NHS Greater Glasgow & Clyde

Strategic Internal Audit Plan 2018/19 – 2020/21

September 2018

Scott-Moncrieff
business advisers and accountants

NHS Greater Glasgow & Clyde

Strategic Internal Audit Plan 2018/19 – 2020/21

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

Our strategic internal audit plan is designed to provide NHS Greater Glasgow & Clyde (NHSGGC), through the Audit and Risk Committee, with the assurance it needs to prepare an annual Governance Statement that complies with best practice in corporate governance. We also aim to support the continuous improvement of governance, risk management and internal control processes by using a systematic and disciplined evaluation approach.

The Public Sector Internal Audit Standards (PSIAS) require the Chief Internal Auditor to produce a risk-based plan, which takes into account NHSGGC's risk management framework, its strategic objectives and priorities, and the views of senior managers and the Audit and Risk 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 the strategic internal audit plan for the three-year period 2018/19 to 2020/21.

Audit and Risk Committee action

We presented the 2018/19 draft internal audit plan to the Audit and Risk Committee on 5 and 19 June 2018 in the context of the three year strategic internal audit plan. At the 19 June meeting agreement was obtained on the reviews to be commenced in the first half of 2018/19. Since then, we have discussed all of the proposed areas for review in 2018/19 with the Chief Executive and executive directors. The plan was then presented to the Board at a seminar on 4 September 2018 and is now submitted to the 11 September 2018 Audit and Risk Committee meeting for final approval.

Delivering the internal audit plan

Internal Audit Charter

At Appendix 4 we have set out our Internal Audit Charter, which details how we will work together to deliver the internal audit programme.

Internal Audit team – indicative staff mix

Grade	Input (days)	Grade mix (%)
Partner/Director	80	15%
Manager	90	17%
Qualified	130	25%
Senior	115	22%
Junior	110	21%
Total	**525**	**100%**

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Our strategic approach

A holistic methodology

We understand that NHS Greater Glasgow and Clyde faces a highly complex and ever evolving landscape and a range of challenging issues and risks. This means that you need to balance competing priorities within demanding timescales and with limited resources. The purpose of this strategic internal audit plan is to support you in addressing these challenges by providing assurance on the internal controls that manage your key risks and by encouraging a culture of continuous improvement throughout the health board.

Our methodology is designed to reflect your environment, minimising the burden on staff to support the audit process whilst maximising the value we add both in each individual audit and from the audit programme as a whole. We plan complementary audits that enable us to provide you with a holistic view of your key risk mitigating strategies and processes. As part of this we design end-to-end process reviews that consider the knock-on impact that issues can have throughout different parts of the healthcare system.

Planning our audit work in this way means that we build our knowledge to better support you in designing and implementing effective management actions that complement changes happening at the same time in different parts of the organisation.

Best value

Our work helps you to determine whether services are providing best value. Every audit report includes an assessment of value for money by considering the design of your systems, processes and controls and whether these are working efficiently and effectively. Where we identify opportunities for improving value for money, we discuss these with management and include them in the management action plan.

Assurance, Process Improvement and Ad-Hoc Reviews

Our plan includes a mix of core assurance and process improvement work, while retaining flexibility to deliver ad-hoc reviews at the request of management or the Audit and Risk Committee. This approach allows us to target audit resource as effectively as possible, utilising the full skills of our team to help the Board address key organisational risks. We will agree the primary objective of each review with management during the planning process.

Core assurance reviews

Core assurance reviews provide the necessary coverage of key control systems on a cyclical basis, looking to confirm that the systems that mitigate your key inherent risks are operating as expected and in support of a robust internal control framework.

Process improvement reviews

Process improvement reviews allow us to look at systems in more depth, working in collaboration with management and the Audit and Risk Committee to focus on areas where it may be acknowledged that further development is required to improve either the efficiency or effectiveness of the process, or both. We work in partnership with management, in an open

way and as a critical friend, to agree improvements in those areas and systems. Systems that typically benefit most from process improvement reviews are those that cut across more than one team or department, as the interface between distinct teams is often the place where inefficiencies can occur.

Ad-hoc

Management support time allows us to react to the board's needs over the course of the year and add value in investigations, systems development and gateway reviews, project input support, risk management development and other areas where our specialist involvement may be of use.

Understanding the Board's audit needs

Risk and audit needs assessment

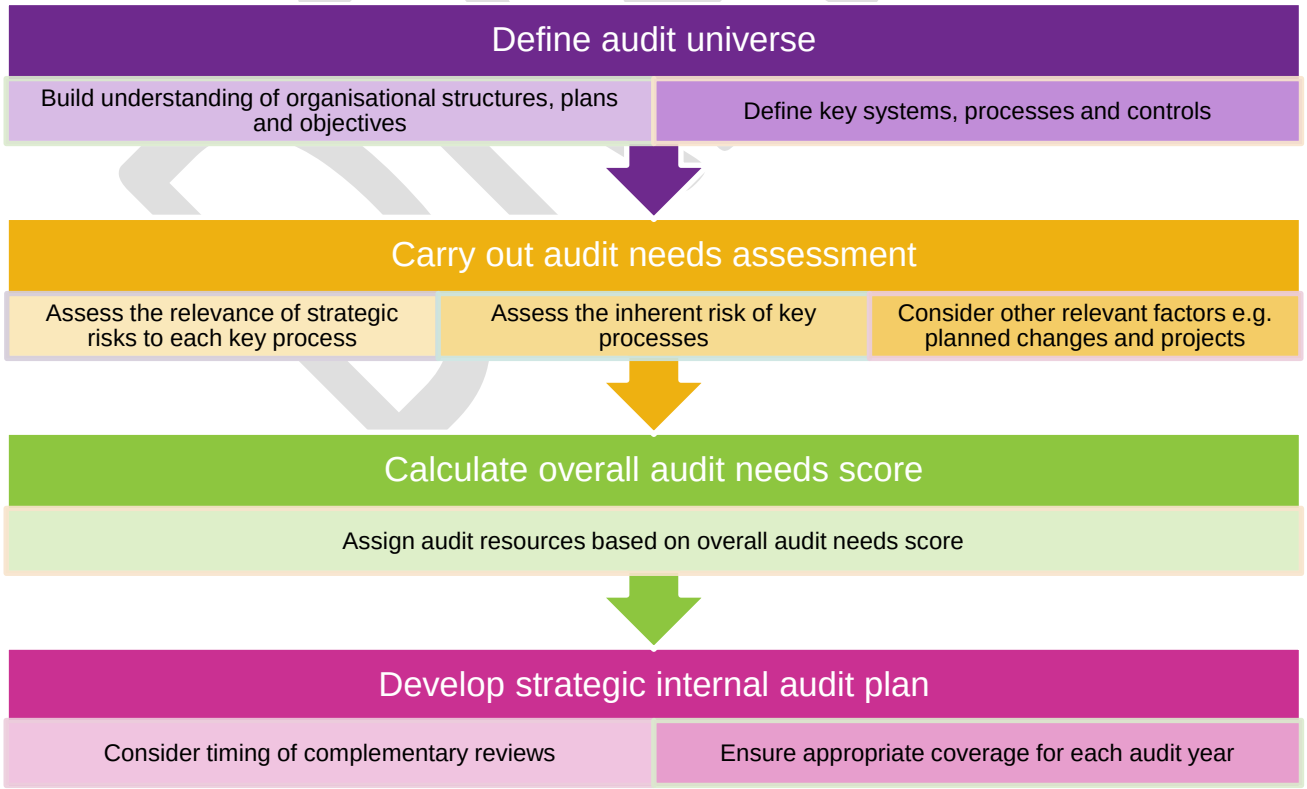
Internal audit plans are based on an assessment of audit need. "Audit need" represents the assurance required by the Audit and Risk Committee from internal audit that the control systems established to manage and mitigate the key inherent risks are adequate and operating effectively. The objective of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

The risk and audit needs assessment involves consideration of both:

- Areas of high residual risk i.e. those that appear on the strategic risk register and are a current focus for the organisation
- Areas of high inherent risk i.e. key processes that are crucial to the organisation's success.

Reviewing the risk profile from both aspects ensures that our audit plan provides the Audit and Risk Committee with assurance over key processes and controls and also helps to drive process improvement and support the organisation in better managing emerging and significant strategic risks.

The risk and audit needs assessment process can be summarised as follows:



Strategic residual risks

During the risk and audit needs assessment, we consider the areas of highest residual risk in your strategic risk register and identify the control systems currently in place to manage those risks. We do this by considering the key processes in place within the Board and the relevance of each strategic risk to those processes. This helps us to understand the scope and potential impact of each risk, as well as the interdependencies across the Board.

The strategic risk register is included in Appendix 2 and cross-referenced to the internal audit plan in Appendix 1.

Inherent risks and audit universe

We also review the Board's audit universe (the potential auditable areas) and assess the inherent risk associated with each area. This enables us to identify the areas where the Audit and Risk Committee most needs assurance that systems and processes are operating effectively.

The board's audit universe and inherent risk rating is included in Appendix 3.

Environmental and change risks

Finally, we take account of ongoing projects, forthcoming changes and our wider knowledge of the NHS and public sector to ensure we provide an appropriate level of audit coverage across all key areas and risks. This includes consideration of the following key sources of information:

- The Board's Corporate Plans/ Local Delivery Plans/ Operational Plans,
- Previous internal audit reports,
- External audit reports and plans,
- The Board's website and internal policies and procedures,
- Our experience at other health boards and our understanding of the sector,
- Discussions with the Senior Management Team, the Audit Committee Executive Group and the Audit and Risk Committee.

The risk and audit needs assessment will be revised on an ongoing basis (at least annually) to take account of any changes in the Board's risk profile. Any changes to the internal audit plan will be approved by the Audit and Risk Committee.

Liaison with external audit

We seek to complement the areas being covered by NHSGGC's external auditors, Audit Scotland. We welcome comments on the internal audit plan from Audit Scotland at any time and we will formally discuss the plan with Audit Scotland on at least an annual basis. This will help us to target our work in the most effective manner, avoiding duplication of effort and maximising the use of the board's total audit resource.

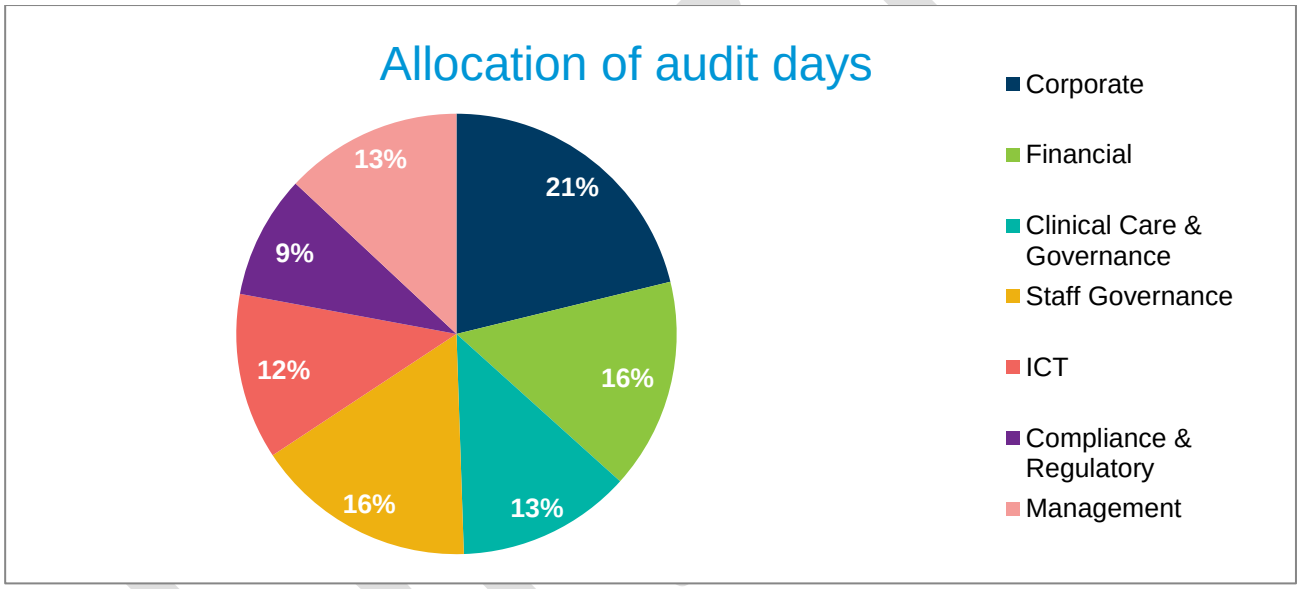
Internal audit plan

Appendix 1 presents the internal audit plan for 2018/19 to 2020/21. The three year internal audit plan is based on our latest risk and audit needs assessment dated August 2018.

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 Audit and Risk 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.

The table below demonstrates how the internal audit days agreed for 2018-21 are allocated across each area of the audit universe:



Appendix 1 – Strategic Internal Audit Plan 2018-21

Audit area	2018/19	2019/20	2020/21	Risk Reg Ref	Audit objectives
A. Corporate					
A.1 Strategic planning alignment	40			2054 2055 2056	To confirm that the NHSGGC Moving Forward Together Transformation Plan and the IJB strategic plans are appropriately aligned to reflect the integration of service deliverables and shift in the provision of health and social care services. This will cover the inclusion of public health objectives. The review will cover strategic integration across the 12 partnerships that NHSGGC engages with.
A.2 Moving Forward Together implementation		35	30	2054 2055 2056	To review delivery of the Moving Forward Together Transformation Plan to achieve system-wide change within NHSGGC. The review will cover the implementation, monitoring and reporting processes to assess progress and impact of individual workstreams.
A.3 Service redesign – project assurance		25	25	2054 2055 2056	Our reviews will provide programme and project assurance on specific service redesign initiatives: **2019/20:** Acute Stroke Services – including additional focus on engagement and communication with members of multi-disciplinary teams and the wider public through campaigns. **2020/21:** Cancer Services – including additional focus on engagement and communication with partners and third parties responsible for delivering cancer services.
A.4 Operational planning		30		2021 2061 2063	To ensure that annual operational planning processes support delivery of strategic objectives; are informed by budgetary, workforce and risk considerations; developed with input from all key parties; are

Audit area	2018/19	2019/20	2020/21	Risk Reg Ref	Audit objectives
				2089	consistently applied across the organisation; and performance is effectively monitored on a frequent basis to assess progress.
A.5 Capacity planning	25	20		2054 2055 2056	**2018/19: Outpatient capacity and productivity programme –** To review the arrangements for assessing service demand and delivering changes to supply. This review will focus on these arrangements within a particular service to be agreed with management. **2019/20 Bed Management and Delayed Discharges** – Considering the policies and procedures to utilise beds and reduce delayed discharges within NHSGGC hospitals, including the use of daily discharge planning and a Multi-Disciplinary Team approach to discharges. We will also consider the impact WardView and PharmacyView have had and how management are monitoring and reporting the ongoing impact on bed utilisation and delayed discharges.
A.6 Risk management			25		To ensure that there is a defined and consistent approach for the identification of risks; that risk registers are embedded throughout the organisation; mitigating actions are identified to manage residual risks down to an acceptable level; and registers are monitored on an ongoing basis.
A.7 Performance reporting	23			2054 2055 2056 2088	To assess the robustness of NHSGGC's overarching performance management framework, including identification of metrics to assess board-wide performance and agreement of an appropriate reporting framework for the Board, its committees and management.
A.8 Stakeholder engagement			23	2054	To ensure appropriate plans and processes are in place

Audit area	2018/19	2019/20	2020/21	Risk Reg Ref	Audit objectives
				2055 2056 2059	to engage with key stakeholders, with particular focus on IJBs. The review will consider whether there are clear communication methods in place to support engagement; the extent to which engagement is appropriately prioritised and linked to strategic and operational objectives; the methods for recording engagement activities; and the reporting that takes place to demonstrate impact and effectiveness of the engagement undertaken.
A.9 Assurance mapping		30			To support management in developing an assurance framework in line with new requirements contained within the Scottish Government's Audit and Assurance Committee Handbook.
A.10 Emergency response planning		30			To ensure the Board has developed an effective emergency response plan in the event of a large scale disaster such as a terrorist attack or similar event. The review will include coordination of plans and resources with other emergency services.
Sub-total A	**88**	**170**	**103**		
B. Financial					
B.1 Financial systems health check	30	50	40	2021 2057 2061 2064	Rolling review of core financial systems covering: **2018/19**: Ledger management; control account reconciliations; bank and cash; treasury management; and investments and endowments. **2019/20**: Expenditure; procurement and purchasing; and accounts payable. **2020/21**: Income; accounts receivable; lease contract management; and property, plant and equipment.

Audit area	2018/19	2019/20	2020/21	Risk Reg Ref	Audit objectives
B.2 Financial planning and budget monitoring	30			2021 2056 2057 2061	To review implementation of the Financial Improvement Programme, including confirmation that progress is monitored regularly and reported to those charged with governance on a consistent basis. This review will also considered the roles of operational service managers in monitoring budgets and taking remedial action to address budget variances, including the clarity of this role, the central support provided and the consistency of application.
B.3 Payroll	20		40		To review the robustness and appropriateness of payroll procedures to ensure that accurate and authorised payroll payments are made to valid employees; changes to payroll standing data are authorised and timely; and appropriate controls are in place for review, authorisation and reconciliation of payments and deductions. May also include consideration of time recording in SSTS and travel and subsistence.
B.4 IJB financial information and reporting		25		2021 2061	To confirm that financial reporting arrangements between the IJB and Board are sufficient to provide appropriate, complete and timely information to allow oversight of Board spend.
B.5 Service costing		25		2021 2061	Review of service costing procedures to ensure appropriate and sustainable budgetary resource allocations for the delivery of acute services.
Sub-total B	**80**	**100**	**80**		
C. Clinical & Care Governance					

Audit area	2018/19	2019/20	2020/21	Risk Reg Ref	Audit objectives
C.1 Hospital Standardised Mortality Ratios	40			2084 2085 2087	To assess the completeness and accuracy of hospital discharge summaries and clinical coding used to calculate HSMR and ensure that agreed coding changes have been systematically applied across different sites (including the RAH) and any other lessons learned have been embedded effectively.
C.2 Clinical pathways		25	25	2054 2055 2056	Reviews covering: **19/20 Ambulatory Care** – Considering whether the criteria for determining the use of Ambulatory Emergency Care (AEC) is clear and understood by staff, whether all staff are aware of AEC and how this can be accessed, if patients accepted for AEC have met the clinical criteria for the service and that admission, readmission and assessment data is monitored to identify patterns and inform changes to the service. **20/21 Frail Older People's Care** – Assessing the implementation and impact of ongoing work to improve care, avoid hospital admission and reduce delayed discharges for frail older people, such as community planning prior to admission and falls prevention, taking cognisance of ongoing work as part of the Moving Forward Together Programme. The review will also consider the monitoring and reporting of the number of frail older people admitted and how this information is utilised to inform service planning.
C.3 Incident/SAE management			20	2060 2082 2083 2084	Covering the management and oversight of adverse events; including significant adverse events. The review will assess arrangements to ensure incidents are classified correctly; staff have received appropriate training; and staff regularly record incidents on Datix. We will also check the level of engagement with patients during the review process and identification of

Audit area	2018/19	2019/20	2020/21	Risk Reg Ref	Audit objectives
					any lessons learned.
C.4 Review of patient results	25				To assess whether revised processes for reviewing patient results are effective and have been implemented consistently by staff.
C.5 IDL drug reconciliation		20			To review new processes for drug reconciliation as part of Immediate Discharge Letters.
C.6 Duty of Candour			30		To assess the Board's arrangements for ensuring staff comply with the Duty of Candour, including training and guidance provided to staff.
Sub-total C	**65**	**45**	**75**		
D. Staff Governance					
D.1 Workforce planning and management	35	35	35	2063 2086 2089	Review covering different aspects of workforce planning and management each year, as identified below: **2018/19: Sickness Absence** – To ensure the NHSGGC Attendance Management Policy is up-to-date and reflective of changes to the National Promoting Attendance PIN policy. The review will also confirm whether the Board has a fair, consistent approach to promoting attendance across different locations; whether a sickness absence tolerance level has been set and is being monitored regularly; and the Board are working to maintain absence levels within this threshold. **2019/20: Succession Planning –** To confirm the Board has an effective succession planning process in place. The review will cover creation and monitoring of succession plans; processes to build resilience; and

Audit area	2018/19	2019/20	2020/21	Risk Reg Ref	Audit objectives
					reporting on impact. The audit will consider the implementation of the new Performance Management Development framework launched in 2018. **2020/21: Staff Performance Management –** Evaluating the robustness of the staff performance management framework, including effectiveness of the performance appraisal, training, disciplinary and appeals processes.
D.2 Use of agency and locum staff			23	2063 2086 2089 2091	To ensure appropriate arrangements are in place to identify staff need and book appropriate agency/locum staff; to confirm agency/locum staff have the necessary requirements and passed appropriate checks; and that the use of bank and agency staff is monitored and reported on.
D.3 NMAHP registration			20	2092	To assess whether NHSGGC has clear policies and procedures to ensure all NMAHPs are registered prior to appointment and re-register as required. The review will also consider procedures to manage NMAHP staff that have not complied with registration requirements and ensure staff without valid registrations are not scheduled to work.
D.4 Health and safety		20		2057 2065	To assess whether the current processes for managing and complying with HSE requirements are fit-for-purpose. To cover training roll-out across operational areas.
D.5 Other leave	20				To review the effectiveness of and staff compliance with processes surrounding all leave other than annual leave (e.g. special leave, study leave, etc); covering both the process for recording and application of policies. This audit will build on the internal review

Audit area	2018/19	2019/20	2020/21	Risk Reg Ref	Audit objectives
					carried out in 2018/19.
D.6 Rostering	30	30		2063 2086 2089	To confirm whether consistent and effective staff resource planning rules are in place; that unsafe working patterns are identified, appropriately reported and managed; and that clinical risk is minimised through the use of suitably skilled staff. Our reviews will focus on: 2018/19 – nurse rostering 2019/20 – job planning
D.7 NMC referrals			20		To assess whether the processes for referring nurses to the NMC are effective, including the existence of clear decision-making criteria and consistent application across the Board. Our review will also confirm whether appropriate action is taken in response to any investigation launched.
D.8 Mandatory training		20			To build on the work done by management to improve completion rates for mandatory training. The review will consider the end to end process from identification of training needs to monitoring and reporting of progress and confirmation of completion to ensure that the process is efficient and that the Board maximises the opportunity to achieve full compliance.
Sub-total D	**85**	**105**	**98**		
E. ICT					
E.1 GDPR compliance	25			2062	To assess NHSGGC's compliance with GDPR requirements and the arrangements to identify and address remaining compliance gaps.

Audit area	2018/19	2019/20	2020/21	Risk Reg Ref	Audit objectives
E.2 eHealth / Digital	30		30	2062	To confirm that there are adequate processes in place for the development and implementation of the Board's Digital strategy. Our review will also consider whether there are effective processes in place to identify the costs of delivering operational and strategic elements of eHealth.
E.3 Records management			30	2055 2062	To ensure there is a detailed Data Management policy in place; responsibilities for data management are clearly identified; and there is an effective process to monitor and manage compliance with legal and regulatory responsibilities.
E.4 Information sharing and management	25				To confirm robust arrangements are in place for sharing information across the Board. The review will cover Caldicott Guardian duties; data-sharing agreements; processes for sharing data; and arrangements for checking compliance with identified protocols on an ongoing basis.
E.5 IT Security		25		2062	To provide assurance that network and user access is subject to adequate control, that there are sufficient measures to protect the network from external attack and that staff are aware of cyber threats, including actions that can be taken to minimise cyber risk.
E.6 eESS project		25			To assess the eESS project post-implementation to confirm whether project actions have been completed effectively and timeously, and whether an assessment has been made of the extent to which project objectives and expected benefits have been achieved.

Audit area	2018/19	2019/20	2020/21	Risk Reg Ref	Audit objectives
Sub-total E	**80**	**50**	**60**		
F. Compliance and regularity					
F.1 Governance statement readiness	5	5	5	All risks	To inform completion and sign off of Board's Governance Statement.
F.2 Waiting times audits	7	7	7		Annual validation exercise of NHSGGC audit procedures on the accuracy and integrity of waiting times data.
F.3 Property transaction monitoring	8	8	8	n/a required compliance review	Review of property transactions as required by Scottish Government Property Transaction Handbook.
F.4 Follow up	32	30	30		To provide assurance that actions are being implemented as agreed.
Sub-total F	**52**	**50**	**50**		
G. Management					
G.1 Contract management	35	35	35		To respond to issues as/when they arise over the year.
G.2 Audit and Risk Committee & ACEG planning and attendance	12	12	12		
G.3 Audit needs analysis - strategic and annual planning	6	3	3		

Audit area	2018/19	2019/20	2020/21	Risk Reg Ref	Audit objectives
G.4 Liaison with external audit	2	2	2		For coordination and efficiency.
G.5 Liaison meetings and progress reporting	18	18	18		
G.6 Annual internal audit report	2	2	2		
G.7 Contingency	-	-	-		Contingency days to cover additional/emergency reviews required by management in-year that cannot otherwise be accommodated by changes to the plan.
Sub-total G	**75**	**72**	**72**		
TOTAL	**525**	**592**	**538**		
OVERALLOCATION		**67**	**13**		

Appendix 2 – Corporate Risk Register

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

Risk ref	Brief Description	Inherent Risk Score		Residual Risk Score		Notes	2018/19 Plan	2019/20 Plan	2020/21 Plan	Reviews
		L x I	Score	L x I	Score					
Operational										
2054	Failure to achieve Elective waiting time targets: Inpatient / outpatient and day case targets / Treatment Time Guarantees Diagnostic targets Cancer targets Condition specific targets	4x4	High	4x4	High		✓	✓	✓	A.1 Strategic Planning Alignment A.2 Moving Forward Together Implementation A.3 Service redesign – project assurance A.5 Capacity Planning A.7 Performance Reporting A.8 Stakeholder Engagement C.2 Clinical Pathways
2056	Increased delays in discharging patients from hospital resulting in increased bed days and deterioration in condition of patients awaiting discharge.	4x4	High	3x3	Medium		✓	✓	✓	A.1 Strategic Planning Alignment A.2 Moving Forward Together Implementation A.3 Service redesign – project assurance A.5 Capacity Planning A.7 Performance Reporting A.8 Stakeholder Engagement B.2 Financial planning and budget monitoring C.2 Clinical Pathways
Clinical										
2055	Failure to achieve unscheduled care targets. Managing emergency patient flows. Managing the impact on downstream bed management.	4x4	High	4x3	High		✓	✓	✓	A.1 Strategic Planning Alignment A.2 Moving Forward Together Implementation A.3 Service redesign – project assurance A.5 Capacity Planning A.7 Performance Reporting A.8 Stakeholder Engagement

Risk ref	Brief Description	Inherent Risk Score		Residual Risk Score		Notes	2018/19 Plan	2019/20 Plan	2020/21 Plan	Reviews
										C.2 Clinical Pathways E.3 Records Management
2085	Compliance with all applicable clinical standards, protocols and strategies to further improve value for money in prescribing is not achieved and balanced, so that patient medicines are not prescribed, dispensed or administered safely at all times, resulting in adverse events, patient harm and wasted resources.	4x4	High	3x4	High		✓			C.1 Hospital Standardised Mortality Ratios
2084	Compliance with all applicable clinical standards and protocols is not achieved within Mental Health Services resulting in death or harm to staff, patients, visitors, and the public arising from:- - suicide or deliberate self harm; - violent patients; - absconding patients; - hospital acquired infection outbreak; - Child protection and Vulnerable Adults - medication errors; - nutrition needs - confidentiality of data.	4x4	High	3x4	High		✓		✓	C.1 Hospital Standardised Mortality Ratios C.3. Incident / SAE management
Financial										
2057	Expected reduction in capital funding and pressure on revenue resources impacts on backlog maintenance and Health and Safety obligations leading to the possibility of non compliance with applicable Health and Safety	3x4	High	3x3	Medium		✓	✓	✓	B.1 Financial systems health check B.2 Financial planning and budget monitoring D.4 Health and safety

Risk ref	Brief Description	Inherent Risk Score		Residual Risk Score		Notes	2018/19 Plan	2019/20 Plan	2020/21 Plan	Reviews
	legislation and SGHD policies and guidance.									
2021	1. The Board faced an unprecedented financial challenge in 2017/18, with an overall savings challenge within the main Board of £97.8m. Savings were identified, all with a significant degree of risk, meaning the original financial plan predicted a y/e deficit of £18.5m. 2. Due to additional pressures and later than expected crystallisation of savings schemes, that projection was revised at Month 4 to be £26m.	4x4	High	3x4	High		✓	✓	✓	A.4 Operational planning B.1 Financial systems health check B.2 Financial planning and budget monitoring B.4 IJB financial information and reporting B.5 Service costing
2061	The reduction in funding and the underachievement of savings throughout 2015-16 and 2016-17 has required the use of non-recurring funds and reserves to balance. However, this has created an underlying recurring deficit of £68m going into 2018/19. This will create a significant financial challenge in-year, unlikely to be met through CRES. Due to the timing of information from SGHD the uplift for 2018/19 is unknown.	4x4	High	4x4	High		✓	✓	✓	A.4 Operational planning B.1 Financial systems health check B.2 Financial planning and budget monitoring B.4 IJB financial information and reporting B.5 Service costing

Risk ref	Brief Description	Inherent Risk Score		Residual Risk Score		Notes	2018/19 Plan	2019/20 Plan	2020/21 Plan	Reviews
Resilience										
2059	Failure to fully meet the requirements of the Civil Contingencies (Scotland) Act 2005 due to a major incident or emergency in the Greater Glasgow and Clyde area.	3x3	Medium	2x3	Medium				✓	A.8 Stakeholder Engagement
Screening										
2060	Breakdown of failsafe mechanisms for all Public Health Screening Programmes - Abdominal Aortic Aneurysm, Bowel, Breast, Cervical, Diabetic Retinopathy, Pregnancy & Newborn, Preschool Vision screening programmes	3x4	High	2x4	Medium				✓	C.3 Incident / SAE management
IT										
2062	Cyber threats are a dynamic and growing threat to the NHS. Until recently, much of the focus of such threats was the theft of financial data, not personal or patient information. However, there is now a growing risk that we will be targeted in order to disrupt a key component of critical National infrastructure.	3x4	High	2x3	Medium		✓	✓	✓	E.1 GDPR E.2 eHealth/Digital E.3 Records Management E.5 Cyber Security
Staffing										
2063	The Board faces a range of risks in relation to the current and future medical workforce. Over the next 5 years there will be major challenges for the service with a number of senior medical staff projected to retire. By 30th November	4x3	High	4x3	High		✓	✓	✓	A.4 Operational planning D.1 Workforce planning and management D.2 Use of agency and locum staff D.6 Rostering

Risk ref	Brief Description	Inherent Risk Score		Residual Risk Score		Notes	2018/19 Plan	2019/20 Plan	2020/21 Plan	Reviews
	2017 19.7% of consultants will have reached the age of 55+ and could have potentially retired or be considering it. This number may be accelerated further by recent changes to the pension scheme, making it more beneficial to retire before normal retirement age. Extrapolating forward to November 2021, 33.3% of the current consultant establishment will potentially have retired, or be eligible to leave. When added to the current difficulties in recruiting to senior medical posts and the general turnover at consultant level, this may result in reduced senior medical cover to deliver patient care or increased locum and agency spend to cover service gaps. Work in relation to reducing Band 3 rotas remains a challenge and a 'live' risk to the Board.									
2086	The training schemes introduced as part of SMT could lead to a significant increase in vacancies. Risks associated with the amount of vacancies of junior doctors may affect rosters and ability to deliver service. This could lead to a reduction in the available doctors for direct patient care.	4x4	High	3x3	Medium		✓	✓	✓	D.1 Workforce planning and management D.2 Use of agency and locum staff D.6 Rostering
2089	Failure to provide safe, equitable and effective nurse staffing levels	4x4	High	4x4	High		✓	✓	✓	A.4 Operational planning D.1 Workforce planning and

Risk ref	Brief Description	Inherent Risk Score		Residual Risk Score		Notes	2018/19 Plan	2019/20 Plan	2020/21 Plan	Reviews
	throughout inpatient areas of NHSGGC.									management D.2 Use of agency and locum staff D.6 Rostering
2091	Failure to undertake a range of preemployment screening processes and checks of new employees, which could lead to risks around child and adult protection, criminality and undisclosed infection risks eg. Hepatitis B.	4x4	High	3x4	High				✓	D.2 Use of agency and locum staff
2092	Failure of Registered nurses to prepare for and meet Nursing and Midwifery Council (NMC) revalidation requirements resulting in removal From NMC register and unable to fulfil NHS GGC contractual obligations as a Registered practitioner	4x3	High	2x3	Medium				✓	D.3 NMAHP registration
Fire safety										
2064	The probability of Queen Elizabeth University Hospital being at high risk due to the incorporation of Aluminium Composite Materials (ACMs) similar but not the same to those used in Grenfell Tower, leading to an increased likelihood of a fire occurring. Update November 2017 - as part of the inspection work on cladding, a further issue has been uncovered regarding a section of ladding on the RHC. HFS have conducted an inspection and deemed the building safe.	2x3	Medium	1x3	Low		✓	✓	✓	B.1 Financial systems health check
2065	Risk of non-compliance with established Board policies and procedures by members of staff during a fire emergency, as a result of lower than	3x3	Medium	2x2	Medium			✓		D.4 Health and Safety

Risk ref	Brief Description	Inherent Risk Score		Residual Risk Score		Notes	2018/19 Plan	2019/20 Plan	2020/21 Plan	Reviews
	expected numbers of staff undertaking mandatory fire training. This may cause delays in evacuating buildings in the event of a fire.									
Protection of vulnerable groups										
2082	Inconsistent assessment and application of Child Protection procedures may result in: 1. poor identification of children at risk or children who have been harmed; 2. legislative requirements not being complied with; and 3. adverse publicity and reputational damage to the Board.	4x5	Very high	3x5	High				✓	C.3 Incident / SAE management
2083	Inconsistent assessment and application of Adult Support and Protection procedures may result in:- 1. poor identification of those at risk or those who have been harmed; 2. legislative requirements not being complied with; and 3. adverse publicity and reputational damage to the Board.	3x3	Medium	2x3	Medium				✓	C.3 Incident / SAE management
Infection control										
2087	Failure to comply with recognised policies and procedures in relation to infection control. Emerging pathogens represent a risk because often the epidemiology and routes of transmission are not fully understood. The consequences are cross transmission and outbreaks.	4x4	High	3x4	High		✓			C.1 Hospital Standardised Mortality Ratios

Risk ref	Brief Description	Inherent Risk Score		Residual Risk Score		Notes	2018/19 Plan	2019/20 Plan	2020/21 Plan	Reviews
2088	Failure to achieve reduction of MRSA/ MSSA bacteraemia to 24 cases per 100,000 occupied bed days by 2018. Pending any updated changes to target at national level.	4x4	High	3x4	High		✓	✓		A.7 Performance Reporting

Appendix 3 – Internal audit universe and audit needs score

Strategic risk score

We assess the relevance of strategic risks to key processes using the following criteria:

Multiplier	Category	Description
0%	Not relevant	Risk has no relevance to the process
25%	Low relevance	Minimal relevance to or overlap within the process
50%	Medium relevance	Risk may have interdependencies with or relevance to this process that require consideration
75%	High relevance	Risk is likely to be a focus or key consideration for this process
100%	Very High relevance	Risk mainly relates to this process area

We apply the multiplier listed to the residual strategic risk score to arrive at an overall audit needs score

Inherent risk scoring

We assess the inherent risk score and assign an audit needs score based on the following criteria:

Score	Category	Description
5	Very low	A control failure in this process would have little or no impact
10	Low	A control failure in this process would have a low impact, meaning performance would not fall to below acceptable levels
15	Medium	A control failure in this process would have a moderate impact and would lead to objectives, goals or targets not being met
20	High	A control failure in this process would have a significant impact and would require urgent remedial action
25	Very High	A control failure in this process would have a severe impact on the organisation and affect critical objectives, goals or targets

Other factors

We use the same methodology as applied within the scoring of process inherent risks to consider whether there are other factors not already captured that should be considered e.g. ongoing projects, previous high-risk audit findings or forthcoming legislative, regulatory or other changes.

Audit needs score

The audit needs score is used to determine the frequency of reviews and the level of audit resource to be allocated. This is determined in consultation with management and by considering the level of complexity of the process in question, the level of assurance the Audit and Risk Committee receives from other sources and whether any of the other audits in the annual plan provide assurance over an element of that process.

Audit Universe

Auditable area	Strategic risk	Risk rating	Strategic risk multiplier	Strategic risk score	Inherent risk score	Audit needs score	2015 /16	2016 /17	2017 /18	2018 /19	2019 /20	2020 /21	Frequency
A. Corporate													
Strategic Planning	*2021*	*16*	*50%*	*8*	*25*	77				✓			*Key risk area, particularly in light of health and social care integration - cyclical audit every 3 years*
	2054	*16*	*75%*	*12*									
	2055	*16*	*75%*	*12*									
	2056	*16*	*75%*	*12*									
	2061	*16*	*50%*	*8*									
Operational Planning	*2021*	*16*	*75%*	*12*	*25*	85					✓		*Key risk area - cyclical audit every 3 years*
	2054	*16*	*75%*	*12*									
	2055	*16*	*75%*	*12*									
	2056	*16*	*75%*	*12*									
	2061	*16*	*75%*	*12*									
KPI Setting & Monitoring	*2054*	*16*	*75%*	*12*	*15*	85.25							*Not identified as key area for review*
	2055	*16*	*75%*	*12*									
	2056	*16*	*50%*	*8*									
	2063	*12*	*50%*	*6*									
	2084	*16*	*25%*	*4*									
	2085	*9*	*25%*	*2.25*									
	2088	*16*	*75%*	*12*									
	2089	*16*	*50%*	*8*									
	2092	*12*	*50%*	*6*									
Capital Works	*2057*	*12*	*50%*	*6*	*15*	26		✓					*Not identified as key area for review*
	2064	*6*	*75%*	*4.5*									
Estate Management	*2057*	*12*	*75%*	*9*	*15*	29	✓	✓					*Not identified as key area for review*
	2064	*6*	*75%*	*4.5*									

Estate Planning	*n/a*	*0*	*0%*	*0*	*15*	15	✓	✓					*Not identified as key area for review*
Facilities Security	*n/a*	*0*	*0%*	*0*	*5*	5							*Not identified as key area for review*
Fleet Management	*n/a*	*0*	*0%*	*0*	*10*	10							*Not identified as key area for review*
Investment Management	*n/a*	*0*	*0%*	*0*	*10*	10							*Not identified as key area for review*
Community Engagement	*n/a*	*0*	*0%*	*0*	*15*	15					✓	✓	*Covered as part of reviews focusing on different aspects of service redesign*
Service Level Agreements	*n/a*	*0*	*0%*	*0*	*10*	10							*Not identified as key area for audit*
Energy & Utilities Management	*n/a*	*0*	*0%*	*0*	*10*	10							*Not identified as key area for review*
Insurance Claims	*n/a*	*0*	*0%*	*0*	*10*	10							*Not identified as key area for review*
Space Management	*n/a*	*n/a*	*0%*	*0*	*10*	10							*Not identified as key area for review*
Waste Management	*n/a*	*0*	*0%*	*0*	*5*	5							*Not identified as key area for review*
Service Redesign	*2054*	*16*	*75%*	*12*	*20*	61		✓	✓		✓	✓	*Key risk area covered by targeted reviews on specific areas of UCC Programme*
	2055	*16*	*75%*	*12*									
	2056	*16*	*75%*	*12*									
	2063	*12*	*25%*	*3*									
	2085	*9*	*25%*	*2*									
Risk Management	*n/a*	*0*	*0%*	*0*	*25*	25	✓	✓	✓		✓		*Moderate risk area covering risk strategy and management - cyclical audit every 5 years*
Risk Strategy & Appetite	*n/a*	*0*	*0%*	*0*	*15*	15					✓		*Moderate risk area covering risk strategy and management - cyclical audit every 5 years*
Performance Management	*2054*	*16*	*75%*	*12*	*20*	86		✓		✓			*Key risk area covered by targeted reviews on performance reporting*
	2055	*16*	*50%*	*8*									
	2056	*16*	*50%*	*8*									
	2063	*12*	*50%*	*6*									
	2084	*16*	*25%*	*4*									
	2085	*9*	*25%*	*2.25*									
	2088	*16*	*75%*	*12*									
	2089	*16*	*50%*	*8*									
Performance Reporting	*2054*	*16*	*50%*	*8*	*15*	47		✓		✓	✓		*Key risk area covered by targeted reviews on performance reporting*
	2055	*16*	*50%*	*8*									
	2056	*16*	*50%*	*8*									

	2088	16	50%	8									
Stakeholder Engagement	2021	16	25%	4	20	58.75					✓	✓	Covered as part of reviews focusing on different aspects of HSCP and service redesign; and dedicated stakeholder engagement audit
	2054	16	50%	8									
	2055	16	50%	8									
	2056	16	50%	8									
	2059	9	75%	6.75									
	2061	16	25%	4									
Partnership Working	2021	16	25%	4	20	55					✓	✓	Key risk area, particularly in light of health and social care integration - cyclical audit every 3 years. Covered as part of IJB-specific and stakeholder engagement reviews.
	2054	16	50%	8									
	2055	16	50%	8									
	2056	16	50%	8									
	2059	6	50%	3									
	2061	16	25%	4									
B. Financial													
Budget Setting	2021	16	100%	16	25	67				✓			Key risk area covering financial planning and management – cyclical audit every 3 years.
	2056	16	25%	4									
	2057	12	50%	6									
	2061	16	100%	16									
Budget Monitoring	2021	16	100%	16	25	57				✓			Key risk area covering financial planning and management – cyclical audit every 3 years.
	2061	16	100%	16									
Accounts Payable	n/a	0	0%	0	15	15	✓		✓		✓		Covered within rolling financial systems healthcheck programme - assurance provided by External Audit
Accounts Receivables	n/a	0	0%	0	15	15						✓	Covered within rolling financial systems healthcheck programme - assurance provided by External Audit
Endowments	n/a	0	0%	0	15	15		✓		✓			Key risk area covering financial planning and management – cyclical audit every 3 years.
Efficiency Targets including savings	2021	16	100%	16	25	57				✓			Key risk area covering financial planning and management – cyclical audit every 3 years.
	2061	16	100%	16									
Financial Planning	2021	16	75%	12	25	53				✓			Key risk area covering financial planning and management – cyclical audit every 3 years.
	2061	16	100%	16									

Financial Reporting	*n/a*	*0*	*0%*	*0*	*20*	20		✓			✓		*Dedicated audit relating to IJB financial information and reporting*
Capital Planning	*2021*	*16*	*50%*	*8*	*20*	36							*Not identified as key area for review*
	2057	*12*	*75%*	*9*									
	2061	*16*	*50%*	*8*									
Cashflow Management	*2021*	*16*	*50%*	*8*	*15*	23				✓			*Covered within rolling financial systems healthcheck programme - assurance provided by External Audit*
	2061	*16*	*50%*	*8*									
Treasury Policies and Procedures	*n/a*	*0*	*0%*	*0*	*10*	10	✓	✓		✓			*Covered within rolling financial systems healthcheck programme - assurance provided by External Audit*
Debt Recovery	*n/a*	*0*	*0%*	*0*	*10*	10						✓	*Covered within rolling financial systems healthcheck programme - assurance provided by External Audit*
Income	*2021*	*16*	*50%*	*8*	*10*	18						✓	*Covered within rolling financial systems healthcheck programme - assurance provided by External Audit*
	2061	*16*	*50%*	*8*									
Intangible Assets	*n/a*	*0*	*0%*	*0*	*10*	10							*Not identified as key area for audit*
Investments	*n/a*	*0*	*0%*	*0*	*10*	10				✓			*Covered within rolling financial systems healthcheck programme - assurance provided by External Audit*
Lease Contract Management	*n/a*	*0*	*0%*	*0*	*10*	10						✓	*Covered within rolling financial systems healthcheck programme - assurance provided by External Audit*
Ledger Management	*n/a*	*0*	*0%*	*0*	*10*	10		✓		✓			*Covered within rolling financial systems healthcheck programme - assurance provided by External Audit*
Bank & Control Account Reconciliations	*n/a*	*0*	*0%*	*0*	*10*	10				✓			*Covered within rolling financial systems healthcheck programme - assurance provided by External Audit*
Patient Funds	*n/a*	*0*	*0%*	*0*	*15*	15							*Not identified as key area for audit*
Payroll	*n/a*	*0*	*0%*	*0*	*15*	15	✓	✓	✓	✓		✓	*Key risk area covering payroll processes - cyclical review every 3 years*

Pension Management	*n/a*	*0*	*0%*	*0*	*15*	15				✓		✓	*Key risk area covering payroll processes - cyclical review every 3 years*
Starters & Leavers	*n/a*	*0*	*0%*	*0*	*15*	15				✓		✓	*Key risk area covering payroll processes - cyclical review every 3 years*
Time recording	*n/a*	*0*	*0%*	*0*	*10*	10				✓		✓	*Key risk area covering payroll processes - cyclical review every 3 years*
Travel & Subsistence	*n/a*	*0*	*0%*	*0*	*10*	10				✓		✓	*Key risk area covering payroll processes - cyclical review every 3 years*
Procurement & Tendering	*n/a*	*0*	*0%*	*0*	*15*	15	✓				✓		*Covered within rolling financial systems healthcheck programme - assurance provided by External Audit*
Property, Plant and Equipment	*2057*	*12*	*75%*	*9*	*10*	22						✓	*Covered within rolling financial systems healthcheck programme - assurance provided by External Audit*
	2064	*6*	*50%*	*3*									
Infection Control	*2087*	*16*	*100%*	*16*	*25*	57							*Moderate risk area - cyclical review every 5 years. Not identified as key area for audit within 3 year plan.*
Prescribing	*2085*	*9*	*75%*	*7*	*15*	22							*Moderate risk area - cyclical review every 5 years. Not identified as key area for audit within 3 year plan.*
C. Clinical & Care Governance													
Clinical Governance	*2060*	*12*	*50%*	*6*	*25*	86	✓	✓	✓	✓			*Key risk area - cyclical review every 3 years*
	2063	*12*	*50%*	*6*									
	2084	*16*	*75%*	*12*									
	2085	*9*	*100%*	*9*									
	2087	*16*	*50%*	*8*									
	2088	*16*	*50%*	*8*									
	2089	*16*	*75%*	*12*									
Clinical Pathways	*2054*	*16*	*75%*	*12*	*20*	90					✓	✓	*Key risk area in light of service redesign of clinical pathways - Annual review focusing on specific areas*
	2055	*16*	*75%*	*12*									
	2056	*16*	*75%*	*12*									
	2060	*12*	*50%*	*6*									

	2082	*20*	*50%*	*10*									
	2083	*20*	*50%*	*10*									
	2084	*16*	*50%*	*8*									
Incident Management	*2060*	*12*	*75%*	*9*	*15*	74.75			✓			✓	*Key risk area - cyclical review every 3 years*
	2082	*20*	*50%*	*10*									
	2083	*20*	*50%*	*10*									
	2084	*16*	*50%*	*8*									
	2085	*9*	*75%*	*6.75*									
	2087	*16*	*50%*	*8*									
	2088	*16*	*50%*	*8*									
Culture	*n/a*	*0*	*0%*	*0*	*15*	15							*Not identified as key area for audit*
Equality & Diversity	*n/a*	*0*	*0%*	*0*	*15*	15							*Not identified as key area for audit*
Fraud Prevention & Detection	*n/a*	*0*	*0%*	*0*	*20*	20							*Not identified as key area for audit*
Freedom of Information	*n/a*	*0*	*0%*	*0*	*10*	10							*Not identified as key area for audit*
Governance Structures	*n/a*	*0*	*0%*	*0*	*15*	15	✓						*Not identified as key area for audit*
Board & Committee Evaluation	*n/a*	*0*	*0%*	*0*	*15*	15	✓						*Not identified as key area for audit*
Member Policies & Training	*n/a*	*0*	*0%*	*0*	*15*	15	✓						*Not identified as key area for audit*
UK Bribery Act	*n/a*	*0*	*0%*	*0*	*15*	15							*Not identified as key area for audit*
Whistle Blowing	*n/a*	*0*	*0%*	*0*	*15*	15							*Not identified as key area for audit*
D. Staff Governance													
Absence Management	*2063*	*12*	*50%*	*6*	*20*	42							*Not identified as key area for audit*
	2086	*16*	*50%*	*8*									
	2089	*16*	*50%*	*8*									
Appeals & Disciplinary Procedures	*n/a*	*0*	*0%*	*0*	*10*	10							*Not identified as key area for audit*
Evaluation & Appraisals	*n/a*	*0*	*0%*	*0*	*15*	15							*Not identified as key area for audit*
HR Policies & Procedures	*n/a*	*0*	*0%*	*0*	*10*	10							*Not identified as key area for audit*
HR Strategy	*2063*	*12*	*50%*	*6*	*25*	46							*Not identified as key area for*

	2086	*16*	*25%*	*4*									*audit*
	2089	*16*	*50%*	*8*									
	2092	*12*	*25%*	*3*									
NMAHP Registration	*2063*	*12*	*100%*	*12*	*10*	22						✓	*Moderate risk area - cyclical audit every 5 years*
People Management	*2063*	*12*	*75%*	*9*	*15*	42							*Not identified as key area for audit*
	2086	*16*	*50%*	*8*									
	2089	*16*	*25%*	*4*									
	2092	*12*	*50%*	*6*									
Recruitment	*2063*	*12*	*75%*	*9*	*15*	40							*Not identified as key area for audit*
	2086	*16*	*50%*	*8*									
	2091	*16*	*50%*	*8*									
Safeguarding	*2082*	*20*	*100%*	*20*	*20*	48							*Not identified as key area for audit*
	2083	*20*	*100%*	*20*									
	2084	*16*	*50%*	*8*									
	2091	*16*	*50%*	*8*									
Staff Rostering	*2063*	*12*	*75%*	*9*	*20*	53				✓	✓		*Moderate risk area covering workforce compliment and rostering - cyclical audit every 5 years*
	2086	*16*	*75%*	*12*									
	2089	*16*	*75%*	*12*									
Training & Development	*2062*	*12*	*25%*	*3*	*20*	66			✓				*Not identified as key area for audit*
	2065	*9*	*100%*	*9*									
	2082	*20*	*50%*	*10*									
	2083	*20*	*50%*	*10*									
	2085	*9*	*25%*	*2*									
	2086	*16*	*25%*	*4*									
	2087	*16*	*50%*	*8*									
Use of Agency Staff	*2021*	*16*	*25%*	*4*	*15*	37			✓			✓	*Moderate risk area covering workforce compliment - cyclical audit every 5 years*
	2061	*16*	*25%*	*4*									
	2063	*12*	*50%*	*6*									
	2086	*16*	*25%*	*4*									

	2089	*16*	*25%*	*4*									
Use of Locums	*2021*	*16*	*25%*	*4*	*15*	37						✓	*Moderate risk area covering workforce compliment - cyclical audit every 5 years*
	2061	*16*	*25%*	*4*									
	2063	*12*	*50%*	*6*									
	2086	*16*	*25%*	*4*									
	2089	*16*	*25%*	*4*									
Health & Safety	*2057*	*12*	*75%*	*9*	*15*	39			✓		✓		*Moderate risk area - cyclical review every 5 years*
	2064	*6*	*100%*	*6*									
	2065	*9*	*100%*	*9*									
Workforce Planning	*2021*	*16*	*50%*	*8*	*25*	74	✓	✓		✓	✓	✓	*Key risk area - cyclical review every 3 years*
	2061	*16*	*50%*	*8*									
	2063	*12*	*75%*	*9*									
	2086	*16*	*75%*	*12*									
	2089	*16*	*75%*	*12*									
Internal Communications	*2054*	*16*	*25%*	*4*	*20*	46					✓	✓	*Covered as part of annual reviews focusing on delivering of services and service redesign*
	2055	*12*	*50%*	*6*									
	2056	*16*	*50%*	*8*									
	2059	*9*	*25%*	*2*									
	2062	*12*	*50%*	*6*									
Midwifery Supervision	*n/a*	*0*	*0%*	*0*	*15*	15							*Not identified as key area for review*
E. ICT													
Business Continuity Management	*2059*	*9*	*75%*	*7*	*25*	38	✓						*Not identified as key area for review*
	2062	*12*	*50%*	*6*									
Cyber Security	*2062*	*12*	*100%*	*12*	*20*	32		✓	✓		✓		*Moderate risk area - cyclical audit every 5 years. Assurance provided via recent IA and EA reviews.*
Data Management	*n/a*	*0*	*0%*	*0*	*20*	20	✓	✓				✓	*Moderate risk area - cyclical audit every 5 years*

Digital Strategy	2062	12	50%	6	15	21	✓						Not identified as key area for review
eHealth	2055	16	25%	4	15	25				✓		✓	Key risk area supporting implementation of UCC actions - cyclical review every 3 years
	2062	12	50%	6									
ICT Disaster Recovery	2059	9	50%	4.5	20	25		✓					Not identified as key area for review
	2062	12	75%	9									
ICT Governance	n/a	0	0%	0	15	15							Not identified as key area for review
ICT Project Management	n/a	0	0%	0	15	15		✓					Not identified as key area for review
ICT Service Management	n/a	0	0%	0	20	20							Not identified as key area for review
ICT Strategy	2062	12	25%	3	15	18							Not identified as key area for review
Installation Security	2062	12	50%	6	20	26							Not identified as key area for review
IT General Controls	2062	12	50%	6	15	21							Moderate risk area - cyclical audit every 5 years. Not identified as key area for audit within 3 year plan.
Network Security	2062	12	50%	6	20	26							Not identified as key area for review
Records Management	2055	12	50%	6	20	26						✓	Moderate risk area - cyclical audit every 5 years
Telecare	n/a	0	0%	0	15	15							Not identified as key area for review
Social media	n/a	0	0%	0	5	5							Not identified as key area for review
Website Content Management	n/a	0	0%	0	10	10							Not identified as key area for review
Compliance and Regularity													
Property Transaction Monitoring	2057	12	25%	3	10	13	✓	✓	✓	✓	✓	✓	Annual review of property transactions as required by Scottish Government Property Transaction Handbook.

Compliance Monitoring	2057	9	50%	4.5	20	60							Not identified as key area for audit
	2059	6	50%	3									
	2065	9	50%	4.5									
	2082	20	50%	10									
	2083	20	50%	10									
	2091	16	50%	8									
Public Health Committee													
Campaigns	2060	16	50%	8	15	23		✓					Not identified as key area for review
Strategic Planning	n/a	0	0%	0	10	10							Not identified as key area for review
External communications	n/a	0	0%	0	10	10							Not identified as key area for review
Public screening	2060	16	50%	8	15	23			✓				Not identified as key area for review
Complaints Management	n/a	0	0%	0	15	15		✓					Not identified as key area for audit
Customer Satisfaction	n/a	0	0%	0									
External Communications	2055	12	25%	3	15	20					✓	✓	Covered as part of reviews focusing on different aspects of service redesign
	2059	9	25%	2									
Change Management	2054	16	75%	12	15	59							Not identified as key area for audit
	2055	16	75%	12									
	2056	16	75%	12									
	2086	16	50%	8									
Project Management	2054	16	50%	8	15	39			✓				Not identified as key area for audit
	2055	16	50%	8									
	2056	16	50%	8									
Project Reporting	2054	16	25%	4	15	19			✓				Not identified as key area for audit
	2055	16	50%	8									
	2056	16	50%	8									
	2088	16	50%	8									
Patient Transport	n/a	0	0%	0	5	5							Not identified as key area for review
Portering	n/a	0	0%	0	5	5							Not identified as key area for review
Theatre Utilisation	n/a	n/a	0%	0	10	10							Not identified as key area for review
Catering	n/a	0	0%	0	10	10			✓				Not identified as key area for audit
Legal Claims Handling	n/a	0	0%	0	10	10							Not identified as key area for

													audit
Contract Management	*n/a*	*0*	*0%*	*0*	*15*	15							*Not identified as key area for audit*

Appendix 4 – 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 Greater Glasgow and Clyde ("the Board").

It helps the Board 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 Audit and Risk Committee, the Audit and Risk Committee Executive Group, the key personnel, timescales and processes to be followed for each internal audit review.

Role

The internal audit activity is established by the Audit and Risk Committee on behalf of the Board. The internal audit activity's responsibilities are defined by the Audit and Risk Committee 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 elements of the Chartered Institute of Internal Auditors' International Professional Practices Framework (IPPF) including the Core Principles, Definition of Internal Auditing, the Code of Ethics and the International Standards for Internal Auditing.

The IPPF's Implementation Guidance, Supplemental Guidance and Position Papers will also be adhered to as applicable to guide operations. In addition, the internal audit activity will adhere to the Board's relevant policies and procedures and the internal audit activity's standard operating procedures manual.

Internal audit activity will also reflect relevant Scottish Government directions, as appropriate to the Board.

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 the Board's 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 Audit and Risk Committee.

Accountability

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

The Audit and Risk Committee 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 Audit and Risk Committee, including between Audit and Risk Committee meetings as appropriate.

Independence and objectivity

The internal audit activity will remain free from interference by any element in the Board, 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 Audit and Risk Committee, 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 the Board, 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 Audit and Risk Committee or management, as appropriate.

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

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 Audit and Risk Committee and the Audit and Risk Committee Executive Group an internal audit plan for review and approval. The internal audit plan will detail, for each subject review area:

- The Board's risk profile;
- The outline scope and audit objectives for the review;
- The number of days budgeted,;
- The timing, including which Audit and Risk Committee the final will report will go to; and
- 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 Audit and Risk Committee for approval, the plan will be discussed with senior management and the Audit and Risk Committee Executive Group. 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(s) 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 10 working days of fieldwork concluding. The covering email will specify the deadline for management responses, which will normally be within a further 10 days. The management comments and response to any report will be overseen by the review sponsor.

The internal auditors will issue the final report to the review sponsor and the Director of Finance. The final report will be issued within 5 working days of the management responses being received. Finalised internal

audit reports will be presented to the Audit and Risk Committee executive group and if appropriate, the Audit and Risk Committee. Finalised internal audit outputs must be in the hands of the committee secretary 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.

Audit and Risk Committee Executive Group

The Audit and Risk Committee Executive Group meets four times a year, normally in June, September, December and March. Dates for 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 Audit and Risk Committee Executive Group.

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

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

Output	Meeting
Audit needs assessment	December
Annual internal audit plan	December / March
Follow-up report	All meetings
Annual report	June
Progress report	All meetings

Audit and Risk Committee

The Audit and Risk Committee meets five times a year, normally twice in June and in September, December and March. Dates for 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 Audit and Risk Committee.

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

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

Output	Meeting
Audit needs assessment	December
Annual internal audit plan	December / March

Annual report	June
Audit summary report	All meetings

The Audit and Risk 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, the Audit and Risk Committee Executive Group and the Audit and Risk Committee 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.