Business Services Organisation

Providing Support to Health and Social Care

INTERNAL AUDIT UNIT
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SOUTHERN HEALTH & SOCIAL CARE TRUST

HIA ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2019

REVISED FINAL REPORT ISSUED ON 30TH MAY 2019

(FINAL REPORT ISSUED ON 25TH APRIL 2019 AND WORKING DRAFT ISSUED ON 13TH APRIL 2019)

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INTRODUCTION

The Business Services Organisation (BSO) Internal Audit's primary objective is to provide an independent and objective opinion to the Accounting Officer, Board and Audit Committee on the adequacy and effectiveness of risk, control and governance arrangements. The basis of this independent and objective opinion is the completion of the Annual Internal Audit Plan. The 2018/19 internal audit plan was developed in conjunction with Client Management and was approved by the Audit Committee in April 2018.

INDEPENDENCE

During 2018/19, BSO Internal Audit has had no executive responsibilities within the audited body and has been sufficiently independent of the activities that it audits to enable us to perform our duties in a manner, which facilitates impartial and effective professional judgements and recommendations.

PERFORMANCE DURING 2017/18

Key Performance Indicator	% Achieved in 2017/18 for SHSCT	% Achieved in 2018/19 for SHSCT
100% Delivery of Annual Audit Plans	100% (100%*)	**100% (97%*)**
85% of First Draft Reports Issued within 4 weeks of fieldwork completion	62%	**66%**
75% of reports finalised within 5 weeks of issue (and within 1 week of receiving management comments) *75% Management Comments should be received within 4 weeks*	62% (83%) 55%	**72% (86%)** ***62%***
% of reports significantly amended between draft report and final report stage[1]	0%	**0%**

*(*Actual delivery against SLA audit days)*

The key objective of the Service is to ensure the delivery of the Internal Audit Annual Plans to all client organisations. Despite considerable resource challenges in 2018/19, this objective was achieved - albeit that the HIA sought permission from SHSCT to defer one planned audit (Incident Management) from 2018/19 into 2019/20 to ensure work was completed within the required timescales.

The Unit is professionally required to have an independent External Quality Assessment (EQA) every 5 years. The Institute of Internal Auditors performed an EQA during 2018/19. They concluded that the BSO Internal Audit Service meet the vast majority of the Standards, as well as the Definitions, Core Principles and the Code of Ethics, which form the mandatory elements of the Public Sector Internal Audit Standards and the Institute of Internal Auditors' International Professional Practices Framework, the globally recognised standard for quality in Internal Auditing.

[1]. Significant change is defined as change in assurance level provided in report, a priority 1 recommendation being completely removed from report, or significant changes in a number of key findings.

The IT audit team continued to develop their expertise in this specialist area during 2018/19. Particular focus included supporting the strengthening of cyber security arrangements in HSCNI by delivering assurance assignments as well as participating as a member of the regional HSCNI Cyber Security Programme Board.

Feedback from client organisations highlighted continued satisfaction with the service and particularly the professionalism of the audit team.

SUMMARY OF WORK UNDERTAKEN

All audit assignments included in the 2018/19 Internal Audit Plan have been carried out, with a number of amendments approved by audit committee.

The 2018/19 Internal Audit assurance work is summarised as follows:

AUDIT ASSIGNMENT	LEVEL OF ASSURANCE
FINANCE AUDITS	
Payments to Staff	Limited
Management & Use of Health Roster	Limited
Non-Pay Expenditure within the Mental Health Directorate	Satisfactory
Cash Management in Cash Offices	Satisfactory
Asset Management	Satisfactory
Management of Contracts with the Voluntary sector (including Sure Start)	Limited
Management of Patient Private Property in Acute Hospitals	Satisfactory
Management of Clients Monies and Cash Handling in Social Services Facilities	Satisfactory (9 facilities)
Management of Client Monies in Independent Sector Homes	Limited – 1 Home Satisfactory – 9 Homes
Estates Procurement & Contract Management	Satisfactory
Ordering and Receipt of Goods	Satisfactory
Management of Trust Homecare within the Older People & Primary Care Directorate	Unacceptable
Visits to 2 Independent Domiciliary Care Providers (Peacehaven Care Services and Lydian Care) *Note: Peacehaven Audit Work Completed in 2017/18 and finalised in 2018/19*	Lydian – Unacceptable Peacehaven - Limited
SHSCT's Compliance with DoH Permanent Secretary's Instructions Regarding Travel (primarily travel outside Ireland and Britain)	Satisfactory
CORPORATE RISK AUDITS	
Children's & Young People Directorate Risk Audit - Management of Children with Disabilities Services	Limited
Management of Standards and Guidelines	Limited
Care/Case Management within Older People and Primary Care (OPPC) Directorate.	Satisfactory
GOVERNANCE AUDITS	
Risk Management	Satisfactory
Board Effectiveness	Satisfactory

AUDIT ASSIGNMENT	LEVEL OF ASSURANCE
Infection Prevention and Control (IPC)	Satisfactory - Oversight of compliance with Policies & Procedures, IPC Audit and training Limited - Anti-microbial Stewardship
Cyber Security	Limited/Satisfactory elements of opinion
Mortality and Morbidity processes (specifically mortality)	Limited

The following significant findings were identified in the above audit assignments, impacting on the assurance provided:

Payments to Staff

1. Corporately significant issues remain primarily over the accuracy of payments resulting in overpayments:
   - In the period April to November 2018, 153 (£137,253) overpayments identified were due to Trust errors. Additionally Senior Finance staff have recently been made aware of a number of significant cases.
   - Although new processes for prevention, investigation and recovery of overpayments through directorates have been introduced in October 2018, these have yet to become fully embedded, particularly across the larger directorates.

Management & Use of Health Roster

2. Access controls to Health Roster require strengthening:
   - The system does not enforce a complex password nor is there enforced password change after a designated time.
   - The process to approve and formally document the creation or amendment of user access is weak.
   - The system does not automatically log users out after a period of inactivity.

   These increase the risk for passwords becoming known.
3. There are a total of 17 user profiles on the system. There are several very similar profiles (which could possibly be merged) and a couple with very small user numbers. Internal Audit carried out a review of 'last date of logon' by user profile on the system and identified 80 users with privileges which permitted them to create and / or approve rosters who had not accessed the system in considerable time and consequently do not require this level of access. It was also noted that five of the eight staff with Systems Administrator access, the highest level of access, work in the bank office - one Band 7, two Band 5 and two Band 3 staff. There are no independent monitoring checks of system administrator activity being performed. These issues indicate that the management of users with access to the system requires strengthening.

Management of Trust Homecare within the Older People & Primary Care Directorate

4. Thirty service user Daily Record Sheets for the period July and August were reviewed. On reconciliation of actual hours delivered as per the daily record sheets against hours commissioned and paid to the Domiciliary Care Worker, the total time delivered by care workers was 734 hours (26.50%) less than that paid to care workers. In 27 out of the 30 cases reviewed, there was significant under delivery of care time against commissioned and paid time ranging from 10% up to 54%. There is no monitoring of actual service delivery times as per daily record sheets against commissioned time to identify cases of regular under delivery of care services by care workers.
5. The only method of ensuring that accurate times have been delivered to service users and subsequently paid to Domiciliary Care Workers is through completion and checking of the Daily Record Sheets (DRS) which are held in service users' homes. Internal Audit examined Daily Record Sheets for 30 service users across the three localities for the period of July and August 18, and found no evidence of checking of times and services delivered by Domiciliary Care

Workers on the Daily Record Sheets selected. There is no formal process of regular review to check that commissioned calls and times are actually being delivered to service users.

6. A review of Daily Record Sheets (DRSs) for 30 service users for the period of July and August 2018 identified that there were a total of 194 calls (3.7% of calls sampled) equating to 97.25 hours which had not been recorded on the Daily Record Sheets and were paid to the care workers. There were 163 occasions (5.3% of calls sampled) where the time in/out was not recorded on the DRS. The care time actually delivered cannot be determined in these cases.

<u>Visits to 2 Independent Domiciliary Care Providers (Peacehaven Care Services and Lydian Care)</u>

Lydian Care:

7. Lydian Care invoice the Trust based on commissioned care time and not actual care time delivered. Our testing of 12 clients over 3 invoicing periods (12 weeks) found the total time delivered by Care Workers was 683.67 (32.27%) hours less than what was commissioned and invoiced to the trust, equating to an approximate potential overcharge of £8,588.09. In 11 out of the 12 client cases reviewed, there was significant under delivery of time against invoiced time ranging from 14% to 55%. There is insufficient monitoring of service delivery to identify and address cases of regular under-delivery of care hours by care workers. Internal Audit reviewed rotas for 4 individual care workers and for one invoice period. Across the rotas reviewed, there was an overlap of care hours of 2 hours 50 minutes. The carer rotas do not transparently demonstrate that all commissioned care time has been included on the rota.
8. Internal Audit requested Care Progress Notes (CPNs) for 15 Service Users selected for the period 4 December 2017 to 25 February 2018. In 6 (40%) cases incomplete records were made available for the period under review. There is no formal process of collecting in CPNs on a regular basis for auditing to check that all commissioned calls and times are actually being delivered to clients.
   A follow up visit was not conducted as this provider has flagged to the Trust its intention to cease services.

Peacehaven Care Services (Audit Work Completed in 2017/18 and report finalised in 2018/19):

9. Care Worker rotas were not retained for the periods tested to verify that all commissioned time was accounted for on a rota. Direct care hours paid to care workers through payroll for the periods requested were not made available to check against invoiced hours and corresponding rotas.
10. As per the Domiciliary Care Contract, invoices should be raised based on actual time delivered. Invoices at Peacehaven are raised based on commissioned time (as per DC1) adjusted for known changes and not on time actually delivered as recorded on Service User Progress Notes. *See Non Assurance work section for update on follow up visit.*

Issues relating to Trust processes during the 2 visits to independent domiciliary care providers:

11. The Trust has limited means of assuring itself that it is receiving all the hours it is commissioning from providers and subsequently paying for.
12. DC1 (commissioning) forms are not always forwarded from the Trust keyworkers to the provider on a timely basis.

<u>Management of Contracts with the Voluntary sector (including Sure Start)</u>

13. Only two of the sample of 30 contracts reviewed had been competitively procured. Existing contracts have been renewed and awarded to the same provider year on year without a competitive procurement process. Many of these contracts have been in place for a considerable period of time. In the absence of competitive procurement processes or alternative measures such as benchmarking, the Trust has limited means to ensure existing contracts represent value for money.
14. The following was noted in respect of contract management:
    - One contract owner advised that they were receiving monitoring information either quarterly or annually for 3 providers. Review by audit identified that this was not the case and monitoring returns had not been received by the Trust for the 2017/18 period. The annual contract sums for these 3 providers were £118K, £98K and £57K.

- Verification checks of activity information submitted by Voluntary Organisations in monitoring returns are not routinely undertaken by the contract owner, to confirm the accuracy of this and to obtain assurance that the services being paid for are being delivered.

Management of Client Monies in Independent Sector

15. Recording of Client Monies at Apple Blossom:
    - On the date of the unannounced visit, the records for client ledgers were not up to date and therefore not available for review by audit.
    - At Apple Blossom the bank account reconciliations were not promptly prepared, the reconciliations for November 2017 through to February 2018 had all been prepared and reviewed on 20.03.18.
    - The resident's bank account reconciliations had not been completed since the initial Internal Audit visit (April 2018).
    - Client records were updated retrospectively onto the CareBlox (Resident ledger system) and the outstanding bank reconciliations for May and June were completed in August 2018.
    - The record keeping in relation to client monies is tedious and open to error, due to the amount of duplication.
    - Clients withdraw money for personal use, expenditure of this money does not require receipts and in most instances the receipt book is not signed by the client to acknowledge they have received the money.
    - At Apple Blossom, there was a missing Trust remittance advice and a double entry for lodgements of £500 on one ledger; a receipt did not match a withdrawal in one case the withdrawal was for £40, but receipt was for £80. This resident is capable of signing for their own money, so it is possible that they used £40 from their own pocket for this purchase. Seven clients had negative balances (£95.13); and balances were held for discharged clients. At the follow up in August the level of negative balances had significantly increased; 12 residents had a negative balance totalling £732.72. In particular, two residents had significant negative of balances of £367.34 and £270.75. When money is handed in by family/next of kin, the white, top copy of the receipt book is not always given to the person depositing the money. Also, the Home's petty cash was used for residents' expenditure for a period during June 2018 as staff couldn't get to the bank to withdraw cash from the Resident's bank account.

Children's & Young People Directorate Risk Audit - Management of Children with Disabilities Services

16. UNOCINI Guidance details timelines for the completion of initial assessment, identification of need and action following the receipt of a referral. Testing of a sample of 30 referrals accepted by the Children with Disabilities Service identified significant delays in the various stages of the process.
17. Unmet needs whilst recorded locally in the service users case notes, are not formally collated / reported upwards to the Senior Management Team, Directorate level etc. to provide visibility over the issue and assurance that actions are being taken to address these unmet needs. In 16 from 30 (53%) sampled instances, some services approved could not be delivered i.e. unmet need resulted, for a variety of reasons.

Infection Prevention and Control

18. Anti-microbial Stewardship (AMS) practices need to be developed further and fully embedded into the organisation. The Antimicrobial Pharmacist has not been conducting all the planned monthly ward rounds and the Microbiologist ward rounds are ad hoc in nature. Internally, AMS reporting has fallen behind schedule with the most recent figures available from October 2018. In addition there is a need to ensure that there is an organisational wide approach to promoting and monitoring the use of antimicrobials this should include all medical, nursing and pharmacy staff.
19. Internal Audit accompanied by the Antimicrobial Pharmacist, carried out visits to three wards and reviewed a sample of 44 patient files. Testing of 44 patient records with the Antimicrobial Pharmacist found an error rate of 9% and the Trust found an error rate of 16% in October 2018.

Management of Standards and Guidelines

20. During the period September 2017 to September 2018, there had been no reporting of compliance with Standards and Guidelines presented to the Board Governance Committee. Consequently the Trust Board has not received assurance that all Standards and Guidelines are implemented on a timely basis and are subsequently being complied with. Previously the Trust prepared an Accountability Report for Standards and Guidelines which was presented to the Trust Governance Committee on a six monthly basis which detailed the Trust's compliance against each standard and guideline received. This Accountability Report is no longer compiled.
21. Review of the Trust Standards and Guidelines register (spreadsheet) found that there are significant gaps in the information held. In particular updates on actions taken by directorates are not recorded on the register by directorate governance teams to enable compliance progress against individual standards and guidelines to be fully tracked and reported.

Mortality and Morbidity processes (specifically mortality)

22. The Regional Guidance for the Mortality and Morbidity process states that the initial review of a patient's death should be completed within 48 hours and that the case should then be discussed at a M&M meeting within 6-8 weeks. For the 393 deaths recorded between April and July 2018, the following was noted:-
    - In respect of adherence to the target to review all deaths within 48 hours, 78% of patient deaths were not reviewed within 48 hours (66% were not reviewed within 1 week). 15% (58) deaths had not yet been recorded (as at October 2018) as reviewed by a Consultant. Delays in reviews were considerable in some cases.
    - 12% of the 393 deaths in the audit period were discussed at a M&M meeting within the 8 week target. Whilst a further 57% deaths had been reviewed at a M&M meeting, the presentation date of these had not been recorded therefore timeliness of review could not be established. 31% of the deaths had no evidence of having been discussed at a M&M meeting despite the fact that these deaths had occurred more than 8 weeks before.
    - There were differences in the date and time of a patient's death and the date the death was recorded on NIECR for 127 of the 393 deaths (97 of the 127 were within 1 day).
23. There is limited learning generated by the M&M groups. The shared learning template is not completed and used within the Trust. 268 of the 270 deaths reviewed through M&M were graded at level 1 with only 2 deaths graded as 2 (suggesting learning). There is an inadequate audit trail of the implementation of any identified learning.

    Across the work conducted in 4 Trusts, Internal Audit have observed very limited evidence of learning resulting from M&M meetings. In the context of concerns raised by the Trust and the findings of these audits, there would be merit in reviewing and further developing processes regionally.

Cyber Security

24–31. 8 significant issues were identified in the cyber security report. Some recommendations associated with these issues require regional action, led by HSCB and others require Trust specific action.

Other Non-Assurance/Consultancy Work

Management of Theatre Utilisation

A consultancy assignment was conducted on the Management of Theatre Utilisation. Based on utilisation information for one month, a number of recommendations have been made.

Management of Waiting list Initiative Payments

Internal Audit carried out an audit of Medical Staff Waiting List Payments (WLI) during March 2019. This audit focused on the implementation of recommendations contained in the 2016-17 Internal Audit of Waiting List Initiative Payments. Of the 10 recommendations previously made, 4 (40%) are fully implemented, 6 (60%) are partially implemented. An additional recommendations was deemed no longer applicable.

The Trust has accepted that the majority of issues identified in the 2016/17 review arose because of weaknesses in the Trust's processes rather than the conduct of staff. The Trust has engaged

extensively with Radiology consultants in relation to work undertaken within WLI sessions and the process requirements.
The Trust has revised its WLI procedures and these now explicitly state that the WLI payment is for pre agreed minimum amounts of work, within the four hour session, including administration. The revised procedures are not yet signed off by the Local Negotiating Committee and are subject to ongoing discussion. In practice, the allocated work (which is the pre agreed minimum activity) is being delivered.

Follow Up Visits to Independent Domiciliary Care Providers
Internal Audit performed a follow up review in two independent providers of Domiciliary Care Services (Homecare Independent Living and Peacehaven), where Limited assurance had previously been provided. Generally, progress was observed in implementing previous audit recommendations.

Assurance Processes Post Controls Assurance Standards
Internal Audit undertook a high-level review of the processes established within the to monitor compliance with the required standards, policies, legislation etc. previously contained within the Controls Assurance Standards and the process for providing assurance on this to the Chief Executive and the Board (and onwards to DoH in the tailored format they have requested).

Internal Audit concluded that the processes adopted by SHSCT for 2018/19 were adequate to provide appropriate assurances internally in the areas previously covered by the former Control Assurance Standards. It should be noted that these processes were ongoing for 2018/19 and not completed, at the time of audit review.

Follow Up Work
A review of the implementation of previous priority one and priority two Internal Audit recommendations was carried out at mid-year and again at year-end. At year-end, 270 (80%) of the 336 recommendations examined have been fully implemented, 62 (19%) of the recommendations have been partially implemented and 4 (1%) recommendations have not yet been implemented.

A breakdown of the status of the implementation of Internal Audit recommendations as at March 2019 is attached in Appendix A to this report.

Shared Service Audits
A number of audits (summarised below) have been conducted in BSO Shared Services, as part of the BSO Internal Audit Plan. The recommendations in these Shared Service audit reports are the responsibility of BSO Management to take forward and the reports have been presented to BSO Governance & Audit Committee. Given that the Trust is a customer of BSO Shared Services, the final reports have been shared with the Trust Director of Finance and a summary of the reports are presented to the Trust's Audit Committee.

Shared Service Audit	Assurance
Payroll Shared Service (September 2018 and March 2019)	Limited
Payments Processing in Accounts Payable Shared Service	Satisfactory
Recruitment Shared Service	Satisfactory
Business Services Team	Satisfactory

QUALITY ASSURANCE

Documented Quality & Improvement Programme

The Unit's Quality Assurance and Improvement Programme is documented in the Internal Audit Manual. A variety of internal and external quality assurance measures are in place, as documented in the Internal Audit Strategy document.

Internal Quality Assessment

The annual Internal Quality Assessment was completed by BSO Internal Audit during 2018/19, to confirm compliance with the Public Sector Internal Audit Standards (PSIAS). The positive outcome of this internal assessment was then subject to review during the External Quality Assessment (EQA).

External Quality Assessment

Internal Audit Units are professionally required to undergo an independent External Quality Assessment every 5 years. The Institute of Internal Audit (IIA) performed the EQA of BSO Internal Audit during February/March 2019.

They concluded that the BSO Internal Audit Service meet the vast majority of the Standards, as well as the Definitions, Core Principles and the Code of Ethics, which form the mandatory elements of the Public Sector Internal Audit Standards and the Institute of Internal Auditors' International Professional Practices Framework, the globally recognised standard for quality in Internal Auditing.

Results were very positive, confirming that the Unit conforms with 60 out of 62 applicable areas of the professional standards and partially conforms in the remaining 2 areas. The 2 partial conformances relate to:

- External Quality Assessments - The previous EQA (performed by DoH in 2012/13) was not deemed by the 2019 EQA team to be sufficiently independent.
- Co-ordination – The HIA should consider how best to support assurance mapping across client organisations and should seek out opportunities to coordinate with other assurance providers.

3 recommendations have been made in respect of these 2 partial conformances; the HIA has accepted these recommendations and action will be taken in line with set implementation dates.

The EQA team assessed 5 elements of the Audit Team's Effectiveness in an Internal Audit Maturity Matrix. Out of 5 possible assessment ratings (Poor, Needs Improvement, Satisfactory, Good, Excellent), the EQA team made the following assessments:

- Reflection of the Standards – Good
- Operating with Efficiency – Good
- Focus on performance, risk and adding value – Satisfactory
- Quality Assurance and Improvement Programme – Satisfactory
- Coordinating and maximising assurance – Needs Improvement

The EQA team commented in their report that "Key stakeholders see the Internal Audit team, as professional, objective and knowledgeable in their work. It was especially clear from our customer survey results, and each of our interviews, that senior managers and other key stakeholders truly value the Internal Audit Service".

Other Quality and Development Work

BSO Internal Audit Unit is accredited with the ISO 9001:2008 quality standard and is an approved ACCA Gold status Employer for Training and Professional Development.

The Internal Audit Partnership Forum met twice (May 2018 and January 2019) during 2018/19. The purpose of the group is to provide a forum for customers of the Internal Audit Unit to ensure the ongoing development of the service in line with customer needs. Internal Audit performance and developments were reported to the Forum.

THE HEAD OF INTERNAL AUDIT'S OVERALL OPINION ON RISK MANAGEMENT, CONTROL AND GOVERNANCE IN THE SOUTHERN HSC TRUST FOR THE YEAR ENDED 31 MARCH 2019

Introduction

The whole Board is collectively accountable for maintaining a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of the overall system. In discharging "accounting officer" responsibilities, the Accounting Officer is required to make an annual Governance Statement on behalf of the Board.

The Head of Internal Audit is required to provide an annual opinion on risk management, control and governance arrangements. This opinion is based upon and limited to, the internal audit work performed during the year, as approved by the Audit Committee.

Purpose of the Head of Internal Audit Opinion

The purpose of the annual opinion is to contribute to the assurances available to the Accounting Officer and the Board which underpin the Trust's own assessment of the effectiveness of the system of internal governance, which, in turn, will assist in the completion of the Governance Statement. The opinion expressed does not imply that Internal Audit has reviewed all risks and assurances relating to the organisation.

Overall Opinion

Overall for the year ended 31 March 2019, I can provide **satisfactory** assurance on the adequacy and effectiveness of the organisation's framework of governance, risk management and control.

Although I am content to provide overall Satisfactory assurance, it is important to note that Limited assurance is provided in a number of areas, including cyber security and Unacceptable assurance is provided in respect of Management of Trust Homecare.

Basis For Forming My Opinion

The basis for forming my overall opinion is an assessment of the range of individual opinions arising from the following risk-based audit assignments performed and reported on during 2018/19:

AUDIT ASSIGNMENT	LEVEL OF ASSURANCE
FINANCE AUDITS	
Payments to Staff	Limited
Management & Use of Health Roster	Limited
Non-Pay Expenditure within the Mental Health Directorate	Satisfactory
Cash Management in Cash Offices	Satisfactory
Asset Management	Satisfactory
Management of Contracts with the Voluntary sector (including Sure Start)	Limited
Management of Patient Private Property in Acute Hospitals	Satisfactory
Management of Clients Monies and Cash Handling in Social Services Facilities	Satisfactory (9 facilities)
Management of Client Monies in Independent Sector Homes	Satisfactory – 9 Homes Limited – 1 Home
Estates Procurement & Contract Management	Satisfactory
Ordering and Receipt of Goods	Satisfactory
Management of Trust Homecare within the Older People & Primary Care Directorate	Unacceptable
Visits to 2 Independent Domiciliary Care Providers (Peacehaven Care Services and Lydian Care)	Lydian – Unacceptable Peacehaven - Limited
SHSCT's Compliance with DoH Permanent Secretary's Instructions Regarding Travel (primarily travel outside Ireland and Britain)	Satisfactory

THE HEAD OF INTERNAL AUDIT'S OVERALL OPINION ON RISK MANAGEMENT, CONTROL AND GOVERNANCE IN THE SOUTHERN HSC TRUST FOR THE YEAR ENDED 31 MARCH 2019

AUDIT ASSIGNMENT	LEVEL OF ASSURANCE
CORPORATE RISK AUDITS	
Children's & Young People Directorate Risk Audit - Management of Children with Disabilities Services -	Limited
Management of Standards and Guidelines	Limited
Care/Case Management within Older People and Primary Care (OPPC) Directorate.	Satisfactory
GOVERNANCE AUDITS	
Risk Management	Satisfactory
Board Effectiveness	Satisfactory
Infection Prevention and Control (IPC)	Satisfactory - Oversight of compliance with Policies & Procedures, IPC Audit and training Limited - Anti-microbial Stewardship
Cyber Security	Limited/Satisfactory elements of opinion
Mortality and Morbidity processes (specifically mortality)	Limited

When forming my overall annual opinion, I have also taken into account the results of the year end follow up on previous audit recommendations, Shared Service audits and the various non-assurance assignments conducted during the year including the high level review of assurance processes post controls assurance standards.

Signed: Catherine McKeown **Date:** 25th April 2019 and 30th May 2019
Head of Internal Audit

SUMMARY OF RESULTS TABLE

	Audit Report / Priority	Implemented	Partially Implemented	Not Implemented	No Longer Applicable	Previously Followed up and Deemed Implemented	Total Number of Recommendations That Should Now be Implemented (i.e. implementation date has passed)	Percentage of Fully Implemented Recommendations
A	Governance Including Board Effectiveness 14-15	0	1	0	0	5	6	83%
	Priority 2	0	1	0	0			
B	Asset Management 15-16	1	0	0	0	7	8	100%
	Priority 2	1	0	0	0			
C	Compliance With Standards & Guidelines 15-16	0	0	0	1	12	12	100%
	Priority 2	0	0	0	1			
D	Laboratory Contracts 15-16	0	1	0	0	14	15	93%
	Priority 1	0	1	0	0			
E	Management of Complaints 15-16	4	3	0	0	9	16	81%
	Priority 2	4	3	0	0			
F	Fraud Processes - Whistleblowing 15-16	2	2	0	0	12	16	88%
	Priority 2	2	2	0	0			
G	Income & Debt Management 15-16	0	1	0	0	3	4	75%
	Priority 2	0	1	0	0			
H	ICT 16-17	0	0	1	0	5	6	83%
	Priority 2	0	0	1	0			

	Audit Report / Priority	Implemented	Partially Implemented	Not Implemented	No Longer Applicable	Previously Followed up and Deemed Implemented	Total Number of Recommendations That Should Now be Implemented (i.e. implementation date has passed)	Percentage of Fully Implemented Recommendations
I	Directorate Finance Audits - CYP (Including Management of Childrens Petty Cash 16-17	1	0	0	0	8	9	100%
	Priority 2	1	0	0	0			
J	Management of Contracts with Voluntary Sector inc Surestart Schemes Visits 16-17	0	0	0	1	4	4	100%
	Priority 2	0	0	0	1			
K	Fleet & Transport Procurement & Contract Management - Management of Taxi Usage 16-17	1	0	0	0	13	14	100%
	Priority 2	1	0	0	0			
L	Case/Care Management 16-17	1	4	0	0	5	10	60%
	Priority 1	0	1	0	0			
	Priority 2	1	3	0	0			
M	GP Out of Hours 16-17	0	2	0	0	10	12	83%
	Priority 2	0	2	0	0			
N	Clinical Audit 16-17	3	1	0	0	7	11	91%
	Priority 1	1	0	0	0			
	Priority 2	2	1	0	0			

	Audit Report / Priority	Implemented	Partially Implemented	Not Implemented	No Longer Applicable	Previously Followed up and Deemed Implemented	Total Number of Recommendations That Should Now be Implemented (i.e. implementation date has passed)	Percentage of Fully Implemented Recommendations
O	Management of Patient Flow 16-17	4	0	0	0	5	9	100%
	Priority 1	1	0	0	0			
	Priority 2	3	0	0	0			
P	Incident Management - Management of Acute Falls 16-17	11	0	0	0	3	14	100%
	Priority 2	11	0	0	0			
Q	Nursing Revalidation 16-17	2	0	0	0	7	9	100%
	Priority 2	2	0	0	0			
R	Absence Management 16-17	0	2	0	0	11	13	85%
	Priority 2	0	2	0	0			
S	Payments to Staff 17-18	2	3	0	0	3	8	63%
	Priority 2	2	3	0	0			
T	Non Pay Expenditure 17-18	1	0	1	0	6	8	88%
	Priority 1	1	0	0	0			
	Priority 2	0	0	1	0			
U	Directorate Finance Audits - Catering 17-18	6	0	0	0	6	12	100%
	Priority 2	6	0	0	0			

	Audit Report / Priority	Implemented	Partially Implemented	Not Implemented	No Longer Applicable	Previously Followed up and Deemed Implemented	Total Number of Recommendations That Should Now be Implemented (i.e. implementation date has passed)	Percentage of Fully Implemented Recommendations
V	Budgetary Control 17-18	2	0	0	0	1	3	100%
	Priority 2	2	0	0	0			
W	Financial Assessment 17-18	1	0	0	0	0	1	100%
	Priority 2	1	0	0	0			
X	Self Directed Support Payments 17-18	2	1	0	0	0	3	67%
	Priority 2	2	1	0	0			
Y	Management of Domiciliary Care 17-18	3	3	0	0	0	6	50%
	Priority 1	1	2	0	0			
	Priority 2	2	1	0	0			
Z	Management of Contracts Adjudication Groups (CAGs) 17-18	1	1	0	0	1	3	67%
	Priority 2	1	1	0	0			
AA	Patient Flow Acute Discharges 17-18	1	6	2	0	0	9	11%
	Priority 1	0	1	0	0			
	Priority 2	1	5	2	0			
BB	Performance Management 17-18	0	1	0	0	2	3	67%
	Priority 2	0	1	0	0			

	Audit Report / Priority	Implemented	Partially Implemented	Not Implemented	No Longer Applicable	Previously Followed up and Deemed Implemented	Total Number of Recommendations That Should Now be Implemented (i.e. implementation date has passed)	Percentage of Fully Implemented Recommendations
CC	Management of Medical Staff 17-18	5	1	0	0	0	6	83%
	Priority 1	1	0	0	0			
	Priority 2	4	1	0	0			
DD	Management of Medical Locums 17-18	5	0	0	0	4	9	100%
	Priority 1	3	0	0	0			
	Priority 2	2	0	0	0			
EE	Mandatory Training & Staff Appraisals 17-18	2	2	0	0	1	5	60%
	Priority 2	2	2	0	0			
FF	Risk Management 17-18	1	1	0	0	0	2	50%
	Priority 2	1	1	0	0			
GG	Culture 17-18	1	0	0	0	0	1	100%
	Priority 2	1	0	0	0			
HH	Paris Implementation 17-18	3	1	0	0	1	5	80%
	Priority 2	3	1	0	0			
II	IT Cyber Security 17-18	0	13	0	0	4	17	24%
	Priority 1	0	1	0	0			
	Priority 2	0	12	0	0			

	Audit Report / Priority	Implemented	Partially Implemented	Not Implemented	No Longer Applicable	Previously Followed up and Deemed Implemented	Total Number of Recommendations That Should Now be Implemented (i.e. implementation date has passed)	Percentage of Fully Implemented Recommendations
JJ	Non Pay Expenditure Invoice Approval 17-18	1	0	0	0	3	4	100%
	Not Prioritised	1	0	0	0			
KK	Peacehaven 17-18	1	2	0	0	0	3	33%
	Priority 1	0	1	0	0			
	Priority 2	1	1	0	0			
LL	PPP - Acute 18-19	2	0	0	0	0	2	100%
	Priority 2	2	0	0	0			
MM	Client Monies in Independent Sector - Residential Homes & ASL 18-19	2	0	0	0	0	2	100%
	Priority 2	2	0	0	0			
NN	Ordering & Receipt of Goods 18-19	2	0	0	0	0	2	100%
	Priority 2	2	0	0	0			
OO	Regional Travel 18-19	0	5	0	0	0	5	0%
	Priority 2	0	5	0	0			
PP	Estates 18-19	7	0	0	0	0	7	100%
	Priority 2	7	0	0	0			

	Audit Report / Priority	Implemented	Partially Implemented	Not Implemented	No Longer Applicable	Previously Followed up and Deemed Implemented	Total Number of Recommendations That Should Now be Implemented (i.e. implementation date has passed)	Percentage of Fully Implemented Recommendations
QQ	Non Pay Expenditure 18-19	6	0	0	0	0	6	100%
	Priority 2	6	0	0	0			
RR	Standards & Guidelines 18-19	4	3	0	0	0	7	57%
	Priority 1	1	0	0	0			
	Priority 2	3	3	0	0			
SS	Risk Management 18-19	0	0	0	1	0	0	
	Priority 2	0	0	0	1			
TT	Contracts with Vol Sector (inc Surestart) 18-19	4	2	0	0	0	6	67%
	Priority 1	1	0	0	0			
	Priority 2	3	2	0	0			
UU	Asset Management 18-19	2	0	0	0	0	2	100%
	Priority 2	2	0	0	0			
VV	Case/Care Management 18-19	0	0	0	1	0	0	
	Priority 2	0	0	0	1			

	Audit Report / Priority	Implemented	Partially Implemented	Not Implemented	No Longer Applicable	Previously Followed up and Deemed Implemented	Total Number of Recommendations That Should Now be Implemented (i.e. implementation date has passed)	Percentage of Fully Implemented Recommendations
WW	Lydian 18-19	1	0	0	3	0	1	100%
	Priority 1	0	0	0	1			
	Priority 2	1	0	0	2			
	Grand Total	**98**	**62**	**4**	**7**	**172**	**336**	**80%**

APPENDIX B DEFINITION OF LEVELS OF ASSURANCE AND PRIORITISATION OF AUDIT RECOMMENDATIONS

Level of Assurance

Satisfactory	Overall there is a satisfactory system of governance, risk management and control. While there may be some residual risk identified, this should not significantly impact on the achievement of system objectives.
Limited	There are significant weaknesses within the governance, risk management and control framework which, if not addressed, could lead to the system objectives not being achieved.
Unacceptable	The system of governance, risk management and control has failed or there is a real and substantial risk that the system will fail to meet its objectives.

Recommendation Priorities

Priority 1	Failure to implement the recommendation is likely to result in a major failure of a key organisational objective, significant damage to the reputation of the organisation or the misuse of public funds.
Priority 2	Failure to implement the recommendation could result in the failure of an important organisational objective or could have some impact on a key organisational objective.
Priority 3	Failure to implement the recommendation could lead to an increased risk exposure.