West Dunbartonshire
Health & Social Care Partnership

Supplementary Agenda

West Dunbartonshire Health & Social Care Partnership Board Audit Committee

Date: Wednesday, 19 June 2019

Time: 14:00

Venue: Ceremony Room, Clydebank Town Hall, Dumbarton Road, Clydebank

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Contact: Nuala Borthwick, Committee Officer
Tel: 01389 737220 nuala.borthwick@west-dunbarton.gov.uk

Dear Member

ADDITIONAL APPENDIX

I refer to the agenda for the above Meeting of the West Dunbartonshire Health & Social Care Partnership Board Audit Committee which was issued on 6 June 2019 and now enclose for your attention a copy of the undernoted additional appendix which relates to Item 5.

Yours faithfully

JULIE SLAVIN

Chief Financial Officer of the
Health & Social Care Partnership

Note referred to:-/

Note referred to:-

5 INTERNAL AUDIT ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2019 149 – 170

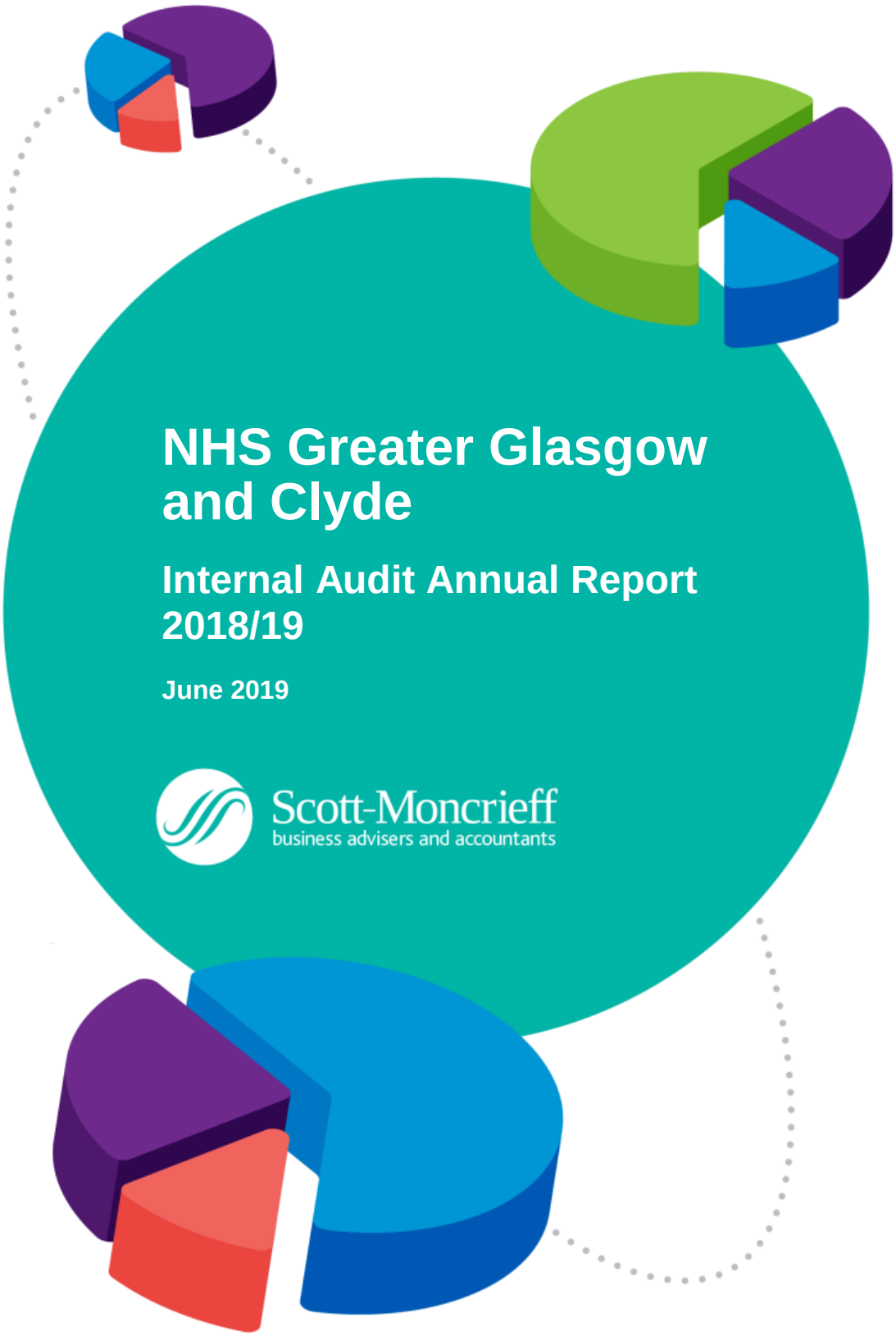
Submit additional appendix (Appendix 4, 'NHS Greater Glasgow and Clyde Internal Audit Annual Report 2018/19') in relation to the above report.

Distribution:-

Voting Members
Marie McNair (Chair)
Allan Macleod (Vice-Chair)
Denis Agnew
John Mooney
Rona Sweeney
Audrey Thompson

Senior Management Team – Health & Social Care Partnership
Mr C. McDougall
Ms Z. Mahmood

Date of issue: 14 June 2019



NHS Greater Glasgow and Clyde

Internal Audit Annual Report 2018/19

June 2019

Scott-Moncrieff
business advisers and accountants

NHS Greater Glasgow and Clyde

Internal Audit Annual Report 2018/19

Introduction

The Public Sector Internal Audit Standards (PSIAS) state that:

“The Chief Audit Executive must deliver an annual internal audit opinion and report that can be used by the organisation to inform its governance statement.”

“The annual internal audit opinion must conclude on the overall adequacy and effectiveness of the organisation’s framework of governance, risk management and control.”

To meet the above requirements, this Annual Report summarises our conclusions and key findings from the internal audit work undertaken at NHS Greater Glasgow and Clyde (NHSGGC) during the year ending 31 March 2019, including our overall opinion on internal systems of control.

Acknowledgement

We would like to take this opportunity to thank all members of management and staff for the help, courtesy and co-operation extended to us during the year.

Overall internal audit opinion

Basis of opinion

As the Internal Auditor of NHS Greater Glasgow and Clyde (NHSGGC), we are required by Public Sector Internal Audit Standards to provide the Audit and Risk Committee with assurance on the whole system of internal control. In giving our opinion it should be noted that assurance can never be absolute. The most that the internal audit service can provide is reasonable assurance that there are no major weaknesses in the whole system of internal control.

In assessing the level of assurance to be given, we have taken into account:

- All reviews undertaken as part of the 2018/19 internal audit plan;
- Any scope limitations imposed by management;
- Matters arising from previous reviews and the extent of follow-up action taken including in year audits;
- Expectations of senior management, the Audit and Risk Committee and other stakeholders;
- The extent to which internal controls address the risk management /control framework;
- The effect of any significant changes in NHSGGC's objectives or systems; and
- The internal audit coverage achieved to date.

In my professional judgement as Chief Audit Executive, sufficient and appropriate audit procedures have been conducted and evidence gathered to support the basis and the accuracy of the conclusions reached and contained in this report. The conclusions were based on a comparison of the situations as they existed at the time against the audit criteria. The conclusions are only applicable for the entity examined. The evidence gathered meets professional audit standards and is sufficient to provide senior management with proof of the conclusions derived from the internal audit work.

Internal Audit Opinion

In our opinion NHS Greater Glasgow and Clyde's internal control framework provides reasonable assurance regarding the achievement of objectives, the management of key risks and the delivery of best value, except in relation to:

- Performance Reporting;
- Payroll; and
- Sickness Absence.

Working closely with management, our reviews in the above areas highlighted significant opportunities for improving controls in order to ensure appropriate mitigation of risk, with 9 amber rated (high risk) actions arising. Further detail on these actions is included in the 'Key Findings' section of this report, at page 9.

Management has committed to implementing the necessary improvement actions in all of the above areas and progress is being reported to the Audit and Risk Committee as appropriate. Our most recent follow-up review for Q4 2018/19 has confirmed that management are making good progress in implementing the actions in line with agreed timescales, and we will continue to monitor this position on a quarterly basis during 2019/20.

Internal audit programme delivery

Responsibilities

Management

It is management's responsibility to establish a sound internal control system. The internal control system comprises the whole network of systems and processes established to provide reasonable assurance that organisational objectives will be achieved, with particular reference to:

- risk management;
- the effectiveness of operations;
- the economic and efficient use of resources;
- compliance with applicable policies, procedures, laws and regulations;
- safeguards against losses, including those arising from fraud, irregularity or corruption; and
- the integrity and reliability of information and data.

Internal auditor

The Internal Auditor assists management by examining, evaluating and reporting on the controls in order to provide an independent assessment of the adequacy of the internal control system. To achieve this, the Internal Auditor should:

- analyse the internal control system and establish a review programme;
- identify and evaluate the controls which are established to achieve objectives in the most economic and efficient manner;
- report findings and conclusions and, where appropriate, make recommendations for improvement;
- provide an opinion on the reliability of the controls in the system under review; and
- provide an assurance based on the evaluation of the internal control system within the organisation as a whole.

Planning process

In order that we can provide an annual assurance statement supporting the Governance Statement, we include all of NHSGGC's activities and systems within the scope of our internal audit reviews.

Our strategic and annual internal audit plans are designed to provide the Audit & Risk Committee with assurance that NHSGGC's internal control systems are effective in managing the key risks and best value is being achieved. The plans are therefore informed by the risk management system and linked to the Corporate Risk Register.

The Strategic Internal Audit Plan was agreed in consultation with senior management and formally approved by the Audit and Risk Committee in September 2018.

We have planned our work so that we have a reasonable expectation of detecting significant control weaknesses. However, internal audit can never guarantee to detect all fraud or other irregularities and cannot be held responsible for internal control failures. Assurance on the management of risk is provided from a number of other sources, including the management team, external audit, and the risk management framework itself.

Cover achieved

Our Internal Audit Plan comprises 525 days per annum, as detailed at Appendix 1. All core audit work in support of our annual audit opinion has been completed.

We confirm that there were no resource limitations that impinged on our ability to meet the full audit needs of NHSGGC as outlined in the agreed plan, and no restrictions were placed on our work by management.

We did not rely on the work performed by a third party during the period.

Independence

Public Sector Internal Audit Standards (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 staff members involved in 2018/19 internal audit reviews were independent of NHSGGC and their objectivity was not compromised in any way.

Conformance with Public Sector Internal Audit Standards

We confirm that our internal audit service conforms to the Public Sector Internal Audit Standards, which are based on the International Standards for the Professional Practice of Internal Auditing. This is confirmed through our quality assurance and improvement programme, which includes cyclical internal and external assessments of our methodology and practice, against the standards.

A summary of the results of our most recent quality assessment is provided at Appendix 2.

Key performance indicators

We use a suite of Key Performance Indicators (KPIs) to monitor the quality of the internal audit service. These are presented to each meeting of the Audit & Risk Committee. Appendix 3 includes a summary of performance against the KPIs. We would welcome any comments on the KPIs currently used.

Results of internal audit work

Summary of reports

We issued nineteen internal audit reports during 2018/19. Where relevant, all reports contained action plans detailing responsible officers and implementation dates. The reports were fully discussed and agreed with management prior to submission to the Audit and Risk Committee. The table below summarises the overall rating, assessment against control objectives and number of actions by grading in each report.

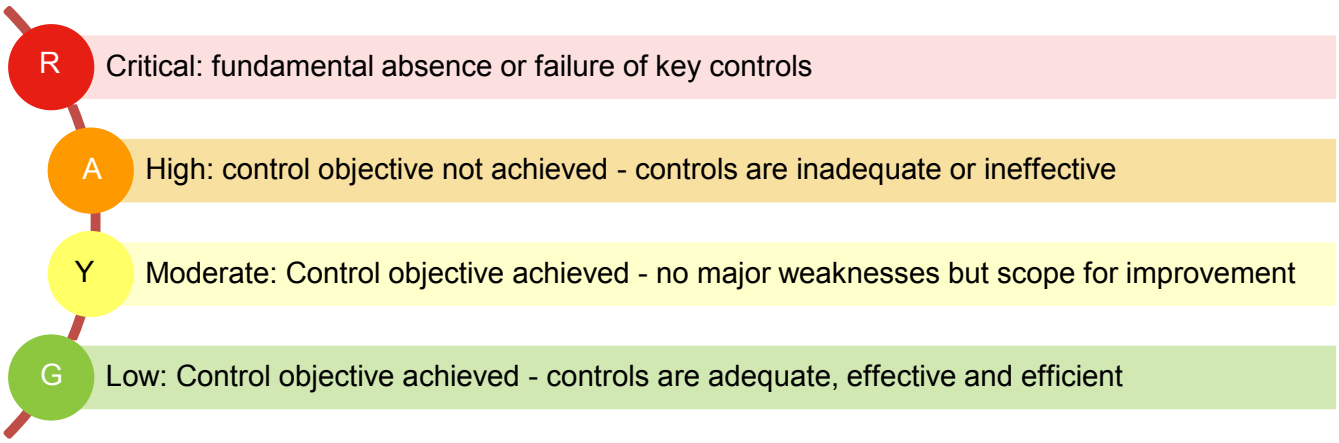
Review	Overall audit rating	Control objective assessment	No. of issues per grading			
			4	3	2	1
A.1 Strategic Planning Alignment	N/A	N/A	-	-	-	-
A.5 Outpatient Capacity Planning	Minor improvement required		-	-	2	1
A.7 Performance Reporting	Substantial improvement required		-	2	2	-
B.1 Financial Systems Health Check	Minor improvement required		-	-	9	1
B.2 Financial Planning – Financial Improvement Programme	Minor improvement required		-	-	3	2
B.3 Payroll	Substantial improvement required		-	2	3	2
C.1 Hospital Standardised Mortality Ratios (HSMR)	Minor improvement required		-	-	3	-
C.4 Review of Patient Results	N/A	N/A	-	-	-	-
D.1 Sickness Absence	Substantial improvement required		-	5	1	1

Review	Overall audit rating	Control objective	No. of issues per grading			
D.5 Other Leave	Minor improvement required		-	-	3	-
D.6 Nurse Rostering	Minor improvement required		-	1	4	-
E.1 GDPR Compliance	Minor improvement required		-	1	1	1
E.2 Digital Strategy	Minor improvement required		-	-	2	-
E.4 Information Sharing	Minor improvement required		-	-	3	1
F.1 Governance Statement Readiness	Effective		-	-	-	1
F.2 Waiting Times Audit	Effective		-	-	-	1
F.3 Property Transaction Monitoring	Minor improvement required		-	-	2	-
F.4 Follow up – Q3[1]	N/A	N/A	-	-	-	-
F.4 Follow up – Q4	N/A	N/A	-	-	-	-

[1] Reported by management for Q1 and Q2 – Internal Audit covers Q3 onwards

Key to report ratings

Control objective assessment definitions



Management action definitions

4	•Very high risk exposure - major concerns requiring immediate senior management attention.
3	•High risk exposure - absence / failure of key controls
2	•Moderate risk exposure - controls not working effectively and efficiently.
1	•Limited risk exposure - controls are working effectively, but could be strengthened.

Significant internal audit findings in 2018/19

Our internal audit work resulted in 11 Grade 3 findings across five review areas as follows:

Performance Reporting

We noted two Grade 3 findings:

- NHSGGC should develop a performance management framework that describes how performance against all corporate objectives will be measured and reported. We recommend also articulating the overarching performance management process, encompassing responsibilities, timetables and reporting lines.
- NHSGGC should develop a fully integrated performance report for the Board. This report should clearly summarise performance against each objective and all strategic KPIs. Where objectives are behind schedule, the report should clearly outline why, detail the mitigating actions being taken and confirm the revised implementation date.

Payroll

We noted two Grade 3 findings:

- From a sample of 24 on-call supplements paid to medical consultants during financial year 2018/19, we identified four instances (17%) where medical consultants were paid a supplement rate in excess of the on-call duties outlined within their rotas; and
- We identified from sample testing that seven of 24 (29%) payments to bank staff were not approved and processed within the required timescales.

Sickness Absence

We noted five Grade 3 findings:

- We identified inconsistent adherence to documented processes for managing employee absence through our sample testing;
- We noted ineffective monitoring of recurring and long-term absences due to lack of formal guidance to staff in this area;
- Staff make use of non-specific absence cause codes, resulting in poor quality data for the purposes of absence monitoring and trend analysis;
- We noted a lack of engagement with iMatter, meaning issues contributing to absence are not identified and addressed as a means of lowering sickness absence rates; and
- HR initiatives aimed at promoting attendance are not consistently planned and monitored as a means of ensuring their successful and effective implementation.

Nurse Rostering

We noted one grade 3 finding:

- Our sample testing identified that quarterly reviews of the ward/area rosters were not consistently carried out, in line with the requirements of the Nursing and Midwifery Rostering Policy.

GDPR Compliance

We noted one grade 3 finding:

- The Information Governance Steering Group and the Audit and Risk Committee may not have adequate and sufficient assurance that NHSGGC is GDPR compliant at a local level.

Management remain committed to implementing the necessary improvement actions to address these high-risk findings, and we will continue to monitor progress in this area through our quarterly follow up reviews.

Key themes

Overall, we have observed that NHSGGC has robust and well-defined policies and procedures in place. Our audit findings relate predominantly to the need to improve uniform, consistent compliance with those policies, and to improve consistent and effective communication and reporting on key areas of performance. There remains, therefore, a significant challenge to address these key underlying control issues in the context of ongoing financial and resourcing pressures, the slow progress of health and social care integration and increasing demand for services.

Follow-up of previous internal audit reports

Management continues to make excellent progress in monitoring and implementing agreed actions from audit reports.

We completed two follow-up reviews during 2018/19 to validate management's progress in implementing agreed audit actions. The table below sets out the movement in actions included on the Audit Recommendation Tracker throughout the financial year.

	Number of Actions
Open actions brought forward from previous auditor	8
New actions added to tracker in period prior to March 19	30
Total actions to follow-up	**38**
Actions closed to May 2019	23
Open actions carried forward	**15**

The chart below summarises the status of the actions at May 2019.

Status of Actions as at May 2019

Of the 15 open actions, 6 (40%) were not yet due for completion at the time of our validation work and the remainder were in progress.

Appendix 1 – Planned v actual days 2018/19

Ref and Name of report	Planned Days	Actual Days
A. Corporate reviews		
A.1 Strategic planning alignment	40	40
A.5 Outpatient capacity planning	25	25
A.7 Performance reporting	30	37*
B. Financial reviews		
B.1 Financial systems health check	30	30
B.2 Financial planning and budget monitoring	30	30
B.3 Payroll	20	20
C. Clinical & Care Governance reviews		
C.1 Hospital Standardised Mortality Ratios	40	40
C.4 Review of patient results	25	25
D. Staff Governance reviews		
D.1 Sickness Absence	35	35
D.5 Other leave	20	20
D.6 Nurse Rostering	30	30
E. ICT reviews		
E.1 GDPR compliance	25	25
E.2 eHealth / Digital	30	30
E.4. Information sharing and management	25	25
F. Compliance and Regularity reviews		
F.1. Governance statement readiness	8	8
F.2 Waiting times audits	5	5
F.3 Property transaction monitoring	7	7
F.4 Follow up Q1	8	1*

F.4 Follow up Q2	8	8
F.4 Follow up Q3	8	8
F.4 Follow up Q4	8	8
G. Management		
G.1 Contract management	35	35
G.2 ARC and ACEG planning and attendance	12	12
G.3 Audit needs analysis - strategic and annual planning	6	6
G.4 Liaison with external audit	2	2
G.5 Quarterly liaison meetings and progress reporting	18	18
G.6 Annual internal audit report	2	2
TOTAL	**525**	**525**

* Outstanding days from Follow-Up Q1 (7) to cover overrun on Performance Reporting, which arose due to increasing the number of meetings required to complete the audit.

Appendix 2 – Summary of Quality Assurance Assessment

We are pleased to disclose the outcome of our regular internal and external quality assessments to provide you with assurance that the service you receive is of a high quality and fully compliant with internal audit standards.

Outlined below are extracts from our most recent external quality assessment undertaken in July 2018.

External Quality Assessment summary

Executive Summary

We are pleased to report that Scott-Moncrieff may state in their internal audit reports that the work "has been performed in accordance with the IPPF". The team similarly conform to the Public Sector Internal Audit Standards (PSIAS).

The Internal Audit team **fully meet the vast majority of the Standards, as well as the Definition, Core Principles and the Code of Ethics,** which form the mandatory elements of the Institute of Internal Auditors' International Professional Practices Framework (IPPF), the globally recognised standard for quality in Internal Auditing. The Institute describe this as **"Generally Conforms"**.

This is an excellent result and is based on an extensive external quality assessment (EQA) covering the team's approach, methodology, processes and a sample of files by an experienced external assessor who is a serving Head of Assurance and Audit Committee Chair.

Overview of the External Quality Assessment Process

We undertook extensive background research covering the team's methodology and processes, before undertaking an intensive onsite visit over 25-28 June 2018, in which we interviewed a small number of team members and reviewed a sample of working files covering a representative range of the team's clients and sectors. After the onsite visit we finalised our evaluation, assessment and reporting.

The EQA involved comparison of working practices against the Institute of Internal Auditors' global International Professional Practices Framework[2] (the IPPF) and the Public Sector Internal Audit Standards (PSIAS).

During this external assessment we have followed this process:

- Examined and reflected upon the requirements of the Definition of Internal Auditing, the Code of Ethics and each International Standard. We have used the relevant Interpretation within the Standards to build our understanding.
- Considered the key conformance criteria needed to demonstrate compliance.
- Recorded the full range and extent of the evidence that exists within the team and that demonstrates conformance with the Standard. We have undertaken this through interviews with team members as well as reviewing files and engagement reports.
- Compared the evidence to the key conformance criteria and assessed the degree of conformance. We have used the standard IIA definitions that are provided below on page 13 to guide our evaluation.

Conformance to the Standards: The International Professional Practice Framework (IPPF)

Our objective of this External Quality Assurance (EQA) review was to undertake an independent, objective external quality assessment of the Scott-Moncrieff Internal Audit team against the IPPF and PSIAS. This included considering the team's conformance to both the IPPF and PSIAS and informally benchmarking the function's activities against best practice.

[2] The global IPPF is followed by more than 180,000 internal auditors in 190 countries around the world.

The Institute of Internal Audit's (IIA's) International Professional Practice Framework (IPPF) includes the Definition of Internal Auditing, Core Principles, Code of Ethics and International Standards. There are 64 fundamental principles to achieve with 118 points of recommended practice.

We include a summary of the Internal Audit Service's conformance to both the IPPF and the core principles below. Overall, we believe that the Internal Audit Service has achieved an excellent performance given the breadth of the IPPF and the diverse organisational contexts and sectors that the team operate across.

Summary of IIA Conformance	Standards	N/A	Does not Conform	Partially Conforms	Generally Conforms	Total
Definition of IA and Code of Ethics	Rules of conduct	0	0	0	12	12
Purpose	1000 - 1130	0	0	0	8	8
Proficiency and Due Professional Care	1200 - 1230	0	0	0	4	4
Quality Assurance and Improvement Programme	1300 - 1322	2	0	1	4	7
Managing the Internal Audit Activity	2000 - 2130	0	0	1	11	12
Engagement Planning and Delivery	2200 - 2600	1	0	0	20	21
Total		**3**	**0**	**2**	**59**	**64**

The overall assessment resulting from the EQA is that the Scott-Moncrieff Internal Audit team "generally conforms to the IIA's professional standards".

The Scott-Moncrieff Internal Audit team are able to say in reports and other literature that it "conforms to the IIA's professional standards" and that its work has been performed "in accordance with the IPPF."

This EQA was conducted as a full external quality assessment using methods recommended by the Chartered Institute of Internal Auditors.

Key Achievements

We believe that the team perform particularly well in a number of areas. We were most impressed by the following points:

- The Scott-Moncrieff Internal Audit team delivers an effective, efficient and economic independent and objective assurance service across a range of client organisations primarily in the government, education, health and social housing sectors.
- The team develop an Audit Charter, Audit Needs Assessment, strategic and annual plans with each client. The team take account of the client's risk maturity.
- Annual planning is comprehensive and is a participative process involving clients and stakeholders at appropriate stages. Progress against the annual plans are documented and reported on regularly to respective audit committees and senior managers.
- The team have developed an appropriate methodology for auditing key objectives, risks and controls across client organisations at a high level. The operational internal audit processes are fit for purpose, documented in a professional audit manual and supported by use of Pentana an effective Audit Management Software application.

- The team are beginning to make use of IDEA, an effective file interrogation software package since its adoption earlier this year. This has the potential to help make the team's internal audit process even more efficient, while enhancing the quality of assurance provided to client organisations.

- The team's standard internal audit engagement report template is professional, useful and represents good practice. The approach is concise. The reports we reviewed were jargon-free and (on the whole) reader friendly.

- Our file reviews demonstrated appropriate compliance with the methodology and sufficient evidence of appropriate supervision and review.

- The team's internal audit delivery is very efficient, with tightly focused engagements resulting in short durations and (usually) minimal elapsed time from start to finish.

- Follow up of outstanding recommendations occurs at least annually.

- Continuous Personal Development (CPD) is encouraged, knowledge sharing occurs across the team through quarterly development days (and other initiatives) and expertise from elsewhere across Scott-Moncrieff can be accessed (if required) for more specialist engagements.

- Client feedback is actively sought following the internal audit engagements and reported to the Audit, Risk and Governance Committee.

Opportunities for Further Development

We believe that the Scott-Moncrieff Internal Audit team fall slightly short against just two Standards, both of which we assess as "partially conforms".

The first of these is Attribute Standard 1312, External Assessments. This Standard states, "External assessments must be conducted at least once every five years by a qualified, independent assessor or assessment team from outside the organisation..." We understand that a CHEIA peer review was the only previous, formal external assessment of elements of the Scott-Moncrieff Internal Audit team. Our current review represents the first formal external assessment and so the team have not fully conformed to this Standard to date.

The second is Performance Standard 2050, Coordination. The Standard states, "The chief audit executive should share information, coordinate activities and consider relying upon the work of other internal and external assurance and consulting service providers to ensure proper coverage and minimise duplication of efforts". The need to consider how best to rely on and coordinate with other assurance providers is an emerging area of internal audit practice. It depends as much on the client and their other assurance providers as it does internal audit. However, we believe that it is something that could be explored more fully as governance, risk management and control maturity increases across larger client organisations.

We also make a small number of additional suggestions for further development to enhance these – and other – areas of the team's service delivery.

We are happy to provide audit committee members with the full report, if required.

Our response

We welcome the findings of this external assessment. A detailed action plan has been put in place to address the areas for further development to further enhance our internal audit practices.

Appendix 3 – Performance against KPIs

The following table summarises performance of the internal audit service against our KPIs.

KPI description	Status	Comments
1. The annual internal audit plan is presented to and approved by the Audit & Risk Committee prior to the start of the audit year.	**N/A**	Our annual internal audit plan for 2018/19 was approved by the Audit and Risk Committee in September 2018 due to the timing of contract award.
2. Assignment plans agreed for each audit at the start of the audit year	**GREEN**	Assignment plans were agreed on an individual audit basis, on average 8 days before commencement of audit fieldwork, due to the timing of contract award.
3. Produce draft audit report within an average of 15 working days of the end of audit fieldwork	**GREEN**	Draft reports were issued to management within an average of 14 working days during 2018/19.
4. Receive management responses within an average of 15 working days of receipt of the draft report	**AMBER**	Management responses were received for draft reports within an average of 23 days. Whilst this exceeds the KPI standard, part of the reason relates to the time required to agree actions that address the key risks, add value and can be realistically implemented by management.
5. Submit final report within an average of 5 working days of receipt of management responses.	**GREEN**	On average, our 2018/19 reports were finalised within 4 working days of receipt of management responses.
6. Carry out quarterly follow up audits by Audit Committee Executive Group (ACEG) deadline.	**GREEN**	We have undertaken quarterly follow up of agreed audit recommendations since Q2 2018/19 due to the timescales of awarding the internal audit contract.
7. Provide Progress Reports and other papers for the ACEG and the Audit and Risk Committee ten working days before the meeting date.	**YELLOW**	With the exception of the June 2019 meeting, all reports and papers were submitted ten working days before the ACEG/ARC meeting.
8. Provide annual internal audit report and opinion for approval by the Audit and Risk Committee at the first meeting after the year-end each year.	**YELLOW**	The Internal Audit Annual Report was presented to the 14 June 2019 Audit and Risk Committee meeting – i.e. the second meeting following the 2018/19 year end. This was due to delays in finalising our individual audit reports, which collectively form the basis of our annual opinion. We shared our draft report with management and Audit Scotland to support the annual accounts audit in advance of the ARC meeting.
9. Attend quarterly contract management meetings and monthly liaison meetings with management.	**GREEN**	During 2018/19, we attended quarterly meetings with the Audit and Risk Committee Chair and the Board Chair and quarterly contract management meetings with the Chief Executive and Director of Finance.

		We also attended monthly liaison meetings with the Financial Governance Manager.
10. The Internal Audit Partner attends at least 75% of Audit and Risk Committee meetings.	**GREEN**	The Internal Audit Partner, Chris Brown, has attended all scheduled Audit and Risk Committee meetings in 2018/19.
11. 90% of audit input is provided by the core team, with continuity of staff maintained year on year.	**GREEN**	90% of our onsite audit work was delivered by our core audit team during 2018/19. We have planned resource for 2019/20 audit work to ensure continuity of staff is maintained.

Key

RED	More than 50% from target
AMBER	Between 25% and 50% of target
YELLOW	Up to 25% from target
GREEN	Achieved