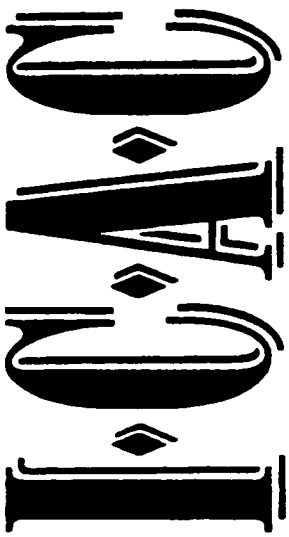
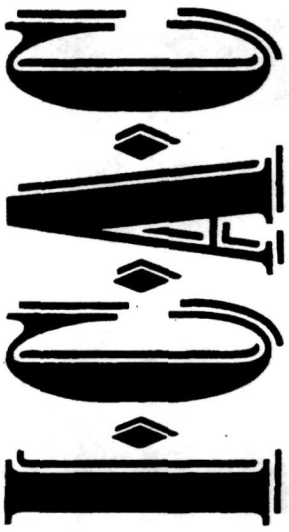


INDEPENDENT
COMMISSION
AGAINST
CORRUPTION

Monitoring Cash Handling in Public Hospitals

A Corruption Prevention Project

August 1994



INDEPENDENT
COMMISSION
AGAINST
CORRUPTION

ICAC and Corruption Prevention

Since its inception the Commission has played a major role in helping organisations to identify and reduce opportunities for corruption by reviewing operations and suggesting changes to policies, systems and procedures. This corruption prevention work is done through projects, seminars and advice to agencies. Its purpose is to facilitate improvements in public sector integrity through organisational and cultural change.

Corruption Prevention Projects

Projects examine public sector practices to identify weaknesses in policies or procedures that could be exploited for corrupt purposes. The Commission takes a broad approach to project work. The aim is to add value to the public sector by recommending changes that solve existing problems and inform agencies about ways to prevent corruption in the future.

Monitoring

Monitoring is an essential corruption prevention strategy. Management responses to areas of risk identified by the Commission are measured as part of monitoring projects. Their purpose is to make sure that agencies have fixed the problem and that changes to the system have not caused new loopholes. The Commission recommends further remedial action based on monitoring results if necessary. In this way the Commission aims to reduce the risk that corruption may recur.

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Contents

Overview

The Independent Commission Against Corruption released the findings of a study into cash handling systems in NSW public hospitals in July 1992. The report made forty-six recommendations aimed at improving cash handling procedures and controls.

In 1993/94 the Commission monitored how well hospitals had implemented the recommendations. The main aim of the cash handling monitoring project outlined in the following report was to find out if management action to improve cash handling systems was effective. To do this, the ICAC project team visited two large hospitals and analysed the results of a questionnaire sent to thirty-three other large and small hospitals around NSW. Briefly, the results of implementation were:

Hospitals Over 90 Average Daily In-Patients

- Hospitals with over 90 average daily in-patients had high compliance levels for recommendations that dealt with centralised controls and review functions, receipting procedures, storage and access controls, and accountability mechanisms for cash collection points.

- Non-compliance in large hospitals was high when managers faced unavoidable restrictions such as limited storage space. Other areas of high non-compliance included the structure of cash handling work and facilities. Wherever possible, managers should consider the requirements of the cash handling recommendations as part of any future up-grading of work areas.

Hospitals Under 80 Average Daily In-Patients

Assessment for compliance in small hospitals was restricted to key accountabilities identified in consultation with the Department of Health:

- The majority of small hospitals reviewed complied with most of the key accountabilities. This result includes a high level of acceptable non-compliance, i.e. modified administrative procedures or controls that differ from those recommended by the Commission but that solve the problem identified in the 1992 Cash Handling Report.

Approaches to Implementation

- The two hospitals visited provide a contrast in methods of implementation. At one hospital senior management adopted strong leadership, delegated key tasks appropriately and centralised co-ordination. At the other hospital, insufficient involvement by senior management in the implementation program reduced its effectiveness.

DEPARTMENT OF HEALTH

The monitoring project benefited from the support and assistance of the Department of Health, and in particular, the Department of Health Audit Branch. This report highlights measures the Department will introduce to ensure that managers take corrective action and maintain improved standards and controls. Initiatives include:

- A checklist of cash handling controls to be incorporated into the Accounting Manuals for Area and District Health Services and hospitals.
- Internal Audit Units to review compliance with the checklists as part of their annual programs.
- The Department of Health Audit Branch to ensure Internal Audit Units verify compliance with the checklists.
- The Department of Health will also take action to have Audit Committees in Area and District Health Services and public hospitals effectively monitor corrective action to help ensure it is taken and maintained as part of the Committees' program to make corporate governance more effective.
- In relation to hospitals with less than 80 average daily in-patients, Internal Audit Units are to review hospitals identified as unsatisfactory during ICAC monitoring to ensure compliance with key accountabilities. The Department of Health Audit Branch will forward a report to the ICAC detailing results of the special reviews.

CASH HANDLING IN PUBLIC HOSPITALS

In July 1992 the Commission published a report on cash handling in public hospitals. The project focused on systems of collecting, receipting, securing and banking funds for cash services provided in public hospitals. The amount of cash collected for direct services is a relatively small proportion of a hospital's total budget, but substantial in general terms. It was estimated that the cash collected at one large Sydney hospital was almost $4 million in 1991. With over 200 hospitals around the State, it was clear that both hospitals and hospital administration stood to benefit from enhancing accountability for cash collection.

The project found that systems to collect cash were inconsistent. Some hospitals had no procedures for giving receipts or for transporting and depositing cash from services such as child care, physiotherapy and other decentralised functions. In particular, the Commission was concerned that managers were not always aware how much or where cash was collected in their hospitals. As a result, the Commission's 1992 Report on Cash Handling in Public Hospitals made forty-six recommendations to improve cash handling procedures. (See Appendix A)

Many of the recommendations in the report were general. They were aimed at providing a framework for managing cash handling systems that could inform improvements in local procedures in hospitals throughout NSW. The Commission's recommendations are advisory. Responsibility for implementing them rests with management. The Cash Handling Report noted that it was up to Chief Executive Officers of hospitals to review cash handling systems in their hospitals and devise procedures to take account of the findings and recommendations.

MONITORING CASH HANDLING

In 1993/94 the Commission monitored how well hospitals had implemented the forty-six recommendations made in the 1992 Cash Handling Report. As part of this monitoring project Commission staff visited two large hospitals and, in addition, analysed the results of a Cash Handling Monitoring Questionnaire sent to thirty-three others around NSW. These hospitals were selected from an analysis of information provided by all public hospitals about action taken to implement the Commission's recommendations. The information was collected by the Department of Health in response to departmental circulars 92/93 and 92/94. Both circulars outlined the Department's policy on, and instructions for, implementing cash handling recommendations in Area and District Health Services.

The analysis grouped hospitals according to apparent compliance levels - compliance, incomplete compliance and possible non-compliance. While most hospitals appeared to comply, there were a number about which the Commission needed more information or which caused concern because of their apparent lack of action to implement the recommendations. In consultation with the Department of Health Audit Branch, the Commission selected

hospitals that showed incomplete or possible non-compliance from each Area and District Health Service to complete the monitoring questionnaire.

METHODOLOGY

All hospitals have some cash functions but not all ICAC recommendations applied to all hospitals. It was important that the Commission devise a monitoring method to suit different hospital sizes and operations. The approach adopted in this monitoring project focussed on:

- whether management had implemented relevant recommendations;
- a thorough analysis of day to day operations in hospitals as the means to understanding management action; and
- where managers modified recommendations to suit local operations, that the changes still met the objectives of the ICAC recommendations.

The approach was intended to facilitate consultation with the Department of Health and hospital managers as well as to provide sufficient information for the Commission to assess if management action to improve cash handling systems has been effective. In cases where managers adapted recommended action to suit local conditions, the approach also sought to give managers a way to explain to the Commission how their decisions address the problems identified in the 1992 project and to demonstrate results.

COMPLIANCE AND ACCEPTABLE NON-COMPLIANCE

Traditional methods of measuring compliance with recommendations usually set 100 per cent implementation as the standard to be achieved. Acceptable non-compliance is an approach to monitoring based on the recognition that management decisions to vary recommended action to suit local circumstances can be cost effective. From a manager's point of view, acceptable non-compliance is corrective action that is different to the Commission's recommendations, but that nonetheless solves the problem.

Monitoring methods measure compliance levels according to criteria such as materiality and risk. The acceptable non-compliance method uses these criteria and introduces others based on general hospital operations to ensure that modified administrative procedures or controls can be included in the Commission's assessment of effective corrective action. There are also management *categories* to cater for factors like size, budget and staffing, and *indicators* to ensure monitoring covers points in cash handling systems where accountability needs to be high, such as cash handling procedures, banking and transporting cash.

Management categories, assessment criteria and indicators can all be used to help determine

acceptable non-compliance. An assessment for acceptable non-compliance is conducted when managers do not implement recommendations, partially implement them or change them to suit hospital operations.

Management Categories

Categories allow the reviewer to consider management activities in relation to implementation and to accept or reject them as explanations for varying the level of compliance to less than 100 per cent. Categories of management activities relevant to the cash handling monitoring project are:

- new administrative policies in areas covered by the recommendations
- alternative solutions
- management/operational priorities
- budget or other constraints
- cash handling function discontinued

Assessment Criteria

The following criteria were set to ensure objective assessment of acceptable non-compliance in each management category. Some hospitals had discontinued cash handling functions prior to monitoring. No criteria were needed for these.

New administrative policies and alternative solutions

- Other management action solves the problem as fully as the recommendations
- Management action does not open new opportunities for corruption

Management/operational priorities

- Priority accords with departmental or hospital policy

Budget/other constraints

- Constraints are externally imposed
- Internally-imposed constraints are documented and subject to audit and review

INDICATORS

Indicators act as warning signals. They point to areas where non-compliance could be high such as hospitals with very many or few cash functions, specialist facilities, and community-based services. There are three types of indicators - positive, negative and 'more information needed'. Where the monitoring project noted positive points it is reasonable to assume compliance is adequate. Negative points can be a sign of inadequate or non-compliance. A selection of hospitals with negative indicators were followed up by either a visit or through the monitoring questionnaire. Indicators in the third group, 'more information needed', reflect unclear or potentially inadequate remedial action. When these indicators appeared the Commission sought more information about implementation before drawing a conclusion.

Table 1 is a summary of the key indicators used to monitor cash handling functions. A total of forty-four indicators were isolated from the hospital responses to the Departmental circulars mentioned above. Those listed below occurred most frequently.

TABLE 1 - EXAMPLES OF INDICATORS USED IN MONITORING

	INDICATORS		
CATEGORIES	Positive	Negative	More Info Needed
Compliance	Recommendations in place Safeguards already in place Compensatory controls	No review conducted Compliance in progress but not verified Recommendations noted but not implemented	Compliance level not stated Management use other criteria for implementation, eg, audit procedures
New administrative policies in areas covered by the recommendations	Procedures in place to control and acquit breaks in the accountability chain		Existing procedures improved
Alternative solutions	Solutions suit local operations		Staff limitations prevent implementation Non-standard positions or tasks
Management/ operational priorities	Management acts within appropriate jurisdiction	Insufficient information to back up management judgement Recommendations incorrectly interpreted	Invisible accountability Indirect accountability Management exercises discretion in implementation
Budget or other constraints	Insufficient funds restrict compliance		Facilities restrict implementation Non-standard systems hinder compliance
Other			Additional cash collection points not covered in the 1992 report

Categories, criteria, and indicators were combined in a checklist covering all forty-six recommendations in the Cash Handling Report. Observations in two hospitals and the results of the Cash Handling Questionnaire were recorded on the checklists. All data were then analysed to indicate general levels of compliance, non-compliance and acceptable non-compliance.

Monitoring Results

Results of the Questionnaire

The Commission recognises that operations can vary according to the size and location of hospitals. To get a fair picture of implementation, hospitals were divided into two groups for monitoring - twelve hospitals with over 90 average daily in-patients and twenty-one with less than 80. The two groups correspond with the Department of Health's classification of large and small hospitals. Acceptable non-compliance was assessed jointly by the Commission project team and an officer seconded from the Department of Health.

Hospitals over 90 Average Daily In-Patients

Hospitals with over 90 average daily in-patients had high compliance levels for recommendations that dealt with centralised controls and review functions. It is not surprising that in these hospitals, banking and audit trails appear to provide adequate controls for cash flows from collection points. Similarly, receipting procedures, storage and access controls, accountability mechanisms for outposts and audit functions had high levels of compliance in many of the hospitals reviewed. (Appendix B presents results for hospitals with over 90 average daily in-patients)

Procedures, controls and audit are key accountabilities. The Commission believes that the risks identified in the original report have been reduced to acceptable levels in most hospitals over 90 beds as a result of implementation. The results include acceptable non-compliance.

Areas of Acceptable Non-Compliance

- review of cash handling positions
- work structures for cash handling positions
- operations of the central cashier's office
- training
- audit and review

Non-Compliance

Non-compliance was high when managers faced unavoidable restrictions such as limited storage facilities. The Commission noted a high level of non-compliance in relation to safes and restricted access to offices. While physical and financial limitations are noted, the Commission believes that the requirements of the cash handling recommendations should be considered further if changes are possible in the future.

Another area of high non-compliance was the structure of cash handling work. Many cash handling officers in large hospitals work in a restricted area accessible to authorised staff only. However, where such controls are unavailable, the Commission considers that recommendations to separate cash floats, receipts and summary of daily takings should be a minimum accountability standard for cash handling.

Action

The Department of Health is undertaking the following initiatives to ensure maximum compliance wherever possible:

- A checklist of cash handling controls with which hospitals must comply will be incorporated into the Accounting Manuals for Area and District Health Services and Hospitals.
- Internal Audit Units of Area and District Health Services are to include on their respective audit programs the requirement to review compliance with checklists incorporated in the Accounting Manual.
- The Department of Health Audit Branch, as part of its program, is to ensure internal audit units verify compliance with the cash handling checklist.
- The Department will take action to have Audit Committees in Area and District Health Services and public hospitals effectively monitor corrective action to help ensure that it is taken and maintained, as part of the Committees' program to make corporate governance more effective.

Hospitals Under 80 Average Daily In-Patients

The situation is different when it comes to hospitals with under 80 average daily in-patients. Not all of the cash handling recommendations in the Commission's 1992 Report apply to smaller hospitals. These hospitals retain minimal amounts of cash, have limited staff and few cash collections points. The Department of Health and the Commission agreed that monitoring for these hospitals should concentrate on compliance with key accountabilities. Thirty-two questions from the cash handling questionnaire were used to assess how effectively small hospitals had implemented the ICAC recommendations.

Key Accountabilities

- cash processing and storage
- receipting procedures
- cash reconciliation for control and audit purposes
- mechanisms to control access to cash and its transport

Compliance and Non-Compliance

The majority of smaller hospitals surveyed complied with most of the key accountabilities. Acceptable non-compliance has been included in the figures for overall compliance. Areas of non-compliance included control of keys and access procedures, staff training, receipts, methods to check the cash flow from source to deposits, and accountable books. (Appendix C presents results for hospitals under 80 average daily in-patients)

Action

Internal Audit Units of Area and District Health Services to review hospitals identified as unsatisfactory during ICAC monitoring to ensure compliance with the checklist of key accountabilities. Department of Health Audit Branch will forward a report to the ICAC detailing results of the special reviews.

Results of Visits to Hospitals

The Commission found that implementation of the forty-six cash handling recommendations was most effective in the hospital visited where senior management provided strong leadership, delegated key tasks appropriately and centralised co-ordination.

At Royal North Shore Hospital, the Chief Executive Officer appointed a project officer who registered all cash handling outposts, identified common features in various cash handling systems and standardised new cash handling procedures using common practices as a guide. The result was that staff received consistent messages about the proposed changes as well as training to facilitate the effective introduction of the new procedures.

An advantage of this approach was that all staff involved reported an increased awareness of the need for cash handling controls and the benefits of better accountability for management. Many of them also reported feeling safer as a result of improved mechanisms for transporting cash from cash collection points to the cashier.

On the other hand, insufficient involvement by senior management at another hospital visited reduced the effectiveness of implementation. In this hospital individual managers implemented recommendations relevant to their areas without the benefit of co-ordination from senior management. As a result, the number of separate cash handling systems in operation increased rather than decreased. Inconsistent systems stayed the same, and weaknesses such as the use of unauthorised receipts continued. Also, the cash flow from collection points to cashiers remained uncontrolled.

The risk of theft in any hospital that devolved responsibility for implementation may still be unacceptably high and may even have gone up as more people become aware of the amount of cash stored and carried around hospitals. The purpose of the original recommendations was to reduce these risks through improved systems and accountability.

Conclusion

The results of hospital visits and the cash handling questionnaire showed that large and small hospitals adopted various implementation strategies. Some worked well, others did not. In relation to management action to improve cash handing systems, a factor contributing to successful implementation was the commitment by senior management to take and maintain corrective action. The Commission reviewed the results of implementation in the hospitals studied with the aim of providing monitoring principles to facilitate the implementation of future recommendations for systems and procedural changes.

Monitoring Principles

The cash handling monitoring project confirmed management involvement and guidance can increase the effectiveness of implementation. An implementation plan is essential and, if possible, new systems and procedures should be introduced to all relevant areas of hospital operations at the same time. Communication with staff about the changes is important in ensuring that new procedures are understood by those who will use them. It is important that cash handling policies are implemented to support new procedures and to ensure ongoing commitment to them.

Management, implementation and effective maintenance of new procedures are inter-related. The following checklist has been compiled from the results of the cash handling monitoring project. The Commission hopes the points noted will make implementation easier and help public sector agencies to gain the maximum benefit possible from the Commission's recommendations.

Implementation Checklist

Points to Consider

1 Who is Responsible for Implementing ICAC Recommendations?

- Appoint an officer to be responsible for implementation. Ideally, this should be a senior manager or appropriate delegate.
- Ensure his/her role, responsibility and contacting particulars are known to all staff.

2 What Changes are Needed?

- Identify all features of current operations, systems and procedures to which recommendations apply.
- Identify changes to be made.
- Consult with staff wherever possible to ensure proposed changes are practical and do not create new problems.

3 How will Changes be Made?

- Ensure implementation is directed from the highest management level possible.
- If responsibility is devolved, ensure there are procedures to report progress to the co-ordinating officer.
- Set timeframes for implementation. Identify key points and ensure reporting arrangements include progress reports.
- Inform staff about changes identified in 2 above. Specify which changes apply to their areas and when implementation will take place.
- Ensure adequate resources are available to facilitate the implementation phase.

4 Training

- Train all staff who will use new procedures, equipment or documents.
- Ensure equipment and documents are available.
- Provide staff with copies of new procedures and policies.

5 When is Implementation Complete?

- Document implementation, including revised implementation dates and any changes to proposed new procedures and policies.
- Inform staff when all recommendations are implemented.
- Set a date for review to ensure new procedures and systems have achieved the stated outcomes and have not introduced new problems.

APPENDIX A

DESCRIPTION OF 1992 CASH HANDLING RECOMMENDATIONS

REC	DESCRIPTION
1	Department of Health to introduce policy and guidelines for establishing commercial services which involve cash handling
2	Review of cash collection points
3	Restructure non-essential cash services
4	Contract out cash services using competitive tendering procedures
5	Establish and maintain an accurate register of cash collection points
6	All funds to be deposited with the central cashier
7	Procedures and conditions to approve decentralised banking arrangements
8	Cashiers to know how often cash from outposts should be deposited and procedures to report missed deposits
9	Review the duties, workload, staffing and structure of the central cashiers office
10	Revised structure for cashier work
11	Supervision by the finance section of positions that require cash handling as more than 40% of duties undertaken
12	Recruit staff with professional skills and provide in-service training
13	Train all staff at cash collection outposts
14	Central cashier to provide a receipt for all deposits from outposts
15	Cashiers receipt to identify the cash collection point, number of receipts issued at that point and the time of issue
16	Cashiers receipting procedures should have full controls - identity codes, cash totals, checks by supervisors and daily reconciliations
17	Provide accommodation for cashiers which is accessible to authorised officers only
18	Provide separate cash storage, secure cash storage facilities

REC	DESCRIPTION
19	Provide separate cash storage facilities and procedures for all staff whose duties include disbursements
20	Provide dual locking safes
21	Access procedures for safes to include controls, such as two officers present, an access register and a record of the signatures of officers who use the safe
22	Procedures for handling cash outside the cashiers operating hours
23	Provide security for staff who transport cash
24	Each cashier to prepare a daily balance which can be traced to a corresponding bank deposit form
25	Limit cash handling procedures at outposts to the smallest number possible
26	Use coin-operated boom gates to collect parking fees
27	Ensure boom gates allow easy access to emergency vehicles
28	Coin-operated machines to have two key access
29	Two staff to clear coin-operated machines
30	Staff who clear coin-operated machines to confirm the amount collected and deposited with the cashier
31	Cash collected from machines to be reconciled with meter readings or stock records
32	Procedures for collecting, receipting and depositing cash should be separate for each cash register operator on duty
33	Cash register control should make use of electronic controls and alarms. Access to cash register keys should be limited
34	There should be standard controlled receipting procedures for all cash collection points
35	Collection of fees for attendance related services should be fully accountable
36	Computer registered receipts should be standardised and secure
37	Guidelines and procedures for authorising and conducting fund raising activities

REC	DESCRIPTION
38	Review and rationalise special purpose and trust fund accounts
39	Fund raising to be directed towards identified priority areas
40	Audit of volunteer organisations which use a hospital's name, resources or staff
41	Limit the number of cash collection points and staff who handle cash
42	Controls for cash collection points to include: identification of the cash collection point, supervision at the collection point, and accountable books
43	There should be central procedures for procuring, distributing and storing accountable books
44	Ensure there is a key register that records the identity and position of staff who have access to any safe, cash register or coin-operated machine
45	An internal audit of cash collection points in the 1992/1993 financial year should have been conducted
46	Procedures to report and investigate cash losses

APPENDIX B

HOSPITALS OVER 90 BEDS AVERAGE DAILY IN-PATIENTS

OVERALL COMPLIANCE WITH ICAC RECOMMENDATIONS (12 HOSPITALS)

		NUMBER OF HOSPITALS		
REC NO.	RECOMMENDATIONS	COMPLIANCE	ACCEPTABLE NON-COMPLIANCE	NON-COMPLIANCE
2	Review non-essential cash services	12	0	0
3	Eliminate, restructure or contract out non-essential cash services	5	7	0
4	Contract out cash services using competitive tendering procedures	3	9	0
5	Establish and maintain an accurate register of cash handling points	12	0	0
6	All funds to be deposited with the central cashier	12	0	0
8	Cashiers and cash handling staff to know how often cash from outposts should be deposited and procedures to report missed deposits	12	0	0
9	Review the duties, workload, staffing and structure of the central cashier's office	9	2	1
10	Revised structure for cashier work	5	2	5
11	Supervision by the finance managers of positions that require cash handling as more often than 40% of duties undertaken	7	3	2
12	Recruit staff with appropriate personal and professional skills and provide in-service training	9	1	2
13	Train all staff at cash collection outposts	10	1	1
14	Central cashier to provide a receipt to all persons depositing funds at the time of the deposit.	11	0	1
15	Cashiers receipt to identify the cash collection point, number of receipts issued at that point and the period of issue	11	0	1
16	Cashiers receipting procedures should have full controls - identity codes, cash totals, checks by supervisors and daily reconciliations	10	0	2

These results do not include recommendations that cover Department of Health policy for Cash Handling, access to hospital grounds for emergency vehicles, volunteer organisations and trust funds. Refer to the list at the end of this table for the recommendations excluded.

		NUMBER OF HOSPITALS		
REC NO.	RECOMMENDATIONS	COMPLIANCE	ACCEPTABLE NON-COMPLIANCE	NON-COMPLIANCE
17	Provide accommodation for cashiers which is accessible to authorised officers only	7	3	2
18	Provide separate secure cash storage facilities for each central cashier	7	2	3
19	Provide separate cash storage facilities and procedures for central cashiers whose duties include disbursements	11	0	1
20	Provide safes with dual locks or internal compartments with separate keys	3	4	5
21	Access procedures for safes to include controls, such as two officers present, an access register and a record of the signatures of officers who use the safe	6	1	5
22	Procedures for handling cash outside the cashier's operating hours	11	0	1
23	Provide security for staff who transport cash	9	0	3
24	Each cashier to prepare a daily balance which can be traced to a corresponding bank deposit form	12	0	0
25	Limit different cash handling procedures at outposts to the smallest number possible	10	0	2
26	Use coin-operated boom gates to collect parking fees	10	2	0
28	Coin-operated machines to have two key access (one to service and the other to the cash box)	6	6	0
29	Two staff to clear coin-operated machines	11	1	0
30	Staff who clear coin-operated machines to confirm in writing the amount collected and deposited with the cashier	11	1	0
34	There should be standard controlled receipting procedures for all cash collection points	9	2	1
41	Limit the number of cash collection points and staff who handle cash	5	4	3

These results do not include recommendations that cover Department of Health policy for Cash Handling, access to hospital grounds for emergency vehicles, volunteer organisations and trust funds. Refer to the list at the end of this table for the recommendations excluded.

		NUMBER OF HOSPITALS		
REC NO.	RECOMMENDATIONS	COMPLIANCE	ACCEPTABLE NON-COMPLIANCE	NON-COMPLIANCE
42	Controls for cash collection points to include: identification of the cash collection point, supervision at the collection point,and accountable books	10	0	2
43	There should be central procedures for procuring, distributing and storing accountable books	11	1	0
44	Ensure there is a key register that records the identity and position of staff who have access to any safe, cash register or coin-operated machine	8	0	4
45	Internal audit cycle for cash collection points and central cashiers	9	1	2
46	Procedures to report and investigate cash losses	10	1	1

RECOMMENDATIONS NOT COVERED IN QUESTIONNAIRE

1 Department of Health to introduce policy and guidelines for establishing commercial services which involve cash handling
7. Procedures and conditions to approve decentralised banking arrangements
27. Ensure boom gates allow easy access to emergency vehicles
31. Cash collected from machines to be reconciled with meter readings or stock records
32. Procedures for collecting, receipting and depositing cash should be separate for each cash register operator on duty
33. Cash register control should make use of electronic controls and alarms. Access to cash register keys should be limited
35. Collection of fees for attendance-related services should be fully accountable
36. Computer generated receipts should be standardised and secure
37. Guidelines and procedures for authorising and conducting fund raising activities
38. Review and rationalise special purpose and trust fund accounts
39. Fund raising to be directed towards identified priority areas
40. Audit of volunteer organisations which use a hospital's name, resources or staff

APPENDIX C

HOSPITALS UNDER 80 DAILY AVERAGE IN-PATIENTS

COMPLIANCE WITH 32 KEY ACCOUNTABILITIES

KEY ACCOUNTABILITY	REC NO	NO OF HOSPITALS	
		C	NC
Review of cash services	2 41	18	3
Location of cashier	17	21	0
Cash storage facilities	5	21	0
Location/access to cash storage facilities	19 21	18	3
Types of cash storage facilities	20	18	3
Authorised access to cash storage facilities	17 18 21	16	5
Key register to control access to cash storage	17 21 44	5	16
Register of cash collection points	4	18	3
Review of duties and procedures for cash handling positions	9	16	5
New procedures for cash handling duties including, receipts, reconciliations, accountable books	12 3 25	14	7
All cash collection to be deposited with central cashier	6	18	3
Is there a central cashier's office	6 8 14	21	0
Cashier to issue receipts	14 34 35	21	0
Accountable, pre-numbered receipts required	14 15 34 35	21	0
Receipts to include standardised controls including,collection point, date, issuing officer, amount, ID numbers	14 16 35	14	7
Accountability mechanisms for cash collection	10 19 35	20	1
Controls for cash collections, transport, deposit and storage	28	19	2

REC NO = Recommendation Number, C = Compliance & acceptable non-compliance, NC = Non-Compliance

KEY ACCOUNTABILITY	REC NO	NO OF HOSPITALS	
		C	NC
Deposits to be recorded by cashier	24	20	1
Reconciliation of amount collected/deposited and banked	24	19	2
Procedures for collecting, receipting & depositing cash with the cashier	32	19	2
Number of staff required to clear coin-operated machines	29	18	3
Safeguards for access to coin-operated machines	28	20	1
Check amounts collected from coin-operated machines with meter readings & stock records	31	12	9
Reconciliation methods for amounts collected from coin-operated machines and deposited with the cashier	30 31	11	10
Procedures for issuing receipts at cash collection outposts	34	14	7
Methods used for checking amounts collected from cash outposts	31	14	7
Safeguards for transporting cash	23	10	11
Accountable documents to be used to record all cash collected	43	21	0
Is there an Accountable Books Register	43	21	0
Controls that apply to Accountable books including, pre-numbered receipts, record of distribution, procedures to return used books	43	19	2
Procedures for reporting thefts	46	17	4
Any mechanisms to deal with theft	46	17	4

REC NO = Recommendation Number, C = Compliance & acceptable non-compliance, NC = Non-Compliance