Report by the Comptroller and Auditor General

Internal Audit in the National Health Service

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National Audit Office
3 April 1987

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Report

Background

1. In his Reports on the Summarised Accounts of Health Authorities in England and Wales and Health Boards in Scotland for 1979 – 80 (HC 312 and 313 of 1980 – 81), my predecessor drew attention to weaknesses in internal audit in the National Health Service (NHS). Generally there was a lack of audit planning and reporting; the coverage of computer systems, capital expenditure and family practitioner services was deficient; and in England staff numbers were below those recommended by regional treasurers to achieve satisfactory financial audit standards. In Scotland, health boards' internal audit units had contributed little to the maintenance of financial control.

2. In giving evidence to the Committee of Public Accounts in March 1982, the Department of Health and Social Security (DHSS) confirmed that the internal and external audit structure was a key element in the control of the NHS in England. They repeated earlier assurances that they would be undertaking a review of NHS audit. Against this background, and as part of their wider review of Internal Audit in Central Government (HC 313 of 86 – 87), the National Audit Office (NAO) examined the progress made by health authorities, boards and family practitioner committees (FPCs) in strengthening internal audit in the NHS.

Subsequent developments

3. In August 1982 the Under Secretary of State set up a joint DHSS/NHS Audit Working Group to undertake the promised review of NHS audit in England. In August 1983 DHSS sought the views of health authorities on recommendations made by the Working Group and in August 1984 issued Health Circular HC 84(18) which gave guidance on implementation of those recommendations. Similar guidance for authorities in Wales was contained in Circular WHC (84)24 issued by the Welsh Office. In particular, the circulars required authorities to:

— prepare and approve a Strategic Audit Plan incorporating the role and objectives of internal audit

— determine the appropriate level of audit coverage and staffing, including the grading of chief internal auditors, by reference to that plan

— establish arrangements whereby the attention of their members and senior officers was drawn to matters of importance arising from audit findings.

4. The Working Group had also stressed the importance of auditors adopting a systems-based approach and of training in the techniques involved. The circulars recorded the Ministers' endorsement of these views and their wish to see early progress in implementing them. In England, computer audit expertise was to be concentrated at regional level with districts looking to regions for assistance and guidance. Somewhat similar conditions applied to the audit of capital expenditure. In Wales, there was no regional tier. But the Welsh Office informed NAO that they were seeking to develop consortium arrangements on an all Wales basis for the provision of a computer and capital internal audit service.

5. The Departments did not seek to define the appropriate level of audit coverage but drew attention to "Internal Audit in the National Health Service" published in 1980 by the Research Committee of the then Association of Health Service Treasurers (AHST) incorporated in the Chartered Institute of Public Finance and Accountancy (CIPFA) (Appendix 1). The publication includes the concept of a minimum acceptable level of audit involving the proper appraisal of the principal internal control systems.

6. The circulars fully endorsed the Working Group's recommendations that authorities, especially smaller ones, should consider entering consortia arrangements and that there was an urgent need for improved training. The NHS Training Authority (NHSTA) was to be responsible for promoting training; statutory auditors were also expected to make a contribution. The guidance recognised the importance of continuing the search for value for money (VFM) in services provided but left to local discretion the extent to which internal audit should be involved in VFM work, and whether health authorities should establish multi-disciplinary VFM units.

7. With effect from 1 April 1985 FPCs in England and Wales became independent employing authorities responsible for their own internal audit, a function previously the responsibility of designated health authorities. In March 1985 DHSS issued guidance to FPCs on internal audit in Circular HC (FP) (85) 6 which in essence repeated that in HC (84) 18. Similar guidance to FPCs in Wales was contained in Circular WHC (FP) (85) 8.

8. In Scotland, initial proposals formulated by Scottish Home and Health Department (SHHD) to eliminate long standing weaknesses in internal audit were significantly influenced by the need to secure agreement to appropriate gradings for senior internal audit posts; this affected their progress. In September 1985 SHHD invited health boards and the Common Services Agency (CSA) to submit plans for the future conduct of internal audit. The plans were to be developed on the basis of the detailed AHST/CIPFA guidelines on role and objectives, and on the key areas to be audited (paragraph 5 above) including family practitioner services which in Scotland are administered by health boards.

Review of present internal audit arrangements

England and Wales

9. NAO staff reviewed the result of a comprehensive questionnaire issued by the NHSTA in October 1985 to all health authorities in England and Wales; 86 per cent had responded fully. NAO supplemented this by a scrutiny of work carried out by statutory auditors following their examination of the annual accounts of health authorities and FPCs, and by direct tests in a small number of health authorities in England.

Audit findings

(a) Audit planning and approach

10. In requiring health authorities and FPCs to produce Strategic Audit Plans, DHSS and the Welsh Office were reflecting the Working Group's view that the most rational and systematic approach to establishing an appropriate level of audit coverage is through a Strategic Audit Plan designed to achieve minimum acceptable levels of audit in all key areas of financial responsibility. In general this medium term plan should identify the field of audit activity, determine the frequency and objectives of audit (the priorities) and thus form a basis for estimating the resources required.

11. Of the English and Welsh health authorities which responded to the NHSTA survey a third did not have a Strategic Plan looking at least three years ahead. The survey also revealed that most authorities had annual plans but 31 per cent had no detailed programmes for each audit area. As to the audit approach, the survey also showed that between 14 and 27 per cent of NHS internal audit units did not consistently use the tailored work programmes, internal control questionnaires, flow charts and systems descriptions normally associated with an up-to-date systems based audit approach. Up to and including 1985 - 86 statutory auditors have consistently commented on weaknesses in audit planning, especially in FPCs.

12. NAO examination at six health authorities in London revealed similar shortcomings. In two cases there were no well established Strategic Plans and in five cases shorter term plans lacked key elements such as the required level of testing. Only two authorities were employing a fully developed systems based audit approach. However, there was evidence of initiatives to improve internal audit arrangements generally. These included the introduction of new procedures, planned detailed reviews and improved training.

(b) Level of audit coverage

13. As noted above (paragraphs 5 & 7) DHSS and the Welsh Office drew the attention of authorities to recommendations in the AHST publication "Internal Audit in the NHS" concerning the appropriate level of audit coverage. Replies to the NHSTA survey revealed that only 52 per cent of treasurers believed that internal audit fully met the objectives set out in that publication. In addition, during 1985 - 86 audits, statutory auditors identified at least 50 health authorities in England (24 per cent) and 35 FPCs (36 per cent) in England and Wales which had failed to achieve minimum acceptable levels of internal audit as defined in the AHST publication; eight FPCs had no coverage at all.

14. Whilst much useful work was being done by internal audit in the six authorities visited by NAO, it was clear that in 1985 - 86 most had not achieved the defined minimum acceptable level of audit coverage. There was evidence that in some cases insufficient work had been carried out in major areas such as debtors, creditors and stores; and in at least two authorities important aspects of salaries and wages (the biggest single item of expenditure) had not been covered.

15. Paragraph 4 above refers to DHSS's view that computer audit expertise in health authorities in England should be concentrated at regional level, and that similar arrangements should be applied to the audit of capital expenditure. The NHSTA survey, which covered England and Wales, showed that over half of authorities in England specialist computer audit cover was provided by regions; and that in England and Wales some 14 per cent of services were contracted out. Nonetheless, two thirds of treasurers were dissatisfied with their specialist computer audit arrangements. Over 80 per cent of chief internal auditors considered that their staff were inadequately equipped to carry out computer audit to professional standards, and some 50 per cent expressed similar reservations regarding the audit of contract expenditure.

(c) Staffing

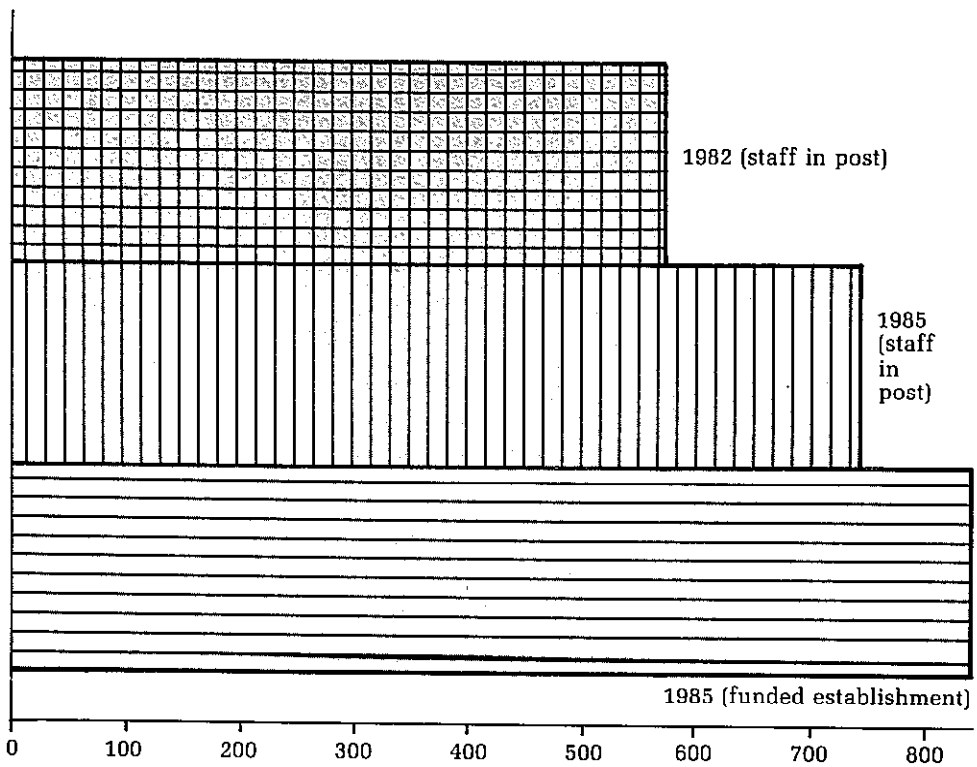
16. At the time of the Working Group's review, the number of internal auditors in England was 570. The Group obtained details from regional and district health authorities of their proposed staffing structures, which in

aggregate showed a projected increase to a total of 823 staff. The Group considered that this might be sufficient to provide a minimum level of audit coverage though they stressed that the number of staff needed could only be established through effective audit planning.

17. A survey by statutory auditors of the position in June 1985 revealed that the funded establishment of internal audit staff in health authorities in England, excluding special health authorities, had risen by 47 per cent to 838, although there were only 740 staff in post (Figure 1). In five regions more than 15 per cent of established posts were unfilled (Figure 2 overleaf). In Wales there were 48 staff in post against an establishment of 52. However, as indicated in paragraph 11, a large proportion of health authorities had not produced comprehensive Strategic Plans, the medium mainly used for estimating the required resource. It seems to NAO therefore, that in those authorities which have yet to develop such plans there must be an element of uncertainty about the appropriate level of staffing.

Figure 1

Internal audit staffing: health authorities (England)

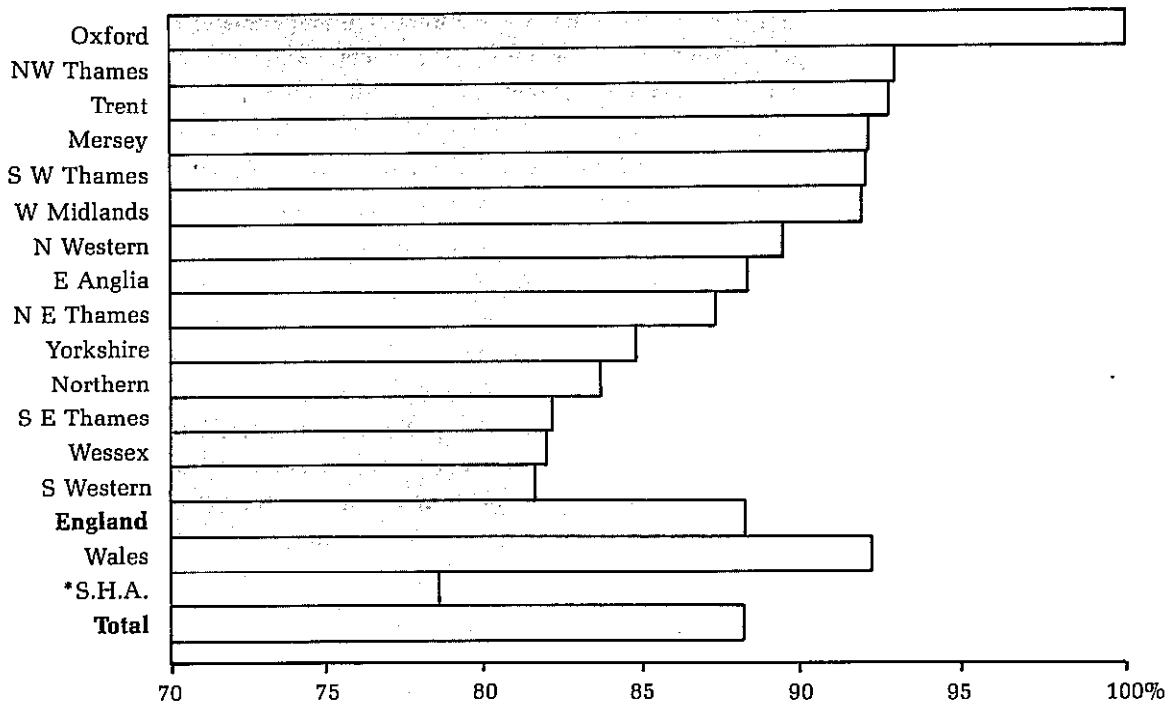


Note: Staff in post in 1982 included FPC staff who are excluded from 1985 totals

18. NAO examination of the statutory audit survey revealed that of those individual health authorities in England and Wales not employing commercial auditors or involved in consortia, staff in post fell short of establishment in 55 cases (25 per cent). Thirteen authorities (6 per cent) were buying in services (wholly or in part) from commercial audit firms. Consortia arrangements were being used by 33 authorities (15.3 per cent), the same number as in 1983 - 84 though less than in 1982 - 83 (Figure 3 overleaf). However at least 19 authorities (8.8 per cent) not involved in consortia had a complement of less than three full time staff: this was below the level at which the Working Group considered it likely that viable audit coverage could be sustained.

Figure 2

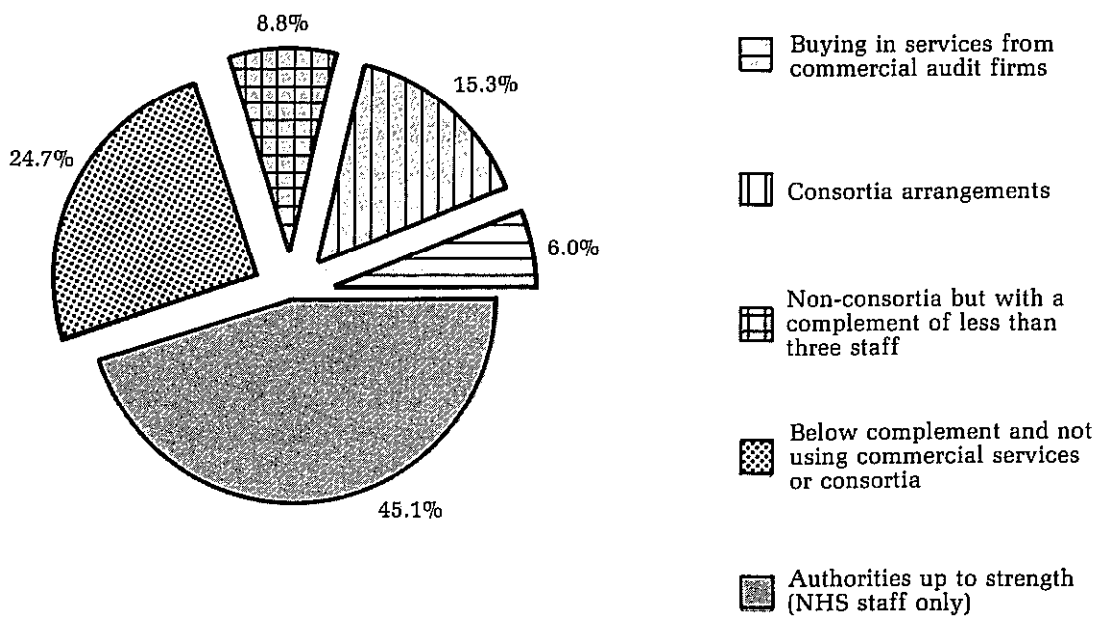
Internal audit staff in post against establishment (health authorities) (1985)



*Special Health Authorities

Figure 3

Internal audit services individual health authorities England and Wales (1985)



19. The statutory audit survey showed that in June 1985, 25 of the 98 FPCs in England and Wales had no internal audit service (17 in England and all 8 in Wales) — though the statutory audit of the 1985–86 accounts, about a year later, showed a significant improvement (paragraph 13). Of the 73 which had a service in June 1985, only two employed their own staff, and two more had entered into consortia arrangements. The remaining 69 had opted for a "bought in" service, 64 from health authorities. DHSS and the Welsh Office recognised that on 1 April 1985 (paragraph 7) FPCs had inherited from health authorities a low level of funds to finance the internal audit of their activities. Therefore in 1986–87 the Departments made available to FPCs additional funding to allow them to increase the level of resources being devoted to internal audit.

20. NAO examination revealed that despite increases in health authority internal audit staff, senior officers and statutory auditors attributed many of the deficiencies in internal audit coverage and audit planning to lack of staff or lack of experienced staff. There was difficulty in recruiting and retaining staff partly due to salary and grading levels. For example the NHSTA survey showed that in those health authorities which responded to the questionnaire (86 per cent) there were 683 internal auditors in post at September 1985, but 430 staff had started and 325 had left in the previous two years. Almost 50 per cent of treasurers and most chief internal auditors were dissatisfied with the structure of their internal audit sections.

21. With regard to the grading of chief internal auditors, over half were graded scale 18 (£12,018–£14,588) or over. Also the proportion of all internal audit staff on or above scale 14 (£10,874–£13,222) had increased to over 20 per cent. These developements are in line with the Working Group's views.

22. At the time of the NAO's examination, three of the six authorities visited by NAO staff were below complement in terms of either numbers or grades. All six authorities had experienced difficulties in recruiting and retaining suitable staff and in some cases this had led to the use of inexperienced staff. At one stage during 1985–86 one of the authorities had four out of six posts unfilled. However, NAO noted that local initiatives included the "buying in" of internal audit services and the proposed use of consortium arrangements.

(d) Reporting

23. The health departments' circulars pointed to the need for the attention of health authority members and senior officers to be drawn to matters of importance arising from audit findings (paragraph 3). The NAO review revealed that in England in 1985–86 statutory auditors were critical of reporting arrangements in at least 15 health authorities, and that they had drawn attention to inadequate management action on audit findings in 27 authorities. One of the six authorities visited by NAO was not receiving an annual internal audit report, and in some cases internal audit was experiencing difficulty in obtaining satisfactory early clearance of its audit observations.

(e) Training

24. Training is an important factor in the development of audit staff particularly as the nature of the work means that for considerable periods of time direct supervision is difficult. It is essential, therefore, that internal

auditors are properly trained to fulfil their responsibilities. Training is currently provided in four main ways: in-house training, regional audit groups, courses provided by accountancy organisations including statutory audit and through training for professional examinations.

25. Despite the observations at paragraphs 10 - 23 above NAO noted that in responding to the NHSTA's survey, general managers, treasurers and chief internal auditors of health authorities had expressed a good degree of satisfaction with the skills, knowledge, attitude and experience of internal auditors (Appendix 2). In particular general managers considered that the NHS obtained value for money from its investment in internal audit although most thought it essential that the standing and profile of internal audit be improved.

26. Against this background both treasurers and chief internal auditors considered that internal auditors required training in a significant number of areas (Appendix 3), most being relevant to the satisfactory achievement of minimum levels of audit. In particular there was, despite the availability of courses run by statutory auditors, widespread concern about the ability of internal auditors to audit computer based systems to a professional standard (paragraph 15).

27. On the basis of survey findings the NHSTA is currently developing a national training strategy for England and Wales. Also, in association with the Healthcare and Financial Management Association (formerly the AHST), they intend to produce in 1987 a manual for internal auditors to promote throughout the NHS an improved and common audit approach; DHSS and the Welsh Office have yet to decide whether to endorse the views of treasurers and require mandatory audit standards. However, some 12 per cent of treasurers and 18 per cent of chief internal auditors commented that a training initiative would not be fully effective unless the NHS tackled the wider issues of salaries, grading and career prospects.

(f) Value for money investigations

28. The NHSTA survey revealed that most general managers and treasurers considered that internal audit should have a significant commitment to VFM investigations. But no central record exists identifying the extent to which internal auditors are involved in VFM investigations. Treasurers and chief internal auditors gave no clear support to the view, favoured by general managers, that internal audit should be staffed on a multi-disciplinary basis for investigations generally including VFM.

Scotland

29. As indicated in paragraph 8, SHHD agreed to the creation of new internal audit units. The number was subsequently established at eight, with three units each responsible for the audit of one major health board, and the remaining five units responsible for the other 12 health boards, the State Hospital (Carstairs) and the Common Services Agency (CSA). The Department recognised that these units would each provide a sufficiently large base of expenditure to justify gradings or posts attractive to able and well qualified staff, especially for the post of chief internal auditor. The units were also expected to promote the development of expertise in specialist areas of audit such as computing and capital expenditure.

30. The first internal audit unit under the new arrangements was set up in July 1983. The remainder were formed mainly in the period October 1984 to May 1985, subsequent to the health board Chairmen's Grading Group agreement on salary scales for chief internal auditors. The statutory auditors of health boards recognised that these consortia arrangements were likely to improve the quality of internal audit and thus, in future, enable them to place reliance on internal audit work during the annual audit of health board accounts.

31. SHHD agreed with this view and took steps to further the improvement. In September 1985 they informed health boards and the CSA that they endorsed the view that internal audit in the NHS should be based on an audit strategic plan. The plan should define the roles and objectives of internal audit and include the concept of a minimum acceptable level of audit with an appropriate staff complement. When implemented the plan should ensure an internal audit coverage sufficiently strong to provide a reliable first line component for all other audit work in the NHS.

32. SHHD noted that some health boards had already taken measures along these lines. But to ensure that, in general, all the new arrangements were sound they requested each health board and the CSA to submit their plans for evaluation. With one exception, SHHD had approved all plans by June 1986. SHHD informed NAO that statutory auditors are reviewing their implementation from 1986 – 87 and will continue to monitor compliance with acceptable auditing standards throughout the period of the strategic plan. Their reviews will take account of the extent to which grading structures and related issues, such as retention and recruitment of staff, may affect progress of the plan particularly against a background where several training initiatives are underway. For example 30 staff (40 per cent) are undergoing technical and professional training, 15 are already fully qualified, with other courses in prospect for unqualified middle range staff.

Conclusions

England and Wales

33. Over the last few years, following acceptance by DHSS, the Welsh Office and NHS of the main recommendations of the Audit Working Group (paragraph 3), considerable progress has been made towards improving internal audit in the NHS. Even so, the shortcomings in audit planning and execution which my predecessor identified in 1981, including coverage of FPCs and computer systems, have yet to be fully remedied.

34. It is however noteworthy that senior health authority officials have recently commended the skills, knowledge, attitude and experience of internal auditors. It is also reassuring to note that, at a time when any NHS organisation must justify its existence, general managers consider that health authorities obtain value for money from their investment in internal audit. The NHSTA survey was a positive step which could provide an informed basis for the further improvement of internal audit and the high response rate from health authorities was a clear indication of the importance they attach to such work. The proposed new training manual and, in particular, the prospective new training strategy are important and timely measures in helping to overcome continuing weaknesses identified by the statutory auditors, treasurers and others.

35. The significant increase in the number of approved posts for health authority internal audit units, mainly in England, and the increased funding made available to FPCs in 1986 – 87 is further recognition of the importance of internal audit. But these increases have not been fully justified through comprehensive strategic planning. There must therefore be considerable uncertainty as to what the appropriate staffing levels should be. This is an important consideration particularly since in 1985 some 50 per cent of health authority treasurers did not consider that their internal audit sections fully met the audit objectives, including a minimum acceptable level of audit coverage, defined in the 1980 AHST publication (Appendix 1). As borne out by NAO's own examination, continuing shortage of suitable staff was the reason most commonly given, a situation aggravated by rapid turnover of staff (paragraphs 17 – 22). The extent to which the salaries, gradings and career prospects of internal auditors contribute towards these difficulties, and affect the overall level of experience and skills in internal audit teams, is an open question.

36. Meanwhile, it is important that DHSS, the Welsh Office and the NHSTA press ahead with practical training which should help to produce a more efficient audit throughout the NHS, directed in the first place to the soundness, adequacy and application of financial and management controls. In the shorter term this will inevitably limit the resources that can be devoted to VFM work, an area in which internal auditors could well make a significant contribution to management of NHS resources. But, overall, it should be a priority to see that the nature and extent of internal audit are determined through emphasis on strategic audit planning and the essential criterion of a minimum audit standard. This should lead in time to the development of a means of measuring the efficiency and effectiveness of internal audit itself.

Scotland

37. Progress in Scotland to eliminate the weaknesses in internal audit reported by my predecessor in 1981 was substantially hindered by difficulty in reaching appropriate gradings for senior internal audit posts. But the initiatives subsequently set in train should, if properly implemented, go a considerable way in securing improvements. The adoption of audit strategic plans approved by the Department is a positive and welcome step in the right direction. It will, however, be important for statutory auditors to continue to evaluate thoroughly the plans in practice and to monitor achievement of stated objectives.

Glossary of Abbreviations

AHST	Association of Health Service Treasurers
CIPFA	Chartered Institute of Public Finance and Accountancy
CSA	Common Services Agency
DHSS	Department of Health and Social Security
FPC	Family Practitioner Committee
HC	Health Circular
NAO	National Audit Office
NHS	National Health Service
NHSTA	National Health Service Training Authority
SHHD	Scottish Home and Health Department
VFM	Value for Money

Appendix 1

Role and objectives of internal audit in the NHS

DHSS and the Welsh Office referred health authorities and FPCs to guidance available in the publication 'Internal Audit in the National Health Service' published by the Association of Health Service Treasurers (AHST). This publication defined the role and objectives of internal audit and provided operational guidance. The report of the DHSS/NHS Audit Working Group noted (paragraph 3.4) that although there were no universally accepted objectives for internal auditors most health authorities followed the recommendations of the AHST, and that they particularly supported the concept of a minimum acceptable level of audit recommended in the AHST publication.

Role

The publication noted (paragraph 4.1) that the role of internal audit is 'to review, appraise and report to management upon:

— the soundness, adequacy and application of financial and other management controls;

— the extent of compliance with, relevance and financial effect of, established policies, plans and procedures;

— the extent to which the organisation's assets and interests are accounted for and safeguarded from losses of all kinds arising from fraud and other offences; waste, extravagance and inefficient administration, poor value for money or other cause;

— the suitability and reliability of financial and other management data developed in that organisation'. . .

Minimum acceptable level of audit

The AHST publication suggested (paragraph 4.2 of Appendix 1) that the minimum acceptable level of audit should cover the following key areas of financial responsibilities:

'— systems for payment of salaries and wages;

— systems for ordering, receipt of and payment for goods and services;

— tendering and contract procedures;

— collection of all income due;

— control and operation of stores;

— security arrangements;

— computer systems;

— banking arrangements;

— contractual payments by Family Practitioner Committees;

— patients' monies, endowment funds, trust funds.'

Audit planning

Paragraph 10.3 of the publication notes that audit planning should be considered on three levels:

— strategic planning

— tactical planning

— operational planning

(a) Strategic Plan

The Strategic Plan may cover a period from two to five years. It should outline the programme setting out in fairly broad terms objectives, areas to be audited and frequency of audit.

(b) Tactical Plan

The Tactical Plan should cover periods of up to one year. It should detail the programme of audits to be undertaken, the objectives of each audit and the resource allocation.

(c) Operational Plan

The Operational Plan should be drawn up for each audit and aimed at meeting the required objectives. Each audit should be broken down into elements against which the required amount of staff should be allocated. It should also detail which methods are to be adopted and the extent to which tests are to be applied and the standards of acceptability.

Appendix 2

NHS Training Authority Survey of Internal Audit of the NHS (Assessment made by General Managers, Treasurers and Chief Internal Auditors of their own Internal Audit sections)

		High/Good			Sub-Total	Low/Poor			Sub-Total
		1	2	3		4	5	6	
(A)	**Skills**								
	General Managers	7	29	47	83	12	4	1	17
	Treasurers	11	34	40	85	11	4	0	15
	Chief Internal Auditors	7	38	45	90	8	2	0	10
(B)	**Knowledge**								
	General Managers	7	27	50	84	13	3	0	16
	Treasurers	11	36	39	86	12	2	0	14
	CIAs	6	*40	*41	87	11	2	0	13
(C)	**Structure**								
	General Managers	4	20	37	61	23	12	4	39
	Treasurers	5	17	30	52	27	13	8	48
	CIAs	10	6	31	47	16	24	13	53
(D)	**Attitude**								
	General Managers	23	*37	29	89	9	1	1	11
	Treasurers	35	44	16	95	4	1	0	5
	CIAs	33	40	19	92	5	2	1	8
(E)	**Experience**								
	General Managers	3	22	46	71	25	2	2	29
	Treasurers	9	30	37	76	19	4	1	24
	CIAs	5	31	43	79	17	4	0	21
(F)	**Contribution to overall management of the Authority**								
	General Managers	2	16	40	58	24	14	4	42
	Treasurers	6	21	46	73	18	9	0	27
	CIAs	8	29	36	73	21	4	2	27

* NHS Training Authority figures adjusted for roundings.

Appendix 3

Internal audit training needs

NHS Training Authority Survey of Internal Audit of the NHS (Assessments made by General Managers, Treasurers & Chief Internal Auditors of their own Internal Audit Training Sections)

Treasurers and Chief Internal Auditors identified the following as the most important training needs for Internal Auditors:

Treasurers	% response	Chief Internal Auditors	% response
Computer Audit	55	Computer Audit	33
VFM Techniques	50	Computer Assisted Audit Techniques	32
Computer Assisted Audit Techniques	39	Contract Auditing	27
Contract Auditing	33	Value for Money	23
Performance Indicators	28	Report Writing	21
Audit Planning	25	Interview Techniques	18
Audit Risk Analysis	25	Micro Computers	18
Motivating others	21	Internal Control Evaluation	13
Project Appraisal	17	Systems Documentation	13
Internal Control Evaluations	17	Flowcharting	10
Time Management	17	Standard Accounting Systems	12
Contracting out Arrangements	13	Analytical Review	10