance arrangements were in place. There were some limitations to the current reporting capabilities, particularly for fully funded CHC cases and for extracting data for historic cases.	A pathway is to be established for the CHC Team to complete reviews for Joint Packages of care with the CCG. Work will be done to complete a written agreement. It is anticipated all of these actions will be completed by March 2022. A Project Management Brief has been completed to consider the 'end to end finance pathway', to help provide clarity and guidance, to reduce risks across the claims process and to provide a transparent claims process. This work is planned to be completed by March 2023.

APPENDIX 2

AUDIT OPINIONS AND PRIORITIES FOR ACTIONS

Audit Opinions	
Our work is based on using a variety of audit techniques to test the operation of systems. This may include sampling and data analysis of wider populations. It cannot guarantee the elimination of fraud or error. Our opinion relates only to the objectives set out in the audit scope and is based on risks related to those objectives that we identify at the time of the audit.	
Opinion	**Assessment of internal control**
Substantial Assurance	A sound system of governance, risk management and control exists, with internal controls operating effectively and being consistently applied to support the achievement of objectives in the area audited.
Reasonable Assurance	There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified which may put at risk the achievement of objectives in the area audited.
Limited Assurance	Significant gaps, weaknesses or non-compliance were identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the area audited.
No Assurance	Immediate action is required to address fundamental gaps, weaknesses or non-compliance identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the area audited.

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.