BOARD MEETING 27.06.18
Agenda Item: 10.3
Purpose: For Assurance

NHS Western Isles

FINAL Internal Audit Plan 2018/19

May 2018

Scott-Moncrieff
business advisers and accountants

NHS Western Isles

Internal Audit Plan 2018/19

Introduction

Internal auditing is an independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, internal control and governance processes.

Section 3 – Definition of Internal Auditing, Public Sector Internal Audit Standards

Scott-Moncrieff's internal audit methodology complies fully with the Public Sector Internal Audit Standards (PSIAS), which cover the mandatory elements of the Chartered Institute of Internal Auditors' International Professional Practices Framework.

Internal audit plan

The PSIAS require the Chief Internal Auditor to produce a risk-based plan, which takes into account NHS Western Isles' risk management framework, its strategic objectives and priorities, and the views of senior managers and the Healthcare Governance and Audit Committee.

The objective of audit planning is to direct audit resources in the most efficient manner to provide sufficient assurance that key risks are being managed effectively and value for money is being achieved.

This document addresses these requirements by setting out a detailed plan for 2018/19 in the context of a two-year strategic internal audit plan for the period 2018/19 to 2019/20.

Healthcare Governance and Audit Committee action

The Healthcare Governance and Audit Committee is asked to approve the draft Internal Audit Plan for 2018/19.

Internal audit approach

Supporting the Governance Statement

Our internal audit plan is designed to provide NHS Western Isles, through the Healthcare Governance and Audit Committee, with the assurance it needs to prepare an annual Governance Statement that complies with best practice in corporate governance. We also aim to contribute to the improvement of governance, risk management and internal control processes by using a systematic and disciplined evaluation approach.

Risk based internal auditing

Our internal audit methodology links internal audit activity to the organisation's risk management framework. The main benefit to NHS Western Isles is a strategic, targeted internal audit function that focuses on the key risk areas and provides maximum value for money.

By focussing on the key risk areas, internal audit should be able to conclude that:

- Management has identified, assessed and responded to NHS Western Isles' key risks
- The responses to risks are effective but not excessive
- Where residual risk is unacceptably high, further action is being taken
- Risk management processes, including the effectiveness of responses, are being monitored by management to ensure they continue to operate effectively, and
- Risks, responses and actions are being properly classified and reported.

We have reviewed NHS Western Isles' risk management arrangements and have confirmed that they are sufficiently robust for us to place reliance on the risk register as one source of the information we use to inform our audit needs assessment.

Audit needs assessment

Internal audit plans are based on an assessment of audit need. "Audit need" represents the assurance required by the Healthcare Governance and Audit Committee from internal audit that the control systems established to manage and mitigate the key inherent risks are adequate and operating effectively. The objective of the audit needs assessment is therefore to identify these key controls systems and determine the internal audit resource required to provide assurance on their effectiveness.

Our audit needs assessment takes both a top-down and bottom-up approach followed by a reasonableness check. The top-down approach involves identifying the areas of highest inherent risk and the control systems in place to manage those risks. The bottom-up approach involves defining NHS Western Isles' audit universe (potential auditable areas) and covering all systems on a cyclical basis in line with their relative risk and significance. The reasonableness check involves us using our experience of similar organisations, together with discussions with other NHS internal auditors, to ensure that all key risk areas and systems have been considered and the resulting internal audit plan seems appropriate.

Our audit needs assessment involved the following activities:

- Reviewing NHS Western Isles' risk registers,
- Reviewing NHS Western Isles' strategic and operational plans,
- Reviewing previous internal audit reports,
- Reviewing external audit reports and plans,
- Utilising our experience at similar organisations and our understanding of the NHS,
- Discussions with the Executive Directors and the Healthcare Governance and Audit Committee.

The audit needs assessment is revised on an ongoing basis (at least annually) to take account of any changes in NHS Western Isles' risk profile. Any changes to the internal audit plan are approved by the Healthcare Governance and Audit Committee.

Best value

Our work helps NHS Western Isles to determine whether services are providing best value. Each year, the plan contains specific reviews that focus on assessing whether the current processes provide best value. In addition, every report includes an assessment of value for money; i.e. whether the controls identified to mitigate risks are working efficiently and effectively. Where we identify opportunities for improving value for money, we raise these with management and include them in the report action plan.

Quality assurance and improvement

Key Performance Indicators

As set out in our Internal Audit Charter, we assess our performance in three ways:

- On-going internal monitoring of KPIs
- Periodic internal assessment
- Periodic external assessment.

As part of our internal monitoring of performance, we agree key performance indicators and targets with you and assess our performance against those targets. Our proposed KPIs are:

KPIs	Description
1	The annual internal audit plan is presented to and approved by the Healthcare Governance and Audit Committee prior to the start of the audit year.
2	90% of audit input is provided by the core team and continuity of staff is maintained year on year.
3	Draft reports are issued within 15 working days of completing fieldwork.
4	Management responses are received within 15 working days and final report issued within 10 working days.
5	At least 90% of the audit recommendations we make are agreed with and accepted by management.
6	At least 75% of Healthcare Governance and Audit Committee meetings are attended by an Internal Audit Partner.
7	The annual internal audit plan is fully delivered within agreed cost and time parameters.
8	The annual internal audit report and opinion is presented to and approved by the Healthcare Governance and Audit Committee at the first meeting after the year-end each year.
9	All internal audit outputs are finalised and submitted to the Board at least 10 working days before the Healthcare Governance and Audit Committee meeting.
10	Members of senior management and the Healthcare Governance and Audit Committee are invited to participate in the firm's client satisfaction survey arrangements.

Reporting

We will report the results of the KPI monitoring within the progress reports presented to each Committee meeting. The results of the annual internal assessment will be reported within our annual report each year, along with details of any improvement actions identified.

Delivering the internal audit plan

Internal Audit Charter

At Appendix 5 we have set out our Internal Audit Charter, which details how we will work together to deliver the internal audit plan.

Internal Audit team – indicative staff mix

Grade	2018/19 Input (days)	Grade mix (%)
Partner / Manager	32	23%
Other qualified staff	37	27%
Unqualified staff	49	36%
Specialist staff	20	14%
Total	**138**	**100%**

Confirmation of independence

PSIAS require us to communicate on a timely basis all facts and matters that may have a bearing on our independence.

We can confirm that all members of the internal audit team for 2018/19 are independent of NHS Western Isles and their objectivity has not been compromised.

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Proposed internal audit plan

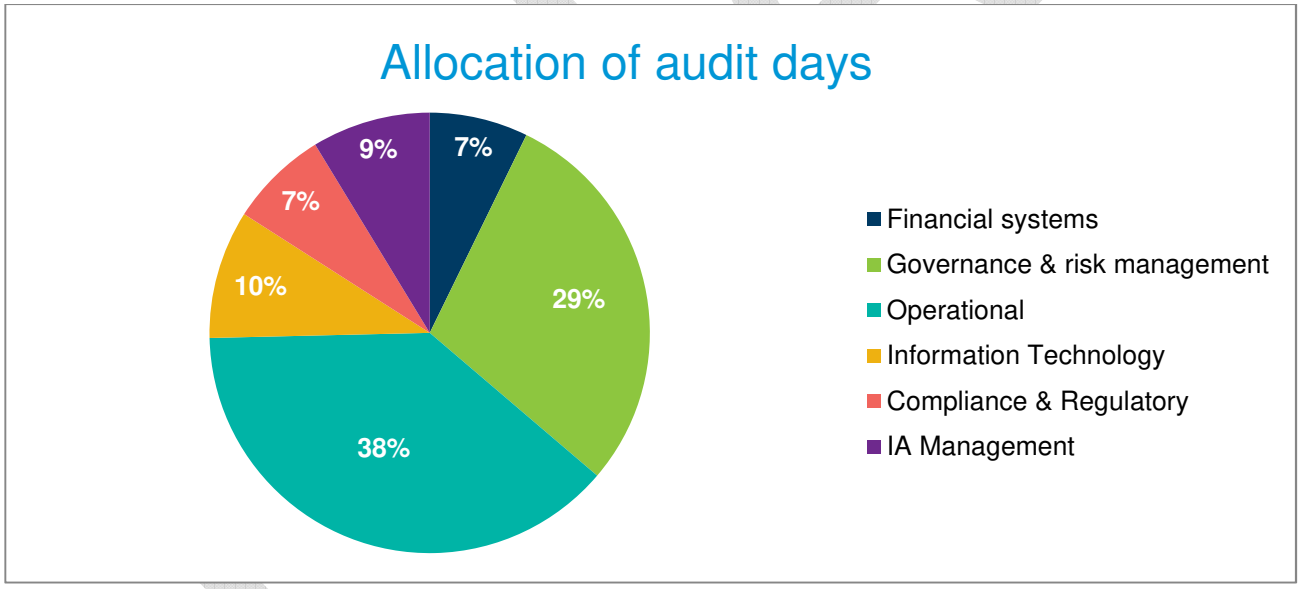
Appendix 1 presents the internal audit plan for 2018/19 to 2019/20.

As our internal audit approach is based on risk, the proposed plan is also cross-referenced to the strategic risk register, which is included in Appendix 2 for reference.

Internal audit is only one source of assurance for the Healthcare Governance and Audit Committee. Assurance on the management of risk is provided from a number of other sources, including the senior management team, external audit, and the risk management framework itself.

We seek to complement the areas being covered by NHS Western Isles' external auditors. Following discussion of this plan at the Healthcare Governance and Audit Committee, we welcome any comment from the external auditors. This helps us to target our work in the most effective manner, avoiding duplication of effort and maximising the use of the total audit resource.

The table below demonstrates how the 138 internal audit days proposed for 2018/19 are allocated across each area of the audit universe:



Appendix 1 – Strategic Internal Audit Plan 2018- 20

Audit area	2018/19 days	2019/20 days	Risk Reg Ref	Notes
A. **Financial systems**				
A1. Financial systems health-check		10		2018/19 – Payroll – controls over payments to staff, including preparation for e-Payroll and interface with e-ESS. 2019/20 – Income & receivables, Budget management.
A2. Payroll	10			See above.
Sub-total A	**10**	**10**		
B. **Risk management and governance**				
B3. Corporate Governance including Information Governance		14	1,13, 18	Review of corporate governance arrangements to ensure MI is being presented, reviewed and challenged by the Board and various governance committees and Information Governance arrangements and compliance with current regulations.
B4. Clinical Governance		11		2019/20 - TBC
B5. Risk management	12		All	Review of revised risk management arrangements including the Corporate Risk Register and Single Operating Division.
B6. Treatment time guarantees	12		4,7	Review of controls over management and reporting of performance against TTG standards.
B8. Complaints management	12		5	To ensure complaints are dealt with in line with procedures and current legislation.
B9. Internal & External communications		12	5, 6	Review of arrangements for internal and external communication throughout the health board, including through line management arrangements and with patient groups, other stakeholders.
B10. Workforce Management		14	15, 18	Review of recruitment and retention, succession planning and use of bank/agency staff.
B.11 Partnership Working	16			Review deferred from 2017/18, review of arrangements for Health and Social Care Integration.

Audit area	2018/19 days	2019/20 days	Risk Reg Ref	Notes
Sub-total B	**40**	**39**		
C. **Operational**				
C3. Health & Safety		10	2,5	Arrangements for governance of health and safety matters.
C6. Service Level Agreements	12			To review the arrangements for developing SLA's and monitoring their performance.
C8. Infection control		11	14	To assess arrangements for ensuring that infection control standards are known, adhered to, and monitored, including CDU.
C9. Staff rostering		11	6	A review of the implementation and compliance with the policy for developing staff rosters.
C10. Mandatory Training requirements	10			Review of oversight of completion of mandatory training.
C11. Stock Control	6			Deferred from 2017/18
C12. Review of TOIL arrangements	13			Review of the compliance with policies and procedures for the application of TOIL and recording of TOIL on SSTS. Review to focus on areas where there are high levels of on call i.e. Theatre, Radiology.
Sub-total C	**53**	**26**		
D. **Information technology**				
D2. IT and Records Security	13			Review of the use of technology, such as iPads, within wards, and the IT security and records security arrangements in place to mitigate potential data breaches as a result of this technology use.
D3. IT Strategy		10		Review of approach taken to develop the IT strategy and alignment to Corporate objectives.
Sub-total D	**13**	**10**		
E. **Compliance and regulatory**				
E1. Property Transaction Monitoring	2	2		Review as appropriate.
E2. Follow up	8	8		Bi-annual follow up of outstanding internal audit actions.
Sub-total E	**10**	**10**		
F. **Management**				

Audit area	2018/19 days	2019/20 days	Risk Reg Ref	Notes
HGAC planning and attendance	4	4		
Audit needs analysis and IA planning	2	2		
Liaison with external audit	1	1		
Contract management	4	4		
Annual internal audit report	1	1		
Sub-total F	**12**	**12**		
G. **Contingency 2018/19** **Contingency 2017/18 Carry Forward**	**-**	**-**		6.79 days contingency have been carried forward from 2017/18.
TOTAL	**138**	**125**		

Appendix 2 – Corporate Risk Register

The table below shows how each risk in the corporate risk register (as at December 2017) is covered over the course of the three year internal audit plan.

Risk ref	Corporate Aim	Risk	Risk Control Action Plan	Risk Rating (Likelihood / Consequence)		Potential IA Response
				Current Risk Rating	Target Risk Rating	
1	To provide person-cantered care, focusing on the evidence based health needs of our population, identifying and taking every opportunity to improve our patients' health and experience and outcomes.	The organisation is at risk of failure to achieve financial balance leading to not achieving statutory duty to break even against revenue resource limit. This risk could impact on the organisation by leading: to failure to achieve efficiency targets, high sickness absence necessitating he use of bank staff, high levels of unplanned or extra contractual activity with mainland providers, failure to adhere to standing financial instructions and delegating limits and external changes to regulations for example VAT and pension's contributions.	1. Regular monthly reporting of performance to budget holders, CMT, Integrated CMT, the Healthcare Governance and Audit Committee, the IJB and the SGHD. 2. Production of a Financial Efficiency Plan which has been implemented and is regularly reviewed for additional measures to achieve savings. 3. Inclusion of contingency budgets to provide a buffer against unforeseen costs.	20 (Very High)	12 (High)	Corporate Governance
2A	To protect individuals from avoidable harm by continually learning, and improving the reliability and safety in	There is a risk that the Board may not be able to respond effectively to a major incident (under the auspice of the Civil Contingencies Act). This risk may impact the Board across many of the organisations risk criteria from	1. Development of National Mass Casualty Plan. 2. Continuously Training Programme for Staff. 3. Engagement with Local, Regional and	15 (High)	12 (High)	Health and Safety

Risk ref	Corporate Aim	Risk	Risk Control Action Plan	Risk Rating (Likelihood / Consequence)		Potential IA Response
	everything we do.	patient safety through business interruption and organisational reputation. Given that the risk is measuring worst case scenario, catastrophic events, the impact rating is primarily extreme	National Emergency Management Multi-Agency Partnerships 4. Development of an internal rolling programme of exercises.			
2B	To protect individuals from avoidable harm by continually learning, and improving the reliability and safety in everything we do.	There is a risk that the Board may not be able to respond effectively to a Major Incident (under the auspice of the Civil Contingencies Act (2004)).This risk may impact the Board across many of the organisations risk criteria from patient safety through business interruption and organisational reputation. Given that the risk is measuring worst case scenario, catastrophic events, the impact rating is primarily extreme.	1. Development of National Mass Casualty Plan. 2. 2. Continuous Training Programme for staff. 3. Engagement with Local, Regional and National Emergency Management Multi-agency partnerships. 4. Development of an internal rolling programme of exercise	16 (High)	12 (High)	Health and Safety
4	To deliver our commitment to partnership working to deliver national standards, targets and guarantees.	There is a risk that NHSWI will not meet Treatment Times Guarantee (TTG) Legal Target for inpatient / day cases without increasing capacity. The impact to the Board is insufficient capacity to meet demand in specialties to meet HEAT waiting times targets and treatment time guarantee legal limit.	1. Resources – additional staff visiting services and local staff for increased sessions to build buffer and manage loss of service through technical service or staff sickness. Severe weather over Winter Period, could cause cancellation of elective lists, and increase pressure on TTG target. 2. Financial – estimate £200,000 required to sustain present targets and significant funding (e.g. additional consultant cost at mainland providers or agency providers) required to prevent TTG breaching.	20 (Very High)	16 (High)	Treatment time guarantees Performance Management
5	To protect individuals from avoidable harm by continually learning, and improving the reliability and safety in everything we do.	There is a risk that staff, patients, public and /or resources may suffer avoidable harm, loss and/or damage due to inadequate security system processes.	1. Security Group Established	12 (High)	9 (Medium)	Internal and External Communications Health and Safety Complaints Management

Risk ref	Corporate Aim	Risk	Risk Control Action Plan	Risk Rating (Likelihood / Consequence)		Potential IA Response
6	To provide person centred care, focusing on the evidence based health needs of our population, identifying and taking every opportunity to improve our patients' health, experience and outcomes.	There is a risk that unsatisfactory patient experience/patient safety incidents will occur because specialist consultant advice is not available. Non-compliance with MHRA/CPA resulting from no professional direction is also a risk for the organisation.	1. Option Appraisal presented CMT – work will now proceed to establish cost of developing partnership services with one of 3 mainland Boards – MoU has been agreed between NHSWI and NHS Highland for the provision of Microbiology clinical advice and professional direction and this service has not started, further discussions are ongoing.	25 (Very High)	4 (Medium)	Internal and External Communications Staff Rostering
7	To deliver our commitment to partnership working to deliver national standards, targets and guarantees.	There is a risk that delayed discharges will affect hospital capacity to meet core healthcare functions. The impact on the Board includes delay in treatment and patients clinical outcome being compromised, inability to meet TTG Legal targets, inability to meet HEAT targets, possibility of increase costs in mainland SLA's and the increased risk of infection due to prolonged hospital stay.	Discharge Manager now in post who will work with SCNs and engage with homes and relatives. Focus on Day of Care audits	15 (High)	16 (High)	Treatment time guarantees
11	To deliver our commitment to partnership working to deliver national standards, targets and guarantees.	There is a risk that the NHS Western Isles Blood Transfusion Service activity will be suspended if MHRA (Medicines & Healthcare products Regulatory Agency) considers that: (a) an action plan to correct non-compliances is inadequate or (b) progress to correct non-compliances does not progress within an acceptable timeframe.	Updated MHRA action plan. Support from SNBTS. Appointment to the Quality Manager Post	20 (Very High)	9 (Medium)	Risk Management Performance Management
13	To provide person-centred care, focusing on the evidence based health needs of our population,	There is a risk that the Board will not identify a significant proportion of its required efficiency savings target; the Board will effectively not have a robust balanced budget with a deliverable financial efficiency plan from the outset; the Board will not	Early and sustained work on identifying recurrent efficiencies through action plans arising from the sustainability and value programme boards.	20 (Very High)	12 (High)	Corporate Governance

Risk ref	Corporate Aim	Risk	Risk Control Action Plan	Risk Rating (Likelihood / Consequence)		Potential IA Response
	identifying and taking every opportunity to improve our patients' health and experience.	deliver on the efficiencies that it does not identify for the LDP; and the board will once again rely on non-recurrent savings in place of required recurrent savings. In addition the establishment of the Integrated Joint Board may have an impact on the identification and delivery of efficiencies within the delegated budgets. The impact to the Board is that it may not deliver on the efficiencies that it does identify for the Local Delivery Plan and it may have to rely on non-recurrent savings in place of required recurrent savings.				
14	To provide person-centred care, focusing on the evidence based health needs of our population, identifying and taking every opportunity to improve our patients' health, experience and outcomes.	There is a risk that the CDU washers could have a catastrophic failure due to age (replacement date was 2012), and availability of components. The unit may not maintain standards due to lack of accommodation. The effect to the Board is services will either have to be stopped or reduced due to lack of decontamination facilities.	1. Draft CDU layout produced for architects to develop proposal and options for new unit within Western Isles Hospital footprint.	20 (Very High)	6 (Medium)	Infection Control
15	To provide person-centred care, focusing on the evidence based health needs of our population, identifying and taking every opportunity to	There is a risk that the current out of hour's service in the laboratory could not be covered in the impact of sickness. This is due to the fact that from 20/05/16 there are only 2 members of staff able to provide cover. The impact to the Board is that Laboratory services OOH will become unsustainable	Training of BMS staff to join the on call rota on going.	15 (High)	9 (Medium)	Workforce Management

Risk ref	Corporate Aim	Risk	Risk Control Action Plan	Risk Rating (Likelihood / Consequence)		Potential IA Response
	improve our patients' health, experience and outcomes.					
16	To continually improve and modernise our integrated healthcare services and assurance systems.	There is a risk to the Board that due to no adequate planning process to enable us to understand future broadband availability for each of our sites, timescales presented are at best optimistic and do not necessarily reflect service levels caused by lack of available infrastructures. The impact to the Board is that the next generation of GP systems will not be usable.	NHS Western Isles IT are working with NSS to understand GP system requirements, and actual bandwidth consumed based on size of site / numbers of devices.	25 (Very High)	9 (Medium)	BTC
18	To protect individuals from avoidable harm by continually learning, and improving the reliability and safety in everything we do.	The risks associated with the current service configuration are; a financial risk that the GP OOH budget will overspend as solutions that either mitigate against vulnerability, or take us along the path of service transformation, are costly; a risk to the well-being of GPs working increased hours OOH; a clinical risk if no GP cover can be found, especially as we move into winter. The impact is that the GPP OOH service is on the brink of breakdown and not sustainable in its current format. It is to the credit of local doctors and administrative staff that the service invoked contingency plans only twice in the last 12 months. In 2012, 15 local GPs participated in the OOH service provision at least monthly; this is reduced to eight doctors in 2017, with all of the doctors doing more shifts than their stated maximum. Daytime over weekends are particularly difficult to cover exacerbating	At least one week per month is covered by an off island GP, either by a directly engaged locum or by an agency locum. OOH paediatricians and/or A&E are covered by a mixture of middle grade locum doctors, the locum paediatrician, local GPs only on call for CODs and the two speciality grade doctors to cover A&E plus paediatrics (when recruited). Resulting in some nights 4 different doctors covering GP OOH, Emergency Department, Paediatrics and FME. All putting pressure on the OOH budget. We are now trying to recruit to the speciality doctor posts via agencies with a resultant finders fee as well as trying to establish a cohort of speciality doctor locums. Currently a speciality trainee locum on fixed term contact is working 40hrs per week Emergency Department, thus enabling the OOH GP to focus on primary care out of hours work, as well	20 (Very High)	15 (High)	Corporate Governance Workforce Management

Risk ref	Corporate Aim	Risk	Risk Control Action Plan	Risk Rating (Likelihood / Consequence)	Potential IA Response
		the situation, of the eight doctors only 4 can cover all aspects of the OOH service, leading to an increasingly complex OOH rota. One of the eight doctors has now indicated that from November onwards she will no longer work OOH and another has indicated that she will reduce the number of shifts she covers from 2019 onwards. Three doctors cover almost 50% of shifts between them.	as a clinical development fellow who covers one shift per week most weeks.		

Appendix 3 – Audit timetable 2018/19

Ref and Name of report	Audit Sponsor	Quarter	Start fieldwork	Complete fieldwork	Draft Report	Mgmt Response	Final Report	HGAC
A2. Payroll	Director of Finance	Q2	Jul 18	Jul 18	TBC	TBC	TBC	Nov 18
B5. Risk Management	Director of Nursing	Q3	Oct 18	Oct 18	TBC	TBC	TBC	Feb 19
B6. Treatment Time Guarantees	Director of Nursing	Q2	Jul 18	Jul 18	TBC	TBC	TBC	Nov 18
B8. Complaints Management	Chief Executive	Q4	Feb 19	Feb 19	TBC	TBC	TBC	May 19
B.11 Partnership Working	Chief Executive	Q4	Feb 19	Feb 19	TBC	TBC	TBC	May 19
C6. Service Level Agreements	Director of Finance	Q3	Nov 18	Nov 18	TBC	TBC	TBC	Feb 19
C10. Mandatory Training Requirements	Director of Nursing	Q4	Jan 19	Jan 19	TBC	TBC	TBC	May 19
C11. Stock Control	Director of Finance	Q3	Nov 18	Nov 18	TBC	TBC	TBC	Feb 19
C12. Review of TOIL Arrangements	Director of Nursing	Q3	Nov 18	Nov 18	TBC	TBC	TBC	Feb 19
D2. IT and Records Security	Medical Director	Q3	Nov 18	Nov 18	TBC	TBC	TBC	Feb 19
E1. Property Transaction Monitoring	Director of Finance	Q1	Jul 18	Jul 18	TBC	TBC	TBC	Sept 18
E2. Follow up – part 1	All	Q2	Nov 18	Nov 18	TBC	TBC	TBC	Nov 18
E2. Follow up – part 2	All	Q4	Apr 19	Apr 19	TBC	TBC	TBC	May 19

Ref and Name of report	Audit Sponsor	Quarter	Start fieldwork	Complete fieldwork	Draft Report	Mgmt Response	Final Report	HGAC
Annual Internal Audit report	N/A	Post y/e	n/a	n/a	n/a	n/a	n/a	May 19

Appendix 4 – Internal audit universe

Audit area	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	Risk Ref	Frequency
A. Key financial systems									
Financial systems health-check	x	x	x	x	x	x	x	M	Cyclical reviews for key financial systems assurance
Financial reporting				x				M	Covered by external audit
Financial ledger		x						M	Covered by Financial systems health-check
Payroll		x				x		H	Cyclical review – every 3 to 4 years
Additional payments								M	Covered by external audit
Budget management	x			x				H	Cyclical review – every 3 to 4 years
Savings plans	x			x				H	Covered every 3 years – as part of Budget management
Treasury and cash management		x						M	Covered by Financial systems health-check
Expenditure and payables			x					H	Cyclical review – every 3 to 4 years
Fixed assets			x					M	Covered by Financial systems health-check
Income and receivables	x			x				M	Covered by Financial systems health-check
SLA income				x				M	Covered by Financial systems health-check
Travel and subsistence		x						M	Covered by Financial systems health-check
Patients private funds (PPF)			x					L	Covered by Financial systems health-check
Endowment funds								M	Covered by external audit
Accounting policies health-check								M	Covered by external audit
B. Governance and risk management									
Risk management		x				x		H	Cyclical review – every 3 to 4 years
Corporate governance	x				x			H	Cyclical review – every 3 to 4 years
Performance management			x				x	H	Cyclical review – every 3 to 4 years
Strategic planning					x			M	Cyclical review – every 3 to 5 years
Service redesign								L	Not identified as area of risk

Audit area	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	Risk Ref	Frequency
Project management – capital projects			x					M	Covered by IT developments- project management
Shared services								L	Not identified as area of risk
Actions from Mid-Staffordshire report								L	Not identified as area of risk
Health & Social Care integration			x	x				M	Covered within strategic planning
CRC Energy Efficiency Scheme		x						M	Estates and Asset Management, including CRC compliance.
Clinical governance			x		x			M	Cyclical review – every 3 to 5 years
Waiting time	x	x						M	Reviews directed by Government in 2012/13 and 2013/14
Delayed discharges		x			x			M	Cyclical review – every 3 to 5 years
Partnership working					x			H	Joint working arrangements with the Council
PFPI				x				M	Covered by External communications
External communications						x		L	Cyclical review – every 5 to 7 years
Internal communications				x		x		L	Cyclical review – every 5 to 7 years
Workforce management	x					x		M	Cyclical review – every 3 to 5 years
Use of medical locums								L	Not identified as area of risk
Use of Bank / Agency staff					x			M	Cyclical review – every 3 to 5 years
Out of Hours Service					x			H	Identified in risk register
Succession planning	x							L	Not identified as area of risk
Recruitment and retention							x	M	Cyclical review – every 3 to 5 years
HR recruitment policies and procedures							x	L	Not identified as area of risk
Annual leave								L	Not identified as area of risk
Sickness absence				x				M	Cyclical review – every 3 to 5 years
Junior Doctors								L	Not identified as area of risk
Conduct issues								L	Not identified as area of risk
Equality and diversity								M	Cyclical review – every 3 to 5 years
Employee contracts								L	Not identified as area of risk
Environmental management								L	Not identified as area of risk
Complaints Management				x				M	Cyclical review – every 3 to 5 years
Estates and asset management		x						M	Cyclical review – every 3 to 5 years
Business Continuity Planning (BCP)					x			M	Cyclical review – every 3 to 5 years

Audit area	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	Risk Ref	Frequency
Information management	x						x	M	Cyclical review – every 3 to 5 years
Quality Management								M	Cyclical review – every 3 to 5 years
C. Operational									
Procurement								M	Cyclical review – every 3 to 5 years
Tendering								M	Covered by Procurement
VfM reviews: – administration costs – staff travel arrangements								L	Not identified as area of risk
Operational planning			x					M	Cyclical review – every 3 to 5 years
Infection control	x			x				H	Cyclical review – every 3 to 4 years
Medicines management			x					L	Cyclical review – every 5 to 7 years
Consultants contracts		x						M	Cyclical review – every 3 to 5 years
Litigation costs								L	Not identified as area of risk
Theatre Usage		X						M	Cyclical review – every 3 to 5 years
Health and safety			x					L	Cyclical review – every 5 to 7 years
Portering and security								L	Not identified as area of risk
Fleet management								L	Not identified as area of risk
Patient transport								L	Not identified as area of risk
Staff rostering				x			x	M	Cyclical review – every 3 to 5 years
Mandatory Training Requirements					x			M	Cyclical review – every 3 to 5 years
NMAHP Registration	x							L	Not identified as area of risk
NMAHP Establishment Review	x							L	Not identified as area of risk Covered by Workforce planning
Scottish Standard Time System	x							L	Not identified as area of risk
Payment verification								L	Not identified as area of risk
Prescribing	x							L	Not identified as area of risk
Medical equipment and devices								L	Not identified as area of risk
Family Health Services			x			x		M	Cyclical review – every 3 to 5 years
Incident management	x				x			M	Cyclical review – every 3 to 5 years
Service Level Agreements (SLAs)		x				x		H	Cyclical review – every 3 to 4 years
Screening programme								L	Not identified as area of risk
Catering								L	Not identified as area of risk
Accommodation								L	Not identified as area of risk

Audit area	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	Risk Ref	Frequency
Patient records			x					M	Covered by records management
Stock controls								L	Not identified as area of risk
Paper records management			x					M	Covered by records management
Waste management								L	Not identified as area of risk
Fire safety								L	Not identified as area of risk
NHS Western Isles Blood Transfusion Activity						x		M	Identified in risk register
D. Information technology									
IT strategy				x		x		M	Covered as "eHealth strategy"
Disaster recovery					x			M	Covered as part of BCP
IT security	x				x			M	Cyclical review - every 3 to 5 years
Network management		x						M	Cyclical review - every 3 to 5 years
IT Best Value toolkit								L	Covered by external audit
IT developments - projects			x					M	Pre- and post-implementation reviews
Information governance	x			x			x	H	Cyclical review - every 3 to 4 years
IT governance								M	Cyclical review - every 3 to 5 years
Real Asset Management								L	Not identified as area of risk
E. Compliance and Regulatory									
Property Transaction Monitoring	x	x	x	x	x	x	x	M	Annual assurance required
Governance Statement readiness								L	Not identified as area of risk given unchanging requirements
Compliance with clinical standards								M	As required by management prior to HIS reviews
Procurement Capability Assessment								L	Not noted as issue - procurement covered separately
Fraud prevention								L	Not identified as area of risk
Caldicott Guardian	x				x			M	Requirement for triennial review
FOI Management	x							L	At management's request

Appendix 5 - Internal Audit Charter

Internal auditing is an independent and objective assurance and consulting activity that is guided by a philosophy of adding value to improve the operations of NHS Western Isles.

It helps NHS Western Isles accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control, and governance processes.

Aim

The aim of this Charter is to set out the management by all parties of the internal audit process. The Charter sets out the context of the internal audit function, including the place of the Healthcare Governance and Audit Committee (HGAC), the key personnel, timescales and processes to be followed for each internal audit review.

Role

The internal audit activity is established by the HGAC on behalf of the Board. The internal audit activity's responsibilities are defined by the HGAC as part of its oversight role.

Professionalism

The internal audit activity will adhere to Public Sector Internal Audit Standards (PSIAS), which are based on mandatory guidance of The Chartered Institute of Internal Auditors (CIIA) including the Definition of Internal Auditing, the Code of Ethics, and the International Standards for the Professional Practice of Internal Auditing.

The CIIA's Practice Advisories, Practice Guides, and Position Papers will also be adhered to as applicable to guide operations. In addition, the internal audit activity will adhere to NHS Western Isles' relevant policies and procedures and the internal audit activity's standard operating procedures manual.

Internal audit activity will also reflect relevant NHS and/or Scottish Government directions, as appropriate to NHS Western Isles.

Authority

The internal audit activity, with strict accountability for confidentiality and safeguarding records and information, is authorised full, free, and unrestricted access to any and all of NHS Western Isles' records, physical properties, and personnel pertinent to carrying out any engagement. All employees are requested to assist the internal audit activity in fulfilling its roles and responsibilities. The internal audit activity will also have free and unrestricted access to the HGAC.

Accountability

The Chief Audit Executive will be accountable to the HGAC and will report administratively to the Director of Finance.

The HGAC will approve all decisions regarding the performance evaluation, appointment, or removal of the Chief Audit Executive.

The Chief Audit Executive will communicate and interact directly with the HGAC, including between HGAC meetings as appropriate.

Independence and objectivity

The internal audit activity will remain free from interference by any element in NHS Western Isles, including matters of audit selection, scope, procedures, frequency, timing, or report content. This is essential in maintaining the internal auditors' independence and objectivity.

Internal auditors will have no direct operational responsibility or authority over any of the activities audited. Accordingly, they will not implement internal controls, develop procedures, install systems, prepare records, or engage in any other activity that may impair internal auditor's judgment.

Internal auditors must exhibit the highest level of professional objectivity in gathering, evaluating, and communicating information about the activity or process being examined. Internal auditors must make a balanced assessment of all the relevant circumstances and not be unduly influenced by their own interests or by others in forming judgements.

The Chief Audit Executive will confirm to the HGAC, at least annually, the organisational independence of the internal audit activity.

Scope and responsibility

The scope of internal auditing encompasses, but is not limited to, the examination and evaluation of the adequacy and effectiveness of the organisation's governance, risk management, and internal control processes in relation to the organisation's defined goals and objectives. Internal control objectives considered by internal audit include:

- Consistency of operations or programmes with established objectives and goals
- Effectiveness and efficiency of operations and use of resources
- Compliance with significant policies, plans, procedures, laws, and regulations
- Reliability and integrity of management and financial information processes, including the means to identify, measure, classify, and report such information.
- Safeguarding of assets.

Internal Audit is responsible for evaluating all processes ('audit universe') of NHS Western Isles, including governance processes and risk management processes. In doing so, internal audit maintains a proper degree of coordination with external audit.

Internal audit may perform consulting and advisory services related to governance, risk management and control. It may also evaluate specific operations at the request of the HGAC or management, as appropriate.

Based on its activity, internal audit is responsible for reporting significant risk exposures and control issues identified to the HGAC and to senior management, including fraud risks, governance issues, and other matters needed or requested by NHS Western Isles.

Annual internal audit plan

The audit year runs from 1 April to 31 March.

At least annually, the Chief Audit Executive will submit to the HGAC an internal audit plan for review and approval. The internal audit plan will detail, for each subject review area:

- The outline scope for the review,
- The number of days budgeted,
- The timing, including which HGAC the final will report will go to,
- The review sponsor.

The internal audit plan will be developed based on a prioritisation of the audit universe using a risk-based methodology, including input of senior management. Prior to submission to the HGAC for approval, the plan will be discussed with senior management. Any significant deviation from the approved internal audit plan will be communicated through the periodic activity reporting process.

Assignment Planning and Conduct

An assignment plan will be drafted prior to the start of every assignment setting out the scope, objectives, timescales and key contacts for the assignment.

Specifically, the assignment plan will detail the timescales for carrying out the work, issuing the draft report, receiving management responses and issuing the final report. The assignment plan will also include the name of the staff member who will be responsible for the audit (review sponsor) and the name of any key staff members to be contacted during the review (key audit contact).

The assignment plan will be agreed with the review sponsor and the key audit contact (for timings) before the review starts.

The internal auditor will discuss key issues arising from the audit as soon as reasonably practicable with the key contact and/or review sponsor, as appropriate.

Reporting and Monitoring

A written report will be prepared and issued by the Chief Audit Executive or designee following the conclusion of each internal audit engagement and will be distributed to the review sponsor and key contacts identified in the assignment plan for management responses and comments.

Draft reports will be issued by email within 15 working days of fieldwork concluding. Management and internal audit will agree on a draft report that is factually accurate and addresses the agreed scope within 15 days of the issue of the initial draft. The covering email will specify the deadline for management responses, which will normally be within a further 15 days. The review sponsor will oversee the management comments and response to any report.

The internal auditors will issue the final report to the review sponsor and the Director of Finance. The final report will be issued within 10 working days of the management responses being received. Finalised internal audit reports will be reviewed by the Corporate Management Team in advance of presentation to the

Healthcare Governance Committee. Finalised internal audit outputs must be in the hands of the Board at least 10 working days before the date of each meeting

The working days set out above are maximum timescales and tighter timescales may be set out in the assignment plan.

The internal audit activity will follow-up on engagement findings and recommendations. All significant findings will remain in an open issues file until cleared.

Healthcare Governance Committee

The Healthcare Governance Committee meets four times a year, normally in February, May, August December. Dates for Healthcare Governance Meetings will be provided to internal audit as soon as they are agreed. The Chief Audit Executive and/ or Internal Audit Manager will attend all meetings of the HGAC.

Internal audit will schedule its work so as to spread internal audit reports reasonably evenly over the Healthcare Governance Committee meetings. The annual internal audit plan will detail the internal audit reports to be presented to each HGAC meeting.

The internal auditor will generally present specific reports to the committee as follows:

Output	Meeting
Audit needs assessment	December / February
Annual internal audit plan	February / August
Follow-up reports	December / May
Annual report	June
Status report	All meetings

The Healthcare Governance Committee will meet privately with the internal auditors at least once a year.

Periodic Assessment

The Chief Audit Executive is responsible for providing a periodic self-assessment on the internal audit activity as regards its consistency with the Audit Charter (purpose, authority, responsibility) and performance relative to its Plan.

In addition, the Chief Audit Executive will communicate to senior management and the HGAC on the internal audit activity's quality assurance and improvement programme, including results of ongoing internal assessments and external assessments conducted at least every five years in accordance with Public Sector Internal Audit Standards.

Review of Charter

This Charter will be reviewed by both parties each year and amended if appropriate.