TIAN
The Internal Audit Network

TIAN News

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Introduction

Welcome to the Internal Audit Network Newsletter

We're delighted to share the latest edition of the Internal Audit Network Newsletter, designed to keep you up to date with insights, updates, and leading practices from across the internal audit profession. In this edition, we explore key developments, showcase perspectives from our network, and feature tools and approaches that are influencing the future of internal audit.

Whether you're responding to regulatory change, strengthening risk management, or embedding innovation into your audit work, this newsletter aims to keep you informed, engaged, and connected.

Leanne Hawkes, Director, 360 Assurance and TIAN Chair

Emergency Preparedness, Resilience and Response Benchmarking

Emergency Preparedness, Resilience and Response (EPRR) refers to the statutory duty of NHS organisations to make sure they are ready to prepare for, respond to, and recover from emergencies that could affect patients, staff, or services. These could be anything from extreme weather conditions, an outbreak of an infectious disease, a major transport accident or a terrorist attack in the area.

MIAA reviewed EPRR processes across several NHS clients, this insight highlights the key themes identified. Read more.

Strengthening assurance, evidence and learning from national maternity reviews

Recent work has highlighted both the progress being made in maternity improvement programmes and the importance of robust systems to underpin learning, transparency, and public confidence.

360 Assurance has delivered work focused on providing independent assurance over large-scale maternity improvement programmes. We assessed how recommendations were translated into actions, how evidence was used to demonstrate completion, and whether arrangements were in place to assure changes were embedded and sustained.

We are often seeing comprehensive governance and delivery frameworks, with clear executive oversight, structured prioritisation, and strong board visibility. The scale of activity is significant, reflecting sustained commitment to improvement.

However, our work has also demonstrated that delivery alone is not enough, and independent scrutiny is required. In a number of cases, evidence is not fully demonstrating

that actions had been completed as intended, or that improvements were embedded in practice. Variation in how assurance decisions were documented, together with the sheer volume of material being reviewed, creates a risk that gaps could go unnoticed. We are finding that further strengthening is often required to consistently demonstrate sustained compliance and to identify early signs of going off-track.

We are seeing a common message: strong governance, clear definitions and high-quality evidence are essential foundations for effective assurance and meaningful learning. Improvement programmes and independent reviews both rely on systems that can withstand scrutiny, demonstrate transparency, and support confidence among patients, families, and regulators.

Internal audit and independent clinical assurance from our specialist midwifery team play a critical role in supporting these aims, not by re-doing the work of operational teams, but by shining a light on where processes can be strengthened to ensure improvements are real, sustained, and trusted.

Safer Staffing Benchmarking

NHS organisations must ensure nurse staffing is safe, monitored, and appropriately escalated, in line with CQC Regulation 18 and its May 2025 updates on workforce competence and development. Recent guidance from the Royal College of Nursing also reinforces the importance of effective nurse leadership, workforce wellbeing, and resilience. MIAA has reviewed Safer Staffing arrangements across NHS organisations, and this insight highlights the key themes identified. Read more.

Root Cause Analysis (RCA)

The Institute of Internal Audit (IIA) describes root cause as a '*core issue or underlying reason for the difference between the criteria and the condition of an activity under review*' and root cause analysis as '*a technique for finding the core causes for problems an organisation may face*.'

Audit Yorkshire's journey to implementing RCA began following our review of the latest Global Internal Audit Standards (GIAS) prior to the conformance date in January 2025. Drawing on IIA recommended literature and best practice we developed and delivered training in RCA techniques and created a suite of root causes.

We then focused on devising a practical operational methodology to embed the consideration of root cause throughout the audit process from the planning stage as recommended in Standard 9.4 based on Standard 14.3 that requires auditors to identify the root causes of conditions via collaboration with clients for inclusion in working papers. We combined this with the requirements of Standard 14.4 that state root causes should also be included in recommendations and action plans. These requirements were used as a framework for updating our K10 Vision audit software to allow auditors to record their evaluation of root causes in each finding in the work programme.

Our software is configured to produce a draft report, however at present the report template does not include a section in each finding to explicitly state the root causes selected by auditors and they have to incorporate them as a narrative in the findings prior to the generation of a draft report.

In terms of reporting the results to Audit Committees, we followed the requirements of Standard 11.3 that include the provision of thematic outcomes of root cause analysis to Audit Committees. We run reports from K10 vision for each client and provide a numeric table showing the spread of results across the root cause groups and a bar chart of the results as percentages.

Our presentation of root causes to Audit Committees in progress reports has been well received, and this paper could conclude here, however we would like to share the difficulties we have encountered on our root cause journey so far to support others, they are as follows:

- The inclusion of root cause analysis is a cultural change; providing the right support to auditors to identify a root cause when the focus has previously been only on risk has proved challenging and we are currently developing further training based on feedback from auditors.
- The application of root cause analysis throughout the audit process, from identification of risks when scoping work, can change the recommendations we would have made previously. Applying RCA significantly influences the effectiveness and sustainability of recommendations by identifying the underlying factors contributing to incidents. It is therefore important that all auditors consistently apply the same approach and this can be difficult to monitor.
- Standardising the approach to the include the narrative for root causes in our working papers and reports is still in development; we want the findings to be pointed and insightful without appearing robotic. There is also the potential for more than one root cause for a single finding and this needs to be worked through logistically and in terms of presentation in audit reports and to the Audit Committee.
- Root causes should be RAG rated in the same way as the recommendations or management actions they generate; at present we report on the actual numbers against each root cause category, which may skew results, we are currently working on rectifying this.

Audit Committees have so far shown interest in root cause analysis, the next stage is determining how clients can use this information to benefit their organisations; it may be useful to consider the following:

- Deep dives across an organisation from the perspective of a single root cause would create a ripple effect in strengthening internal control in a particular area identified as weak.
- Standard 9.4 recommends using root causes to inform annual plans. The plans could include a section in each audit that requires review of the three top weaknesses identified in the previous year
- Consultancy work based on failures of improvement plans in a particular area could benefit from intense root cause analysis.

In conclusion, Audit Yorkshire continues on the journey to fully implement and understand the implications of root cause analysis and how it can be harnessed to support clients to improve and provide meaningful oversight for Audit Committees. Thorough review of each stage of the process during and following implementation is necessary to ensure it reflects

the spirit of the standards and using the findings of root cause analysis creatively is essential to ensure that this methodology provides an innovative, quality service to our clients.

Digital Transformation, Exclusion and Inequality

The National Health Service is undergoing rapid digital transformation as part of its long-term modernisation agenda. The NHS Long Term Plan identifies a shift from analogue to digital as a central pillar of reform, aiming to improve efficiency, expand access and enhance patient experience. Innovations such as the NHS App and the expansion of remote consultations illustrate how this ambition is being implemented in practice.

Digital transformation has delivered clear benefits. Online booking systems and remote consultations can make access to care quicker and more convenient, particularly for working patients or those with mobility challenges. The NHS App allows users to manage prescriptions and view records without needing to contact their GP, reducing administrative burden on staff. Digital records also improve information sharing, supporting more coordinated and timely care. However, these benefits are not experienced equally. Many GP practices now rely heavily on online booking systems, which can disadvantage older patients or those without internet access. There are reported instances where patients struggle to secure appointments because telephone options are limited and digital platforms are prioritised. Similarly, digital first triage systems may favour those who are more confident with technology, leaving others at a disadvantage.

The use of the NHS App further highlights this divide. While widely used, uptake remains uneven across different groups. Individuals from lower income households or certain ethnic minority backgrounds are less likely to engage with digital tools, often due to limited access, skills or trust. In rural areas, poor connectivity can also restrict the ability to use online services, reinforcing geographical inequalities. There are also implications for long term and mental health care. Digital monitoring and online consultations can support ongoing care and increase flexibility, but patients who cannot engage with these tools risk reduced contact and poorer outcomes. In mental health services, digital provision can expand access, yet it may exclude those without private space, digital confidence or reliable technology.

These examples illustrate a central tension. The move from analogue to digital has the potential to improve access and efficiency, yet without careful implementation it can deepen existing health inequalities. Digital exclusion is shaped not only by access to devices, but also by skills, confidence and trust. Addressing these factors is essential if the NHS is to ensure that innovation benefits all patients rather than a select group.

The Role of Internal Audit in Mitigating Risk

Internal audit plays an important role in ensuring that digital transformation does not worsen health inequalities. Auditors provide independent assurance that risks linked to digital exclusion are recognised and managed. This includes reviewing whether alternative access routes remain available and whether services are designed with inclusivity in mind.

They also assess governance processes, ensuring that equality considerations are embedded in decision making and supported by data on service access. By identifying gaps and highlighting emerging risks, Internal Audit helps organisations ensure that digital innovation supports fair and inclusive healthcare.

Events Round-up

TIAN has partnered with Bowne Jacobson LLP to facilitate a national forum to discuss NHS Group Governance Models, bringing together NHS organisations that are currently operating within group structures or exploring the development of group models.

The network will provide a collaborative forum for participants to discuss the benefits, challenges and lessons learned from different governance approaches. Each session will include a presentation from an NHS organisation currently operating within a group model, followed by a roundtable discussion where participants can share perspectives and explore common governance issues.

Discussions will be supported by expert legal insight from Rebecca Hainsworth, Partner at Browne Jacobson, alongside governance specialists from across TIAN.

The first meeting was held in May 2026 and the next will be scheduled for September 2026. To register your interest please visit: NHS Group Models Forum

About Us:

TIAN is the collaborative network of NHS based audit and assurance providers – see www.tian.org.uk for further details. Together our members deliver assurance services to over 40% of all NHS bodies across the country, as well as helping to support a range of other clients across the wider public sector. The member organisations comprising TIAN are:

Get in touch: To find out more, or if you have feedback on any areas covered in this edition, please contact: **Leanne Hawkes, Director, 360 Assurance.** Leanne.hawkes@nhs.net **07545423040**