Manchester City Council
Report for Information

Report to: Audit Committee - 26 November 2020

Subject: Adults Services Audit and Assurance

Report of: Executive Director Adult Social Services

Summary

This report provides Audit Committee with an update on progress in the implementation of outstanding audit recommendations across Adults Services.

Recommendation

Audit Committee is asked to consider and comment on the report.

Wards Affected: All

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Background documents (available for public inspection):

- Internal Audit Assurance and Outstanding Recommendations Monitoring Reports to Audit Committee 2018/19 and 2019/20
- Adult Social Care Improvement Programme: Audit Committee October 2019
- Adults Services Outstanding Audit Recommendations Report: Audit Committee 15 September 2020
- Budget Options Report Health Scrutiny Committee: 4 November 2020

1. Introduction

1.1. Over the last three years, Internal Audit have supported the ongoing process of improvement across Adults Services through the performance of audits and assurance reviews focused in areas of risk. Through the annual planning cycle a range of areas for detailed, independent assessment have been agreed and the findings and recommendations from these have informed management action and improvement planning.

1.2. As a result of this work Internal Audit have issued several limited assurance opinion reports containing high priority audit recommendations. Whilst progress has been made on developing solutions a number of actions have not been fully implemented. These have been reported regularly to Audit Committee as part of the quarterly Outstanding Audit Recommendations report.

1.3. In addition to regular Internal Audit reports, Audit Committee have been provided with updates from the Executive Director, Adult Social Services on the Adult Social Care Improvement Programme, the actions being taken to address recommendations and areas of remaining risk. Audit Committee have raised concerns over the low assurance opinions that continue to be received and the time taken to address areas for agreed improvement. A number of these recommendations and planned improvements remain substantially overdue and timescales have been further impacted by the redirection of resources to respond to the Covid19 pandemic.

1.4. This report sets out the key issues arising from the limited assurance reports where recommendations remain outstanding, the most recent Internal Audit assessment of implementation status and an update on planned actions to be taken to ensure these recommendations and risks are fully addressed.

2. Adults Audits Completed in the Last Three Years

2.1 Internal Audit have completed 18 audits and made 50 high priority recommendations for improvement across Adults Services in the last three years. Eleven of these audits have resulted in limited assurance with three moderate/reasonable and four substantial opinions. Four follow-up reports have also been issued.

2.2 Audits have focused on areas of concern and potential risk agreed between the Adults Services Leadership Team and Internal Audit. From a management perspective this work is intended to provide an independent assessment of assurance; and highlight gaps in systems of governance, management of risk and internal control that need to be addressed and where possible be integrated into the wider programme of service improvement.

2.3 The tables below summarise the current position on recommendations from each audit and highlights those that remain outstanding. In summary:

- 16 actions agreed in 10 separate audits are agreed as having been fully completed (Table 1).

- 15 actions agreed in 5 audits have not been fully completed and are shown as outstanding (Table 2).
- 7 actions agreed in 3 audits are not yet due (Table 3).

2.4 Sections 3-8 of the report confirm the most recent Internal Audit assessment and proposals for further action to assure implementation of agreed recommendations.

Table 1: Audits where no high risk recommendations were made or where all agreed actions have been confirmed by management and Internal Audit as complete

Audit Title	**Opinion**	**Actions Complete**
Contractor Selection and Award: Manchester Support for Independent Living *(May 2017)*	Substantial	N/A
Afghan Resettlement Project *(Oct 2017)*	Substantial	N/A
Client Financial Services Appointeeship Support – Cash Delivery *(Dec 2017)*	Limited	6
Contract Management: Homecare *(March 2018)* and Follow Up Audit (Dec 2018)	Limited	3
Manchester Health and Care Commissioning: Operational Plan *(Aug 2018)*	Substantial	N/A
Manchester Health and Care Commissioning: Governance *(Jan 2019)*	Moderate	2
Manchester Local Care Organisation: Governance *(Sept 2019)*	Limited	1
Manchester Health and Care Commissioning: Financial Framework Compliance *(Oct 2019)*	Substantial	N/A
Deprivation of Liberty Safeguards *(May 2019)* and Follow Up Audit *(June 2020)*	Limited	2
Disability Supported Accommodation Quality Assurance (Feb 2018) and Follow Up Audit (Sept 2019)	Limited	2
Total		**16**

Table 2: Audits where action to address high risk recommendations are overdue

Audit Title	**Opinion**	**High Risk Recommendations**		
		Made	**Actions Complete**	**Over due**
Transitions (*Feb 2018)*	Limited	5	2	3
Management Oversight and Supervisions (*April 2019)*	Limited	6	4	2

Audit Title	Opinion	High Risk Recommendations		
		Made	Actions Complete	Over due
Mental Health Casework Compliance (*April 2019)* and Follow Up Audit *(Jan 2020)*	Limited	8	2	6
Floating Support Team – Support to Homeless Citizens in Temporary Accommodation (*May 2019)*	Limited	3	2	1
Adults Services Improvement Plan (*Jan 2020)*	Reasonable	3	0	3
Totals		**25**	**10**	**15**

Table 3: Audits where high risk recommendations have been made but planned implementation dates are not yet due

Audit Title	Opinion	High Risk Recommendations		
		Made	Actions Complete	Not Yet Due
Safeguarding Casework Management *(May 2020)*	Limited	3	1	2
Manchester Health and Care Commissioning: Financial Sustainability Plan *(May 2020)*	Reasonable	2	0	2
Supported Accommodation: High Needs Decision Making (*Aug 2020)*	Limited	4	1	3
Totals		**9**	**2**	**7**

3. Transitions

3.1. From the Transitions audit report issued in February 2018 there are three major risk recommendations where a range of actions have been progressed but where work is ongoing. These relate to the need to develop the strategy and vision for transitions, to develop an operational plan to deliver the revised transitions offer and develop a suite of measures to support performance management of the service. These actions are all classed as partially complete by Internal Audit, in recognition of the reduction in risk from the position reported in the original audit and the work still planned to finalise and embed new arrangements.

3.2. An interim transitional policy was developed at the end of last year which detailed the vision based on National of Institute of Clinical Excellence (NICE) guidance and legislative requirements. An action plan was also developed by adult and children's social care and education to support the policy. Since

then, we have continued to work with other partners to understand and develop the various pathways required to ensure smooth transitions occur. We have developed some initial performance metrics, but this requires further development and needs to be embedded.

3.3. The strategy and vision will now need to be updated to reflect all the work that has been completed with the support of a new interim Service Manager post over the past year. We have also recruited a permanent member of staff to this role and they come into post in December 2020. This will help to embed the changes to the strategy, policy and action plan; and ensure effective communication between partner agencies continues.

4. Disability Supported Accommodation Quality Assurance Framework

4.1. An audit completed in February 2018 provided limited assurance that the Quality Assurance Framework for the Disability Supported Accommodation Service (DSAS) was operating effectively and in accordance with expectations to support delivery in line with legislation.

4.2. Two major priority recommendations were agreed for implementation by August 2018, to strengthen the tool and current audit process; and develop the wider quality assurance framework for the service.

4.3. A follow-up audit completed in September 2019 concluded that that both recommendations remained outstanding pending sign off and launch of the audit tool. Actions after the follow up audit were taken to ensure the two recommendations were completed with the audit tool operational by the end of 2019. The revised quality assurance process including guidance on service audits, moderation process and schedule of activity was subsequently signed off by the Adults Management Team by 31 January 2020.

4.4. The audit process was started, and some audits were completed but then action was paused. As a result, the process has not yet been fully embedded due to priority actions that had to be taken to respond to the Covid19 pandemic. The top priority has been to ensure the safety of citizens and staff and additional systems and processes have been developed and implemented with new controls in place to mitigate any increased risks of Covid19 transmission to citizens. This includes a PPE audit for each property. It is intended to restart audit activity as soon as practicable.

4.5. Internal Audit have confirmed that the actions from the audit are largely completed but we have agreed to await the resumption of the service audit process to be able to confirm that these actions are operating effectively and to demonstrate full implementation of the improvements in that were made before the pandemic.

Management Oversight and Supervisions

4.6. The scope of the audit was to provide assurance over the arrangements in place to ensure sufficient and appropriate supervision and management oversight arrangements in Adults Services and in particular that:

- there are appropriate policies and procedures in place;
- records demonstrate consistent compliance with agreed arrangements;
- management information is produced to support performance management; and
- there are links into and out of the Adults Services Quality Assurance process.

4.7. The audit provided limited assurance mainly due to the insufficient frequency of supervisions at the time of the review. Interviewees did confirm that informal supervisions happened more regularly, but formal supervisions in line with guidance were not taking place as expected and the records of ad hoc discussions were not consistently retained. Internal Audit also noted a lack of supervision training for managers and the need for a monitoring and quality assurance framework to provide confidence that supervisions were taking place and to support corrective action where required.

4.8. Recommendations were made to improve the clarity over what should be recorded in Case Notes in the social care system and on the supervision record as the audit found a discrepancy between guidance and actual practice. Whilst audit noted that the timeliness in which managers signed off key episodes and actions was reasonable, greater clarity was recommended to demonstrate an effective level of management oversight in case files.

4.9. There were six high risk recommendations made, of which four have been agreed as having been addressed. The two remaining actions related to the establishment of a programme of supervision training and inclusion of measures within management arrangements to assure monitoring the actual frequency and quality of supervisions.

4.10. A programme of supervision training has been established and there has been a recent "mop up" session for new starters and for those unable to attend previously. We have also established a process for collating supervision information to assure senior managers that supervision is taking place. This is reported at the service manager meeting where further interrogation happens to investigate where compliance looks low. We will report this into the Performance Board once we are assured that migration to Microsoft 365 has been completed.

4.11. Now that we have assurance that regular supervision is taking place, we have re-convened the supervision group to develop a process for auditing the quality of supervision. This has been discussed and agreed with service managers and assistant directors and is aligned to the quality assurance processes. We are also updating the supervision policy to include any changes in practice requirements and feedback from practitioners who have been using it for the past 11 months, and this will be subject to regular review.

4.12. Based on actions taken and those planned over the next couple of months as the transition to Microsoft 365 is embedded, we anticipate that the agreed

actions will be evidenced as completed by the end of February 2021.

5. Mental Health Casework Compliance

5.1. An audit finalised in April 2019 reported a limited assurance over delivery of delegated statutory social care functions by the Greater Manchester Mental Health Foundation Trust (GMHH) in line with relevant policies and procedures. This was based on concerns with timeliness, record-keeping, management oversight and reporting in respect of annual reviews, safeguarding referrals and care packages.

5.2. The audit made eight significant and major priority recommendations. A follow up audit completed in January 2020 confirmed that three remained outstanding and three were partially implemented. The recommendations were based around the service obtaining assurance from GMMH over:

- consistency in recording safeguarding investigation activities;
- whether the Paris case management system could provide improved controls over the initial response to safeguarding concerns;
- manager approval being actively monitored to ensure compliance with quality and time standards;
- how the timely and appropriate conclusion of investigations can be better managed and monitored;
- a monthly reconciliation between safeguarding referrals sent by the Council and received by GMHH; and
- performance against the agreed key performance indicators (KPIs) being reported accurately and consistently in line with the Section 75 agreement.

5.3. To address the risks noted in the audit recommendations there has been a sustained programme of partnership work between the Council and GMMH which goes beyond the points raised in the audit to ensure a sustained level of improvement and confidence in arrangements. We plan to work through the detail of this with Internal Audit in December with the aim of demonstrating how actions taken to date have addressed the underlying risks around recording and reporting of compliance that were the focus of the audit.

5.4. Assurance over the level of compliance with recording standards is based on each division having been given its own safeguarding plan which is held by the senior leadership team in GMMH and on which regular reporting and interrogation is in place. Practice quality and consistency has been supported by an update of the safeguarding policy and a comprehensive programme of training. Compliance for mandatory training for safeguarding is currently at 85% and is being delivered virtually. In addition to the mandatory training, relevant practitioners have completed additional modules that have recently been developed regarding safeguarding and decision making, section 42 enquiries and mental capacity.

5.5. The divisions now also have a system in place to monitor the safeguarding referrals and the completion of section 42 enquiries and can track compliance. A system for reviews is now led by the divisional leads and safeguarding is a mandatory agenda item of everyone's supervision. The Council and GMMH

have recently commenced a qualitative audit of safeguarding referrals, the results of which will be discussed at the GMMH and Council partnership meeting. We have also appointed 3 social care leads, one for each locality for a trial 6-month period for them to focus on quality assurance of adult social care statutory functions, legal literacy and care act and mental capacity act compliance. We are monitoring this work in our monthly MCC/GMMH operational meeting and if successful will make the roles permanent.

5.6. Although there is a comprehensive monthly performance report provided by GMMH detailing information relating to social care activity and statutory functions, there are not yet clear and relevant key performance indicator monitoring in place. This will be resolved via a review of the section 75 agreement which remains outstanding. A timescale for this needs to be agreed with the Council, the Manchester and Care Commissioning partnership and GMMH.

6. Floating Support Team (Homelessness)

6.1. The audit of the Floating Support Team that had been developed within the Homelessness Service resulted in limited assurance. This was largely due to the lack of shared and consistent processes and inconsistency in the understanding and discharge of roles and responsibilities. The audit observed that practices adopted across the floating support teams were varied and inconsistent leading to significant differences in the support provided to citizens. It was acknowledged in the report that these findings were consistent with a service that had grown and evolved rapidly to respond to increasing demand; and that a recognised need for agreed actions to address these areas for known improvement was a key factor why management had requested the review.

6.2. The report issued in May 2019 contained two major recommendations and one significant recommendation. The service has analysed the documentation required to ensure effective casework and this has been accompanied by a series of management-led actions to improve consistency, supported by performance management. The ongoing monitoring of these has indicated that there have been major improvements in the consistency of casework and this is regularly reviewed and reported to senior management. These agreed improvement actions have been confirmed with Internal Audit as having been completed and addressed two of the three recommendations.

6.3. The other recommendation was to determine whether the documentation to support case activity for all key tasks could be managed more effectively through the core social care system (Liquid Logic). As this development activity has been interrupted by the need to respond to Covid19 further action is planned to review the ongoing position regarding the efficacy of Liquid Logic and to further streamline and improve procedures, including reducing duplication of data inputting and investment in ICT equipment to facilitate real-time remote working. A realistic target for completion as part of the phase 2 development of Liquid Logic and given the ongoing likely impacts of Covid19 on the service is mid 2021.

7. Adults Services Improvement Plan: Governance

7.1. The audit of improvement plan governance resulted in reasonable assurance with recommendations made to:

- clarify and simplify the categorisation of actions with agreed priority levels and milestones/sequencing
- streamline reporting to focus on a manageable number of improvement actions; and ensure these align with the risk register and agreed areas of focus; and
- refresh the Technology Enabled Care (TEC) and workforce workstream plans using the standard template, to allow for increased clarity over action owners, target timescales, and updates on current status.

7.2. The actions to address these recommendations were to be included as part of the plan refresh scheduled for April 2020. This refresh was postponed as a result of the need to prioritise focus and resources on the Covid19 response.

7.3. The delivery of the Adults Improvement Programme will now be progressing as part of an overarching transformation programme, within the MLCO portfolio, following a stock-take in September 2020 of outstanding activity within the improvement programme, alongside work to identify wider opportunities for managing demand into the service in the context of the Council's budget challenge. This approach has been approved by the Directorate Leadership Team and was presented to Health Scrutiny Committee on 3 November and the Executive on 11 November as part of the update on budget options for 2021/22.

7.4. The governance, resourcing and planning for the programme are in development which will include a consistent approach to managing activity and reporting across the proposed workstreams – with a plan to be in place by January 2021. This will be supported by project management capacity from within the service, MLCO and with support from MHCC and led by the Deputy Director Adult Social Care. A further update on the programme will be provided to Health Scrutiny in the New Year as part of the budget cycle and updates.

7.5. The recommendations will therefore be taken forward as part of this approach.

8. Safeguarding Casework Management

8.1. An audit of compliance with case management standards for adult safeguarding incidents was finalised in May 2020. The limited assurance from this review was based on audit concerns regarding the effectiveness of recording of initial screening of referrals; the completeness and quality of contemporaneous records; the appropriateness of closure of some referrals; and the inconsistent quality of the records. The review noted that from an independent perspective it was difficult to confirm that timely activity took place as required, particularly during the first few days after a referral was received.

8.2. The report included three high priority recommendations to improve initial screening and recording of decisions; provide further training for all social care staff undertaking or approving safeguarding; incorporate the recording of safeguarding activity within management assurance arrangements; and agree the management information that is required to support the timely and appropriate recording of the closure of safeguarding activity.

8.3. Timescales for actions were discussed with Internal Audit with an aim for completion of most of the agreed actions by the end of December 2020. Despite the need to also respond fully to Covid19 progress has been positive and most of the recommendations are well on track for completion within the proposed timescales. There have been regular meetings with Internal Audit to keep them fully briefed on developments and from this engagement one of the agreed actions have been confirmed as completed. The evidence to confirm progress made in implementation of a further recommendation will be provided at the next scheduled update meeting for 22 December 2020.

8.4. The final recommendation does however require a series of training that cannot commence until Covid 19 infection rates reduce/are stabilised. This is due to the requirement to bring staff together (as virtual training is not appropriate for this training course), so there will be some slippage in the original planned timeline for recommendation two beyond December 2020. To address this and in line with wanting to improve standards we have developed and issued a briefing note, practice guidance and checklist to the workforce so that social workers practice is enhanced by using these tools, that have also been reviewed and supported by audit. This is to ensure we are moving forward in mitigating the issues noted in audit recommendations.

9. Supported Accommodation: High Needs Decision Making

9.1. At the request of the Deputy Chief Executive & City Treasurer and the Director of Adult Social Services, Internal Audit were asked to undertake a review of processes for assessment and funding decisions where additional needs for citizens in supported accommodation have been identified and delivered. The request was based on known concerns over the costs of service provision and the audit was intended to help provide an independent perspective on the issues that might be impacting the high costs of support.

9.2. The audit report from this work was issued in August 2020 and as anticipated it resulted in limited assurance. This was primarily due to the lack of clearly defined approach and supporting procedures for how and by whom decisions changes in support should be made and authorised. The audit testing found significant variation in practice and resulted in the following five high priority recommendations:

- Policy statement defining key principles and expectations for additional needs and process map confirming actions and approval requirements.
- Completion of social work reassessments for all DSAS citizens.
- Recording of decisions in individual Liquid Logic records to ensure a complete record of decisions made about a person's care and support.
- Development of mechanisms to trigger further review and approval after a defined period of additional support.

- Relevant DSAS staff being given access to Liquid Logic for the recording of case notes on the citizen records to ensure there is a complete record of activities and approvals including changes in care and support needs.

9.3. The policy statement and process map have been independently confirmed by Internal Audit as having been completed. The timescales for completion of remaining actions were agreed during Covid19 and are between October 2020 to March 2021.

- Urgent actions have been addressed with all social work reassessments been completed. We have also added in a challenge session process with managers from supported tenancy and social work to ensure that the assessment of need and actual level and quality of support put in place match. This provides us with a high level of verification. In each Assessment Team, two workers (Care Managers) have been allocated the reviews for the year in their area as part of their agreed annual caseload, amongst other pieces of work. This will improve the process for annual reviews being completed and provide additional consistency in order to support improved outcomes for independence, choice and control for citizens of Manchester.
- Decisions made at the Quality Assurance Meeting (QAM) are now recorded on Liquid Logic by Team Managers and Seniors who attend the meeting representing their area. This is an interim arrangement pending the panel reviews that are included in the Learning Disability Programme. Testing of the interim measure is due to take place from 3 December 2020.
- Work is ongoing with ICT to identify the best solution to enable DSAS managers to use Liquidlogic in order to be able to update citizens records and to be able to raise alerts when there are changes in care and support needs. The aim is for the solution to be agreed by end of this year and implemented by 31 January 2021.
- Despite the impact of Covid19 good progress has been made in response to this audit and we are confident that remaining actions will be completed as planned and will be independently confirmed by Internal Audit by March 2021.

10. Conclusions

10.1. Actions agreed in response audit reports over the last three years have taken longer to implement than originally planned and have been an understandable cause of concern for Audit Committee. Whilst agreed recommendations have now been implemented for many audits completed, the time taken to achieve this position and the need to remain focused on the remaking outstanding actions is a key service priority. To embed change and ensure that resources are focused on areas of highest risk this must be done alongside other high priority improvement actions as set out in the Adults Improvement Plan.

10.2. In those areas where recommendations remain outstanding there is clarity over actions required and plans in place to achieve this as set out in the report. Management will continue to work with Internal Audit to ensure that Senior Management Team, Executive Members and Audit Committee are

provided with updates and assurance over progress.

10.3. A key factor in the time taken to address specific actions arising from Internal Audit reports has been the wider programme of work that was required to stabilise and develop process, practice, workforce and resources across Adults Services; and deliver health and care integration. This work has been substantial and has impacted on the time taken to implement changes; many of which include system wide inferences, reliance on partner organisations and the implementation, adoption and embedding of new systems and working practices. The time required to action and assure the implementation of recommendations in some areas has slipped considerably and this has been further impacted by the prioritisation of response and recovery work required to support communities as a result of the impact of Covid19.

10.4. These areas of broader focus were reported in the October 2019 Improvement Plan Update to Audit Committee which focused on the following key priorities where progress has been reported to Health Scrutiny Committee:

- Recruitment and Increasing Capacity across the workforce
- Introduction of strengths-based assessments, support planning and workforce development programme.
- Reducing Waiting Lists
- Social Care Case Management System Implementation
- Strengthening Staff Communications and Engagement
- Launch of Social Work apprenticeship Programme
- Widening Access to Technology Enabled Care
- Mobilising new Our Manchester Homecare Contract.
- Developing Commissioning and Contracting Capabilities
- Health and Care Integration – Provider (MLCO) including developing Integrated Neighbourhood Teams.

10.5. In light of the impacts of Covid19 and associated delays in delivery of Improvement Plan, as well work sponsored by Manchester's Health and Social Care leaders (Transformation Accountability Board) to accelerate progress towards health and social care integration and the budget setting process, areas of priority and planned focus have been reviewed and are highlighted in the Budget Options 2021/22 report to be presented to Health Scrutiny Committee on 4 November.

10.6. The Directorate Leadership Team will continue to work with Internal Audit to provide updates on recommendation implementation as part of their regular assurance and recommendation monitoring reports and will continue to provide assurance updates to the Executive Director, Chief Executive, Executive Member and Audit Committee.

11. Recommendation

11.1. Audit Committee is asked to consider and comment on the report.