# Risk Management Arrangements Review 2019/20

## The Walton Centre NHS Trust

QD-5 Rev 1

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## 1. Introduction, Background and Objective

A review of the Trust's Risk Management systems will be conducted in accordance with the requirements of the 2019/20 Internal Audit Plan, as approved by the Audit Committee.

Risk Management means having in place corporate and systematic processes for evaluating and addressing the impact of risks in a cost effective manner and having staff with the appropriate skills to identify and assess the potential for risks to arise. Put simply, risk management is about good management, it is about being risk-aware but still being able to take risks in a controlled and managed environment.

Risk management and internal controls should be fully embedded at all levels of the organisation. NHS risk registers are populated from a wide range of sources. This adds to the complexity of achieving a coordinated and consistent approach to assessing, recording and managing risk. This review is to consider the specific risk management processes operating within the Trust.

The review will evaluate the risk management arrangements, focusing upon wards, departments and Divisional level and escalation above these levels as required.

The overall objective of the audit is to assess the adequacy of systems and processes in place to ensure that risks are identified and appropriately and accurately escalated through the Trust's risk management structures as documented within the Risk Management Strategy.

## 2. Executive Summary

There is a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently.

**Substantial Assurance**

The following provides a summary of the key themes.

| Sub Objective | Key Themes |
|---|---|
| Risk Management Strategy | The Trust has a Risk Management Policy that was approved by the Patient Safety Group in February 2019 which is accessible to all employees in the Trust, through the local intranet. This is next due for review in February 2022.<br><br>Section 4 of the Policy identifies segregation of duties for senior management within the Risk Management Process. Organisational arrangements are also identified highlighting the roles in which each committee has to perform.<br><br>The Trust has a Risk Management Strategy in place which is accessible to staff and highlights roles in managing Risk Management. |

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| Risk Management Responsibility | The Risk Management Policy is accessible to all staff on the Trust Intranet which highlights the role all staff have in the reporting of risks and demonstrates segregation of duties for management on how risk is reported.<br><br>The Job Description of the Clinical Governance Lead identifies who is responsible for overseeing Risk and reports to the Head of Risk. Within the job description of the Head of Risk clearly outlines the roles and responsibilities in relation to Risk Management and reporting requirements. |
| Training | The Trust offers One to One Training to New Starters on induction detailing how to identify a risk and how to escalate a risk. Procedure notes are available on the Trust Intranet detailing how staff can report a risk (Risk 1 and Risk 2) this training formulates part of the TNA (Training Needs Analysis) and is referenced in the Mandatory Training and Induction Policy provided by the Trust.<br><br>Training updates are reported to the Health and Safety Committee monthly. Risk Management training is required every 3 years and the Trust provided evidence of registers of attendance to support staff attendance at training. The Trust reports that currently 97% have completed Risk Management training as part of Induction. |
| Risk Scoring | Testing of a sample of Risk Registers identified that risks are initially scored within Datix when they are identified and recorded, they will then be added to a holding area whereby they are reviewed by management. Gaps in controls and gaps in assurance are added and the score is then modified to reflect the risk. Risks are reviewed regularly and testing identified dependent on scores risks are escalated from Ward level to Divisional Level then when deescalated will be moved down a register.<br><br>Risks in the holding area are reviewed by the assigned Risk Manager and key controls are added and any action plans that may be required. Review of action plans for the sample tested identified a number of gaps where deadlines for actions were not clearly defined. **(Recommendation 3)**<br><br>Within the holding area it is the responsibility of Divisional Governance and the risk preparer for approval of the risk score. Once approved they are reported in the risk activity summaries which are reviewed by the Head of Risk before being circulated to the wards and reported to Patient Safety group. |

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| | Reminder emails to management are sent out to ensure the scoring of risks is reviewed regularly. |
| Open Risks | At the time of testing it was identified that there were 18 Open Risks within the Trust. Sample Testing of open risks on Datix identified all risks that were tested had a future review date for the risk lead to update the score, action plan and any other gaps in controls and assurance.<br><br>Testing identified 1 occasion whereby the risk review date had not been updated however evidence provided confirmed the Clinical Governance lead sent a reminder email for the risk to be updated which was physically evidenced during fieldwork. |
| Risk Register and BAF | Review of a sample of minutes from Divisional Governance and risk meetings has confirmed that risks from the wards and within the division are being reviewed regularly within these meetings.<br><br>Review of a sample of minutes from the Patient Safety group identified that in addition to the risk activity summaries the group also receives and reviews the Divisional and Corporate risk registers on a cyclical basis.<br><br>Testing confirmed that the Quality Committee receive the minutes from the Divisional Governance and risk committees at each meeting and also receive the BAF and the Trust risk register periodically as confirmed from review of minutes and papers.<br><br>Review of Trust Board papers and minutes confirmed that the Board receives the BAF on a regular basis and also receives the Chairs report from the Quality Committee which regularly includes references to risks within the organisation.<br><br>As per the policy only risks that have the capacity to affect the Trust at a Strategic level will be reported in the BAF. Section 7 of the Risk Management policy states "Risks graded between 1 and 10 are the responsibility of the local ward/department, 12 to 25 are the responsibility of the Divisional Director of Operations which forms the Trust Risk Register" these risks will be reviewed by the Patient Safety Group on a rotational basis and the Executive Team on quarterly basis. Risks that the Patient Safety group consider significant will be escalated to the BAF.<br><br>Testing of a sample of risks identified all risks graded as 12 or above following management adding controls were reported to the Patient Safety Group. All risks regardless of risk score were |

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|---|---|
| | reviewed at either a group or committee level suitable to the score.<br>Testing of the BAF identified that a number of risks were not being removed from the BAF despite having a score lower than the stated threshold of 12 and covering reports highlighting the removal of some risks were not actioned. **(Recommendation 1)** |
| Performance Monitoring | The Risk Management Team run a local assurance report (Risk Activity Summaries) for the wards that is reported to the Patient Safety group. These are run monthly to bi-monthly and are circulated across the wards.<br>Risks and the BAF should be reported to Audit Committee, BPC (Business Performance Committee) and the Quality Committee as per the policy. Minutes from Audit and Quality Committee identified that this takes place. However review of BPC papers and discussions with the Head of Risk identified that the Trust Wide Risk Register is not escalated to the BPC as per the Terms of reference for BPC. **(Recommendation 2)** It is acknowledged that some members of BPC attend other sub committees of the Board where risk registers are submitted and reviewed however this does not cover all members and attendees of BPC. |

## 3. Findings, Recommendations and Action Plan

The review findings are provided on a prioritised, exception basis, identifying the management responses to address issues raised through the review.

To aid management focus in respect of addressing findings and related recommendations, the classifications provided in Appendix B have been applied. The table below summarises the prioritisation of recommendations in respect of this review.

| Critical | High | Medium | Low | Total |
|---|---|---|---|---|
| 0 | 0 | 3 | 0 | 3 |

Other detailed findings and recommendations are set out below.

# 4. Detailed Recommendations

| 1. Updating the BAF | Risk Rating: Medium |
|---|---|
| Operating Effectiveness<br><br>Issue Identified – Testing of the BAF identified that a number of risks were not being removed from the BAF despite having a score lower than the stated threshold of 12 and covering reports highlighting the removal of some risks were not actioned.<br><br>Specific Risk – Lack of accountability, for completion and maintenance of the risk registers, Inconsistent Grading, treatment and management of identified risks. Trust Board receiving reports on risks do not affect achievement of strategic objectives which should be managed operationally.<br><br>Recommendation – The BAF should be updated regularly to ensure that Risks with a score lower than 12 are removed from the BAF, unless specific exceptions are identified and clearly documented.<br><br>Management Response (Remedial Action Agreed) – Risks on the BAF that fall below the agreed threshold will be de-escalated and transferred onto the Trust wide Risk Register for onward management and monitoring by the respective committee or divisional governance & risk group in line with the Risk Management Policy.<br><br>Responsibility for Action – Tom Fitzpatrick Head of Risk<br><br>Deadline for Action – 31/11/2019 | |

| 2. Business Performance Committee (BPC) | Risk Rating: Medium |
|---|---|
| Control design<br><br>Issue Identified – Risks and the BAF should be reported to Audit Committee, BPC (Business Performance Committee) and the Quality Committee as per the policy. Minutes from Audit and Quality Committee identified that this takes place. However review of BPC papers and discussions with the Head of Risk identified that the Trust Wide Risk Register is not escalated to the BPC as per the Terms of reference for BPC. It is acknowledged that some members of BPC attend other sub committees of the Board where risk registers are submitted and reviewed however this does not cover all members and attendees of BPC.<br><br>Specific Risk – BPC not being kept informed of significant risks identified and Trust risks not driving Trust Board agendas and meetings. BPC not receiving details and managing risks which are under their remit and responsibility to ensure these are managed and monitored appropriately with action plans put into place as required.<br><br>Recommendation – The Trust wide Risk Register should be escalated to the BPC as stated in the Terms of Reference. | |

Management Response (Remedial Action Agreed) – Immediate action to include receipt of Trust wide risk register on the BPC work plan.

The Trust wide Risk Register will be reinstated as a standing item on the BPC agenda, with the relevant risks for discussion and monitoring on a quarterly basis e.g. Finance, HR & IT in line with the Risk Management Policy.

Responsibility for Action –

Deadline for Action – 31/01/2019

| 3. Action Plan Deadlines | Risk Rating: Medium |
|---|---|

Operating Effectiveness

Issue Identified – Risks in the holding area are reviewed by the assigned Risk Manager and key controls are added and any action plans that may be required. Review of action plans for the sample tested identified a number of gaps where deadlines for actions were not clearly defined.

Specific Risk – Actions to address and mitigate risks identified are not being effectively managed and mitigated in a timely manner.

Recommendation – The Trust should ensure that all actions identified are allocated at an appropriate time frame so that these can be monitored and managed in a timely manner.

Management Response (Remedial Action Agreed) – The Clinical Governance Lead will include an item for reviewing actions at divisional governance & risk groups which will in turn be overseen by Patient Safety Group.

Responsibility for Action –

Deadline for Action – 31/11/2019

## Follow-up

In light of the findings of this audit we would recommend that follow-up work to confirm the implementation of agreed management actions is conducted within the next 12 months.

# Appendix A: Terms of Reference

The overall objective of the audit was to assess the adequacy of systems and processes in place to ensure that risks are identified and appropriately and accurately escalated through the Trust's risk management structures as documented within the Risk Management Strategy.

The following sub-objectives have been identified:

- The Trust has an up-to-date Risk Management Strategy underpinned by policies and procedure notes, which have been appropriately approved and communicated to all staff;
- Responsibility for risk management has been clearly defined at all levels of the organisation and communicated.
- Comprehensive training is available and provided for staff to be able to identify and manage risks.
- There are adequate and established methods for identifying, grading, scoring, recording, monitoring and managing risks from a range of sources, across all levels of the Trust, in line with the Risk Management Policy and these are effectively deployed;
- Open risks on the Risk Register are regularly reviewed and action plans are produced and reviewed regularly to mitigate risks in line with the Risk Management Policy;
- There are clear links, communications and channels of escalation between the Corporate Risk Register and BAF; and
- There is an appropriate reporting mechanism to the Board to provide assurance in respect of risk management.

# Limitations inherent to the internal auditor's work

We have undertaken the review of the process, subject to the objectives outlined above.

**Internal control**

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgement in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

**Future periods**

The assessment of controls relating to the process is that at September 2019. Historic evaluation of effectiveness is not always relevant to future periods due to the risk that:

The design of controls may become inadequate because of changes in the operating environment, law, regulation or other; or

The degree of compliance with policies and procedures may deteriorate.

## Responsibilities of management and internal auditors

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

We shall endeavour to plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we shall carry out additional work directed towards identification of consequent fraud or other irregularities. However, internal audit procedures alone, even when carried out with due professional care, do not guarantee that fraud will be detected. The organisation's Local Counter Fraud Officer should provide support for these processes

# Appendix B: Assurance Definitions and Risk Classifications

| Level of Assurance | Description |
|---|---|
| High | There is a strong system of internal control which has been effectively designed to meet the system objectives, and that controls are consistently applied in all areas reviewed. |
| Substantial | There is a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently. |
| Moderate | There is an adequate system of internal control, however, in some areas weaknesses in design and/or inconsistent application of controls puts the achievement of some aspects of the system objectives at risk. |
| Limited | There is a compromised system of internal control as weaknesses in the design and/or inconsistent application of controls puts the achievement of the system objectives at risk. |
| No | There is an inadequate system of internal control as weaknesses in control, and/or consistent non-compliance with controls could/has resulted in failure to achieve the system objectives. |

| Risk Rating | Assessment Rationale |
|---|---|
| Critical | Control weakness that could have a significant impact upon, not only the system, function or process objectives but also the achievement of the organisation's objectives in relation to:<br>• the efficient and effective use of resources<br>• the safeguarding of assets<br>• the preparation of reliable financial and operational information<br>• compliance with laws and regulations. |
| High | Control weakness that has or could have a significant impact upon the achievement of key system, function or process objectives. This weakness, whilst high impact for the system, function or process does not have a significant impact on the achievement of the overall organisation objectives. |
| Medium | Control weakness that:<br>• has a low impact on the achievement of the key system, function or process objectives;<br>• has exposed the system, function or process to a key risk, however the likelihood of this risk occurring is low. |
| Low | Control weakness that does not impact upon the achievement of key system, function or process objectives; however implementation of the recommendation would improve overall control. |

## Appendix C: Report Distribution

| Name | Title | Report Distribution |
|---|---|---|
| | Director of Nursing & Governance | Draft & Final |
| | Deputy Director of Nursing & Governance | Draft & Final |
| | Director of Finance | Final |
| | Deputy Director of Finance | Final |

## Discussion meeting held with

| Name | Title | Date |
|---|---|---|
| | Head of Risk | August 2019 |
| | Clinical Governance Lead | August 2019 |

## Review Completion

| | Planned Date | Actual Date |
|---|---|---|
| Fieldwork Starts | August 2019 | August 2019 |
| Discussion Document to Client | September 2019 | September 2019 |
| Responses by Client | September 2019 | September 2019 |
| Final Report | October 2019 | October 2019 |

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## Acknowledgement and Further Information

MIAA would like to thank all staff for their co-operation and assistance in completing this review.

This report has been prepared as commissioned by the organisation, and is for your sole use. If you have any queries regarding this review please contact the Audit Manager. To discuss any other issues then please contact the Director.

MIAA would be grateful if you could complete a short survey using the link below to provide us with valuable feedback to support us in continuing to provide the best service to you.

https://www.surveymonkey.com/r/MIAA_Client_Feedback_Survey