To: **Renfrewshire Health and Social Care Integration Joint Board Audit Committee**

On: **29 June 2018**

Report by: **Chief Internal Auditor**

Heading: **Summary of Internal Audit Activity in Partner Organisations**

1. Summary

1.1 The Renfrewshire Health and Social Care Integration Joint Board directs both Renfrewshire Council and NHS Greater Glasgow and Clyde to deliver services that enable the Renfrewshire Integration Joint Board to deliver on its strategic plan.

1.2 Both Renfrewshire Council and NHS Greater Glasgow and Clyde have Internal Audit functions that conduct audits across each organisation and report the findings of these to the respective audit committees.

1.3 Members of the Integration Joint Board have an interest in the outcomes of audits at both Renfrewshire Council and NHS Greater Glasgow and Clyde that have an impact upon the Integration Joint Board's ability to deliver the strategic plan or support corporate functions.

1.4 This report provides a summary to the Renfrewshire Integration Joint Board's Audit committee of the Internal Audit activity undertaken within these partner organisations.

2. Recommendations

2.1 That the Integration Joint Board Audit Committee are asked to note the content of the report.

3. Renfrewshire Council Internal Audit Activity

3.1 The following Internal Audit reports have been issued to the Renfrewshire Council Audit Risk and Scrutiny Board, which are relevant to the Integration Joint Board.

Audit Engagement	Assurance Level (note 1)	Number and Priority of Recommendations (note 2)			
		A	B	C	I
Adults with Incapacity	Limited	-	5	-	-
Charging and Payments for Adult Services	Limited	1	4	1	1
Corporate Health & Safety	No Assurance	4	6	1	-
Records Management	Limited	0	6	4	-
Corporate Purchase Cards	Reasonable	-	1	5	-

Note 1 – For each audit engagement one of four assurance ratings is expressed:
Substantial Assurance – The control environment is satisfactory
Reasonable Assurance – Weaknesses have been identified, which are not critical to the overall operation of the area reviewed
Limited Assurance – Weaknesses have been identified, which impact on the overall operation of the area reviewed
No Assurance – Significant weaknesses have been identified, which critically impact on the operation of the area reviewed

Note 2 – Each audit recommendation is assigned a priority rating:
A = Critical Recommendation - Addresses a significant risk, impacting on the area under review
B = Important Recommendation – Implementation will raise the level of assurance provided by the control system to acceptable levels
C = Good Practice Recommendation – Implementation will contribute to the general effectiveness of control
I = Service Improvement – Implementation will improve the efficiency / housekeeping of the area under review

3.1.1 **Adults with Incapacity**

The objectives of this audit were to ensure that there is documentary evidence that the process flow chart has been followed for the use of Adults with Incapacity (Scotland) Act 2000 and that the process is undertaken timeously. A sample of 20 case files were selected for review.

The audit identified that although there is a process in place for the use of Adults with Incapacity (Scotland) Act 2000, the guidance available to officers is outdated and on some occasions the relevant paperwork in relation to referring and applying for Adults with Incapacity intervention was unable to be located and those that were found were not always signed. A revised policy, process flow chart, referral forms and supporting guidance have been developed to ensure the accuracy and timely completion of the relevant paperwork and required authorisation process.

3.1.2 **Charging and Payments for Adult Services**

The objectives of this review were to ensure that there are adequate documented procedures in place for preparing financial assessments and arranging for invoices to be raised; controls exist to ensure that financial assessments are accurate; all invoices are raised timeously and are accurate and posted onto the accounts receivable ledger; and that there are appropriate procedures in place to regularly review financial assessments and deal with changes in circumstances timeously.

The audit identified that there are procedures in place for preparing financial assessments. However, delays between the date a client starts receiving care and the date they are first charged for care result in the council not receiving full payments for the services provided and some clients may not be charged the correct rate if full financial assessments and reassessments are not carried out for new and existing clients.

It is acknowledged that Charging and Payments management have implemented new procedures and are continuing to work to improve controls in this area. Management within Finance and Resources, agreed to action the recommendations made, including; working with Adult Services to put measures in place to minimise any delays in processing financial assessments / reassessments for non-residential care, preparing adequate documentation detailing clearly the processes to be followed by staff and improving the document filing system.

3.1.3 **Corporate Health and Safety**

The purpose of the audit is to carry out a review of the arrangements in place for corporate Health and Safety. The review covered the arrangements in place during 2016/2017. Key controls were reviewed and evaluated in relation to, clearly defined and

understood roles and responsibilities, including risk identification; adequate and up-to-date policies and procedures in place which were readily available to those that need them; regular engagement with other service areas to ensure compliance with legislative requirements; a programme of health and safety audits was in place and results were followed up adequately; adequate arrangements in place for reporting, accidents, incidents and near misses and these were adequately followed up; and performance monitoring and reporting arrangements were appropriate.

Four key risk areas were identified from the audit review:

Although there is a Health and Safety Policy in place, which details the high level governance arrangements including the roles and responsibilities of key officers, current practice does not follow the arrangements as set out in the policy at both a corporate and service level. There is a risk that health and safety activity may be uncoordinated, reactive and not subject to an appropriate level of scrutiny.

The policy is also not being followed at an operational level with pro-active health and safety audit inspections not being undertaken as expected at a corporate level and there is inconsistency at a service level. This increased the risk that action is not taken in a timely manner to rectify any issues that would have been identified through the checking regime.

There is a corporate process for logging incidents, however there is a lack of effective monitoring and follow up of the mitigating actions required. This increases the risk that remedial action is not taken in a timely manner.

Performance information in relation to health and safety is not being prepared, monitored and reported consistently. Without adequate monitoring and reporting of both Corporate and Service health and safety performance, there is an increased risk that trends are not identified and remedial action taken where necessary and the arrangements are not subject to an appropriate level of scrutiny.

Based on the audit work carried out the control environment was assessed as unsatisfactory. The Auditor was concerned that the governance arrangements may not be fit for purpose. Operational arrangements were not adequate and there is a lack of appropriate processes and scrutiny. The audit recommended that management review the governance and operational practice as a matter of priority.

In relation to the key risks management has addressed these by implementing an independent strategic review of the corporate health and safety governance and operational arrangements. A formal Corporate Health & Safety Team duty officer process has been developed, which includes a daily check of the systems to ensure any actions required as a result of an incidents are being effectively dealt with. All previous actions have now been reviewed. KPIs will be developed for the Corporate Health & Safety Team and these will be agreed with the senior management.

3.1.4 **Records Management**

The objectives of this audit were to ensure that the records management improvement action plan is progressing as expected and is regularly monitored by management; there is an adequate process developed to facilitate scheduled reviews and update of the plan; services are complying with a sample of elements in the plan; and there is sufficient evidence held by Services to demonstrate compliance with the Records Management Plan.

The audit identified that scheduled reviews of the Records Management Plan are in place and progress is monitored by management. However, not all actions within the improvement action plan are progressing as expected and the deadlines for these actions have not been revised. Following the audit review, management have also identified that the recent resignation of the Records Manager may further impact on the progress of the plan should there be difficulties in recruiting to the post. There was also evidence that all services are not complying with some of the elements in the Records Management Plan e.g. completion of Destruction Certificates.

A new Records Manager has recently been recruited and management agreed to review the timescales and revise these to be more realistic in light of the first year of implementation having passed and taking into account lessons learned. The Records Management Service Working Group meetings have been re-introduced, this group will be the forum for raising awareness of the requirements for records management and embed processes within services.

3.1.5 **Corporate Purchase Cards**

The purpose of the audit was to ensure that the corporate purchase cards are being utilised in accordance with the documented policy and guidance. The review also sought to ascertain the main suppliers of goods and services purchased using the Pcard identifying areas of off contract spend and to consider if best value would be achieved by establishing contracts with these suppliers.
The review identified that frequent transactions are in the main below £499.99, in line with the intended use of Pcards. There may also be security/compatibility implications if Pcards are used to purchase IT goods or services that do not have prior approval from ICT Services and value for money may not be achieved if non-contract purchases are made with Pcards.

The supplier Amazon was found to have the largest non contracted spend via Pcard in the financial year 2016/2017. Due to the time taken to ascertain the details of items purchased in each transaction and the large variation of items identified as being purchased during testing, the auditor was unable to identify any large areas of spend where there is already a preferred method of purchase. No specific recommendation was made in this regard.

The PCard Procedures have been updated to reflect the audit recommendations made and PCard holders have been reminded of their roles and responsibilities regarding the issues raised in the audit report.

4. NHS Greater Glasgow and Clyde Internal Audit Activity

4.1 The following Internal Audit reports have been issued to the NHS Greater Glasgow and Clyde Audit Committee, which are relevant to the Integration Joint Board. A summary has been provided for those reports with individual findings graded as medium or high.

Review	Report classification (Note 2)	Number of individual findings		
		High	Medium	Low
Key financial controls: payroll	Low	-	-	-
Clinical and care governance	Low	-	-	2
Public Health: screening programmes	Low	-	-	2
Information Governance	Low	-	1	2

Gifts and hospitality compliance	Medium	-	3	1
Programme management	Low	-	-	1
Health and safety compliance	Medium	-	3	-
Corporate risk management	Low	-	1	2
Achieving Financial Balance	Medium	1	-	-
Financial Planning 2018/19	Medium	-	2	1
Total findings		**1**	**10**	**11**

Note 2
***High risk indicates findings that could have a significant**:*
impact on operational performance; or
monetary or financial statement impact or
breach in laws and regulations resulting in significant fines and consequences; or
impact on the reputation or brand of the organisation.

Medium risk indicates findings that could have a moderate:
impact on operational performance; or
monetary or financial statement impact; or
breach in laws and regulations resulting in fines and consequences; or
impact on the reputation or brand of the organisation.

Low risk indicates findings that could have a minor:
impact on the organisation's operational performance; or
monetary or financial statement impact; or
breach in laws and regulations with limited consequences; or
impact on the reputation of the organisation.

4.1.1 Information Governance – low risk, 1 medium finding

The primary objective of this audit review was to examine the progress made to design and implement a Board-wide Information Asset Register, populate the Register with the right data for it to be an effective information source against which other data protection requirements can be fulfilled, and to establish the operational processes to ensure the Information Asset Register remains effective.

The medium risk finding was in relation to populating the IAR; over 350 information assets have been registered at the time of writing. The Information Governance Team continues to work with the wider Directors to ensure the work progresses, but as asset questionnaires are submitted there will be an ongoing need to review submissions and ensure the controls in place to protect personal and sensitive personal data assets are appropriate under GDPR requirements. It is important to be able demonstrate to the regulator that risk assessment of the controls around each asset has been undertaken, and remedial action has been taken. This 'paper shield' will be important in the event of a regulator audit or data breach. Management should ensure an assessment of the controls for each asset is documented against the health Board's information security standards and requirements for the protection of personal and sensitive personal data.

4.1.2 Gifts and hospitality compliance – medium risk, 3 medium findings

The Directorate for Health Finance of the Scottish Government instructed all Scottish Health Boards to consider a number of actions to provide assurance as to the extent and adequacy of controls that are in place for the notification and recording of gifts and hospitality. These were to commission an internal audit review of the processes for notification and recording of gifts and hospitality; to confirm that hospitality registers are up to date and conform to Standing Financial Instructions; to provide a reminder to staff that they must comply with these SFIs and ensure they are read and understood; and to invite Counter Fraud Services to present to key staff on provisions of the Bribery Act.

PwC's review covered the following areas: the guidance available in the Code of Conduct, additional guidance available to some staff groups (eHealth, Pharmacy, the Area Drugs and Therapeutic Committee and Procurement were considered), reporting and approval, maintenance of the register and governance arrangements.

They noted that there are areas where the current policies and procedures in relation to gifts and hospitality could be improved. The medium risk findings were:

There were aspects of both the staff and Board Members' Codes of Conduct which could be strengthened - no timescale is specified in either Code of Conduct for how quickly declarations should be made following receipt of gifts/hospitality and for Board Members, nor is there a requirement to declare declined gifts/hospitality, which is inconsistent with the staff code of conduct.

Some board members who had joined the Board had not yet completed a declaration of interests; Board Members' interests should be disclosed per the code of conduct.

There was no procedure in place to ensure that items of gifts or hospitality are given approval timeously.

4.1.3 **Health and safety compliance – medium risk, 3 medium findings**

This review considered the steps taken by management to progress a sample of actions to address points raised by the Health & Safety Executive (HSE) and also considered the processes across Acute, Partnerships and Property Procurement and Facilities Management (PPFM) for identifying and undertaking investigations into any incidents which must be reported to the HSE under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).

The three medium risk findings were:

Only the Partnerships H&S team had a formally documented process for the identification, reporting and investigation of RIDDOR incidents and there is an inconsistent approach taken across the Board's three H&S teams for conducting investigations into RIDDOR incidents. As a result of the inconsistencies noted, the processes in place within Acute and PPFM are considered less robust than the process in place within Partnerships.

From a sample of twenty-five incidents reported to RIDDOR, it was found that seven of these were not reported to HSE within the required timescales.

There is no consistent process in place to monitor progress against identified recommendations resulting from RIDDOR investigations, to provide oversight that required lessons learned are being taken and on a timely basis.

4.1.4 **Corporate risk management – low risk, 1 medium finding**

The purpose of this review was to consider the effectiveness of the Board's corporate risk management arrangements, including the work that was undertaken to revise the Corporate Risk Register.

The review identified one medium risk finding: PwC found that Datix could be used more effectively in the organisation. Inconsistencies were noted between updates that are being made 'offline' on a hard copy of the CRR and the information held on Datix, as updates are not being made to Datix on a timely basis. At a Directorate level, they also noted that risks were not being reviewed on Datix on a regular basis.

4.1.5 **Achieving financial balance – medium risk, 1 high finding**

Whilst the overall rating of this report was medium, there was a high risk finding. In successfully achieving financial balance in the year, the Board relied heavily on the use of non-recurring support. The percentage of total savings achieved which were on a non-recurring basis was approximately 70% in 2017-18, compared with around 40% in 2015-16. While non-recurring savings will always form part of a Board's savings, the lack of enduring savings increases future financial challenges and poses a risk to the NHS Board's financial sustainability. PwC noted that it was critical that the NHS Board puts in place a transformation plan that will deliver recurring savings and provide financially sustainability for the future. Measures recently put in place, such as the Financial Improvement Programme, should clearly and regularly communicate to the Finance and Planning Committee and the Board on the progress made to reduce the Board's recurring deficit.

4.1.6 **Financial planning – medium risk, 2 medium findings**

The scope of this review focussed on the planning process and key assumptions that underpin the Board's 2018/19 financial position. The process was to establish the Board's net cash efficiency challenge for 2018/19, and no service redesign or transformation assumptions were applied efficiency challenge.

The review concluded that overall, the planning process has been undertaken with an objective of transparency and there is clarity over the key assumptions underpinning the 2018/19 cash efficiency challenge. Addressing the two medium risk findings identified would also further strengthen the transparency of the financial planning process. The findings were:

In the Board's key financial plan assumptions, the level of certainty that can exist for each assumption varies. This is a normal feature of the planning process, however given the extent of the financial challenge it is important that these areas of risk in the plan are clearly understood by the Board and are subject to regular monitoring.

The Board's planning arrangements are intended to set out the total saving challenge to be addressed. In most cases the presentation of information is shown on a gross basis before any saving plans are applied. However, PwC noted that for primary care prescribing cost pressure is presented net of planned saving schemes.

Implications of the Report

1. **Financial** - none.

2. **HR & Organisational Development** - none.

3. **Community Planning** - none.

4. **Legal** - none.

5. **Property/Assets** - none.

6. **Information Technology** - none.

7. **Equality & Human Rights** - none

8. **Health & Safety** - none.

9. **Procurement** - none.

10. **Risk** - The subject matter of this report is the matters arising from the risk based Audit Plan's Renfrewshire Council and NHSGGC in which the IJB would have an interest.

11. **Privacy Impact** - none.

List of Background Papers – none.

Author: Andrea McMahon, Chief Internal Auditor