 <p>BAY OF PLENTY DISTRICT HEALTH BOARD HAUORA A TOI</p>	AUDITING STANDARDS	Policy 2.1.5 Protocol 1
AUDITING PROTOCOL		

PURPOSE

The role of Internal Audit in the Bay of Plenty District Health Board (BOPDHB) is to provide an independent, objective assurance to the Board, Audit, Finance and Risk Management Committee (AFRMC) and Executive Committee (EC) that organisational objectives are being met.

Internal Audit aims to help the organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of:

- Risk management;
- Internal control; and
- Governance processes set up by management and clinical departments to ensure effective and safe clinical practice.

OBJECTIVE


There are no restrictions placed upon the scope of BOPDHB Internal Audit's work. Members of the Internal Audit function engaged on Internal Audit work are entitled to receive whatever information or explanations they consider necessary to fulfil their responsibilities to senior management and senior clinical staff, within appropriate policies. In this regard, Internal Audit may have access to any records, personnel or physical property subject to relevant policies.

STANDARDS

1. Responsibilities of the Organisation

- 1.1 The Internal Audit Department is responsible for recommending to the AFRMC the scope of Internal Audit work, after consultation with EC, Chief Executive Officer (CEO) and any other relevant groups or individuals.
- 1.2 AFRMC is responsible for:
 - a) Ensuring that Internal Audit is adequately resourced
 - b) Reviewing Internal Audit Reports and providing feedback or endorsing recommendations
 - c) Monitoring agreed actions contained in Internal Audit Reports until benefits have been realised and obtaining feedback from Executive Committee when there is lack of progress on outstanding recommendations.
- 1.3 EC is responsible for ensuring the Internal Audit function is:
 - a) Supported by staff throughout the organisation, and
 - b) Internal Auditors have direct access and freedom to report without unreasonable constraint.
- 1.4 DHB Managers are responsible for maintaining Internal controls and management of risk, including:
 - a) Proper accounting records
 - b) Other management information suitable for running the business.
 - c) Proper clinical processes and operational systems.
 - d) Clinical information suitable for providing safe and effective patient care.

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Protocol Steward: Team Leader, Internal Audit	Authorised by: General Counsel	

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2. Responsibilities of Internal Audit

- 2.1 Internal Audit will conduct their role with:
- a) Integrity & Objectivity
 - b) Confidentiality
 - c) Competency
- 2.2 Internal Audit is responsible for discharging the Annual Internal Audit plan in accordance with agreed organisational policies.
- 2.3 Internal Audit is responsible for conducting their work in accordance with the Institute of Internal Auditor's Code of Ethics and the International Standards for the Professional Practice of Internal Auditing (Standards).
- 2.4 Internal Audit will provide assurance on the organisation's governance, risk management and control processes to help achieve legislative, strategic, operational, financial and compliance objectives.
- 2.5 Internal Audit is responsible for improving the organisation's effectiveness and efficiency by providing insight and making recommendations based on analyses and assessments of data and Clinical and Business processes. Thus, improving controls, processes, procedures, performance, and risk management and reducing expenses.
- 2.6 With its commitment to integrity and accountability, Internal Audit will provide value to the Board, the Audit, Finance & Risk Management Committee and senior management as an independent source of objective advice.
- 2.7 Internal Audit will provide consulting and advisory services on controls and related matters, ad-hoc reviews or assignments and assistance with investigations of suspected fraudulent or other irregular activities within the organisation as required.
- 2.8 The Team Leader Internal Audit will liaise closely with the AFRMC with regards to prevention and detection of fraud.
- 2.9 Internal Audit will recommend appropriate amendments to the Audit plan to be approved by AFRMC.
- 2.10 All final Audit reports will be submitted to EC and AFRMC by Internal Audit.
- 2.11 Internal Audit is not responsible for any of the activities that they Audit. Members of the Internal Audit function will not assume responsibility for the design, installation, operation or control of any procedures, although Auditors do have a role in education and design.

3. Internal Audit – Other Support

- 3.1 Internal Audit will provide other support to the organisation by means of:
- a) Providing consultation and feedback on Quality Improvement projects to ensure best audit practice is maintained.
 - b) Advising on policy / protocol development
 - c) Facilitating departmental audit by:
 - i) Supporting staff to understand and use audit processes
 - ii) Training and development of audit skills

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4. Links with External Auditors

- 4.1 Internal Audit will co-ordinate their work with External Audit and will ensure that the Internal Audit function complements the External Audit Plan to minimise duplication of audit effort. This will be accomplished by:
- a) Maintaining a good relationship with External Auditors
 - b) Overseeing External Audits performed in the organisation
 - c) Being aware of External Audits that are coming up
 - d) Meeting and providing assistance to External Auditors when required
 - e) Liaising with other internal staff responsible for quality improvement for example, Quality and Patient Safety and Service Improvement teams.
 - f) Providing access to the Internal Audit documentation

5. Links with Other DHBs

- 5.1 To ensure the BOPDHB gets value for money, the Team Leader Internal Audit will actively participate in the Public Health Sector Internal Audit Forums and Midland Regional Internal Audit Team Meetings. This will drive best practice and ensure that Internal Audit does not need to “reinvent the wheel” when performing standard audit work.

6. Status of Internal Audit

- 6.1 The Team Leader for Internal Audit will report to the AFRMC, a sub-committee of the Board. Communication and liaison with the committee will ordinarily be provided by the Team Leader Internal Audit’s attendance at Committee meetings. The Team Leader for Internal Audit has direct access to the CEO, the Chair and the Deputy Chair of AFRMC as required.
- 6.2 All External and Internal Audits must be registered on a central database with the Internal Audit department as per BOPDHB policy.

7. Scope and Authority of Internal Audit Work

- 7.1 Internal Audit will complete the reviews identified and agreed in the Annual Audit plan. This may include (list is not exhaustive):
- a) Legislative compliance.
 - b) Systems and process established by EC to ensure management of major risks.
 - c) Reliability and integrity of financial, clinical and operating information and the means used to identify, measure, classify and report such information;
 - d) Means of safeguarding assets and, as appropriate, verifying the existence of assets;
 - e) Appraising the economy and efficiency with which resources are employed;
 - f) Operations or programmes - to ascertain whether results are consistent with objectives and whether they are being carried out as effectively and efficiently as planned;
 - g) Compliance with BOPDHB policy and procedures.
 - h) Auditing the process around clinical performance and outcomes.
 - i) In addition, allowance will be retained for the internal audit resource’s to address areas of concern of either Board or Executive Committee.

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8. Planning

- 8.1 Internal Audit will submit a rolling three year Internal Audit Plan to AFRMC for approval, setting out the recommended scope of their work in that period.
- 8.2 Internal Audit should lead the development of an Annual Audit plan. This will include the process of consultation with the Clinical Governance Committee and Executive Committee, identifying organisational risks from the Risk Register and reference to the Audit Universe.
- 8.3 The Annual Audit Plan will be developed with reference to a longer term strategic direction for Internal Audit work, prepared in conjunction with EC and should have regard to the business plans including clinical services and strategic outlook of the organisation as a whole. The schedule will be forwarded to the AFRMC for authorisation on an annual basis. This will be reviewed and aligned, as necessary, with any changes that have resulted from the review of the risk profile of the Group.

9. Internal Audit and Risk

- 9.1 Internal Audit Planning, Processes and Reports will be aligned with the BOPDHB Risk Assessment Framework. This will ensure a compatible perspective of the significance of a particular risk.
- 9.2 Internal Audit will also liaise with the Quality & Patient Safety Manager on a monthly basis.

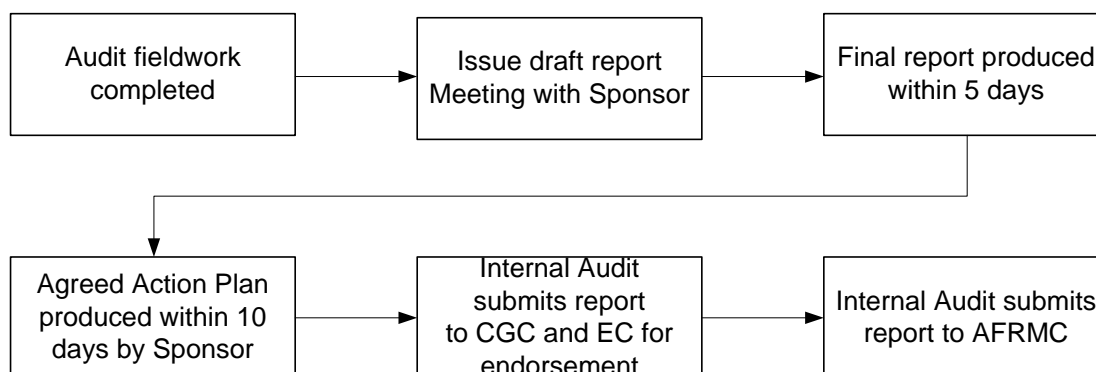
10. The Audit Process

- 10.1 Audits undertaken by Internal Audit will follow a standard process.
- 10.2 The Audit Process is illustrated in the [Process Map in Appendix 1](#):


11. Reporting

- 11.1 The key elements of Internal Audit reporting will be as follows:

- a) The following diagram illustrates the process of Internal Audit Report.



- b) An Audit Report will be tabled at the conclusion of each Audit assignment to Management. The manager responsible for the area under review (the Sponsor) will have the opportunity to comment on any recommendations made. These comments will be included in the final report as appropriate.

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- c) Reports will be focused and action orientated – summarising the issue, the control implication, Internal Audit’s recommendation, clinical/management staff comment including the action to be taken to resolve the issue – action, by whom and when.
- d) If required comments / feedback from clinical / management staff are not returned by the expected date, the report will go to EC to arrange for comments to be provided. Internal Audit will pro-actively manage the process to ensure wherever possible completed reports are submitted to EC.
- e) In addition to the Audit Reports, Internal Audit will report monthly to AFRMC against the agreed Annual Internal Audit plan detailing:
 - i) Progress against the schedule.
 - ii) Key findings for that period.
 - iii) Recommendations for refinement of the schedule for the following Audit period.
 - iv) Follow-up of implementation of recommendations from prior reports.

12. Requirements of the Quality Assurance and Improvement Program

12.1 The quality assurance and improvement program must include both internal and external assessments¹.

12.2 Internal assessments must include:

- a) Ongoing monitoring of the performance of the internal audit activity; and
- b) Periodic self-assessments or assessments by other persons within the organisation with sufficient knowledge of internal audit practices.

12.3 External assessments must be conducted at least once every five years by a qualified, independent assessor or assessment team from outside the organisation. The Team Leader Internal Audit must discuss with the board:

- a) The form and frequency of external assessment; and
- b) The qualifications and independence of the external assessor or assessment team, including any potential conflict of interest.

ASSOCIATED DOCUMENTS

- Bay of Plenty District Health Board policy 2.1.5 Auditing

¹ External assessments can be in the form of a full external assessment, or a self-assessment with independent external validation.

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Appendix 1: Process Map

