Risk Management

Internal Audit Report

Cwm Taf Morgannwg University Health Board

2020/21

January 2021

NHS Wales Shared Services Partnership

Audit and Assurance Services

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1. Introduction and Background

Our review of Risk Management was completed in line with the 2020/21 Internal Audit Plan for Cwm Taf Morgannwg University Health Board (the 'Health Board' or the 'organisation').

During late 2019, Audit Wales ('AW'), formally known as the Wales Audit Office ('WAO') and Healthcare Inspectorate Wales ('HIW') undertook a review of quality governance arrangements within the Health Board. In undertaking their review, AW/HIW considered key documents such as the Integrated Medium Term Plan ('IMTP'), Board Assurance Framework ('BAF') and Corporate Risk Register, assessing whether these are effectively linked, monitored and scrutinised, and whether the process followed is compliant with the Health Board's Risk Management Strategy.

The resultant report had a number of key risk management findings, including the need to ensure a clear and comprehensive risk management system is in place at corporate and directorate levels which is compliant with an overarching Risk Management Strategy. Since the start of 2020 the Health Board has been reviewing its risk management arrangements in order to address the findings of the AW/HIW report and to ensure systems align to the new operating model that was introduced within the Health Board on 1 April 2020.

To assist this process, an appointment to an Assistant Director of Governance and Risk role was made. The Health Board also approved a new Risk Management Strategy and Board Assurance Framework.

The relevant lead for the review is the Director of Corporate Governance & Board Secretary.

2. Scope and Objectives

The overall objective of this audit was to evaluate and determine the adequacy of the systems and controls in place within the Health Board for risk management. The review sought to provide assurance to the Health Board's Audit and Risk Committee that risks material to the system's objectives are managed appropriately.

The areas that this review sought to provide assurance on were:

- A plan is in place for reviewing the risk management system both in the short term and longer term, with key milestones and timeframes set and appropriate monitoring and updates as necessary.
- A risk management strategy, and associated assurance framework, is in place that has been appropriately approved, communicated to staff, and aligns to other key documents including the terms of reference of relevant responsible committees.
- Training in relation to the new risk management approach is underway at all levels within the Health Board, including those recording risk on Datix and Independent Members responsible for monitoring risk.

- A consistent risk scoring approach is applied at each level within the Health Board. Where the recorded mitigating actions reduce an inherent risk score to a much lower residual score, those actions are robust. Where risk scores increase or decrease especially at organisational or strategic levels, decisions can be evidenced.
- An effective process is in place for the escalation and de-escalation of risks through the Health Board.
- Consideration has been given to the development of a board assurance framework with a plan in place for how this will be populated with the Health Board's strategic risks.
- Effective monitoring and reporting of risks takes place at the various tiers within the Health Board including at committee level.

The work we have carried out as part of our Integrated Locality Group/Clinical Service group reviews looks at the ownership and monitoring of risk at that level. This review worked alongside our Integrated Locality Group/Clinical Service group reviews to see the flow of risks up through the organisation.

3. Associated Risks

The main risk considered in this review was the Health Board's difficulty or failure to achieve strategic, operational and financial objectives and the potential impact on the quality of services delivered, resulting from a poor approach to risk management and the ineffective management of risk under the new operating model.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context. The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with established controls within Risk management is **Reasonable assurance**.

RATING	INDICATOR	DEFINITION
Reasonable assurance		The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.

A significant amount of work has been undertaken within the last year to improve the risk management process within the Health Board despite the ongoing Covid-19 pandemic.

A 'Risk Management Improvement Plan' was produced outlining how the Health Board is intending to improve their risk management process. Updates to the plan were provided to the Board, Management Board and Audit & Risk Committee at regular intervals throughout the year. In cases where the timelines had been missed, there were updates confirming the reasons for the delays. In addition, the Risk Management Improvement Plan has been updated to incorporate additional tasks as needed. The Health Board plans to have the Board Assurance Framework in place by December 2021.

The Risk Management Strategy was updated in March 2020 and has since been further revised and is currently going through the approval process. Linked to the Risk Management Strategy is the Risk Management Policy and Risk Assessment Procedure which have both been recently updated. We understand that approval for these will sought at the same time as the updated Risk Management Strategy.

The Board, its committees and the Management Board have continued to receive regular risk updates throughout the pandemic on the Organisational Risk Register (ORR). Reporting has included highlighting risks that have been added onto the register, risks scoring that has increased and decreased within the period and closed risks. Narrative reasons for such the changes are included in the reports.

Further work is needed to ensure that the revised risk management process is fully embedded through all levels of the organisation. A key factor that will help determine success is the roll out of training across the organisation. This will ensure a consistent approach is applied, allowing meaningful risk registers to be developed at all levels within the organisation from departments, Clinical Service Groups (CSGs), Integrated Locality Groups (ILGs) and Corporate Functions up to the ORR.

Five formal Risk Management Strategy and Risk Assessment training sessions have been held to date with attendees from across the locality groups. Following requests, further training was seen to have taken place for ILG Directors, Board Members and the Rhondda Taf Ely (RTE) ILG Clincial Service Group leads. The Assistant Director of Governance and Risk has also separately met with directorates including Facilities, ICT, Estates, to review their risk registers and undertake a peer review.

Our testing within the Facilities directorate and RTE ILG confirmed these areas had reviewed high scoring risks and have plans to review the remaining risk. Other areas of the Health Board should develop similar plans to review their risk registers to ensure that the ORR is comprehensive and captures all of the relevant escalated risks.

As part of our audit, we had intended to undertake significant testing within the Surgery Clinical Service Groups located in each of the ILGs. However, due to the timing of our review and the impact of the second wave of the pandemic our testing was limited. However, our limited fieldwork identified anomalies in the escalation from the CSG risk registers to the ILG registers through to the ORR. However, we acknowledge that registers were being updated during the course of our fieldwork and as such this may be a timing issue.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

Assurance Summary					
1	Plan for the risk management system			✓	
2	Risk management strategy				✓
3	Risk management training			✓	
4	Risk scoring approach				✓
5	Escalation and de-escalation of risks			✓	
6	Board Assurance Framework				✓
7	Monitoring and reporting of risks			✓	

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review highlighted one issue that is classified as weaknesses in the system control/design for risk management.

Operation of System/Controls

The findings from the review highlighted four issues that are classified as weaknesses in the operation of the designed system/control for risk management.

6. Summary of Audit Findings

In this section, we highlight areas of good practice that we identified during our review. We also summarise the findings made during our audit fieldwork. The detailed findings are reported in the Management Action Plan (Appendix A).

Objective 1: A plan is in place for reviewing the risk management system both in the short term and longer term, with key milestones and timeframes set and appropriate monitoring and updates as necessary.

We identified the following areas of good practice:

- A Risk Management Improvement Plan has been developed detailing a series of tasks for completion to improve the risk management process within the Health Board. The plan includes both short term and longer-term tasks. Timelines are given for implementation of the tasks and status updates are included confirming the actions taken and reasons for any delays in completion.
- Updated versions of the improvement plan have been reported to the Health Board, Audit & Risk Committee and Management Board throughout the year.
- Our review of the tasks and their target timescales established that there was only one task that had not been completed from the original 'Risk Management Improvement Plan' in relation to the transfer of the Datix Risk Management System to the Director of Governance. The task had now been updated and a revised timescale had been given.
- Facilities have a detailed plan in place for updating their risk register in line with the Health Board wide Improvement Plan.

We identified the following finding:

- There is a Risk Management Improvement Plan that covers all areas of the Health Board. However, it is not clear if there are local plans in place within each of the ILGs, CSGs or directorates that are aligned to the improvement plan to ensure that all of the tasks identified at an organisation level can be undertaken in line with set timeframes. (Finding 5)

Objective 2: A risk management strategy, and associated assurance framework, is in place that has been appropriately approved, communicated to staff and aligns to other key documents including the terms of reference of relevant responsible committees.

We note the following areas of good practice:

- The Risk Management Strategy was updated and approved in March 2020 by the Board. Since that date there have been further reviews and refinements that were approved by the Management Board and Audit & Risk Committee ahead of the planned endorsement by the Board in January 2021. We reviewed the two versions of the strategy and there have been a number of changes made including updating the risk domains and risk appetite information has been added.
- At the time of our review, the previous Risk Management Policy and Procedure had been updated and had been distributed for feedback. The draft documents were in line with the Risk Management Strategy.
- In the main, the responsibilities outlined in the terms of reference for the Health Board's committees and groups aligned to the Risk Management Strategy. The terms of reference for the three ILGs'

Quality, Safety, Risk and Experience Group confirm that they have a specific duty to 'monitor the arrangements in place to assess, control and minimise risk and regularly review the high and extreme risks included on the ILG Risk Register'.

We identified the following finding:

- The terms of reference for both the Planning, Performance & Finance Committee and the Population, Health & Partnerships Committee need to be aligned to the revised Risk Management Strategy, as they do not refer to scrutinising risk and make no reference to risk management. (Finding 2)

Objective 3: Training in relation to the new risk management approach is underway at all levels within the Health Board, including those recording risk on Datix, and Independent Members responsible for monitoring risk.

We note the following areas of good practice:

- A number of awareness sessions on risk and the new Risk Management Strategy have been held within the Health Board including:
  - Bespoke training on the organisational risk register within the Rhondda Taf Ely (RTE) ILG.
  - Targeted risk training to Senior Nurses and Clinical Leads within Children, Adolescent Mental Health Services (CAMHS).
  - A Board development session to help determine the Health Board's risk appetite and principal risks.
- The Assistant Director of Governance and Risk has held meetings with the Datix team to review the risk management module within Datix and to align the Datix system to the new organisational structure.

We identified the following finding:

- There has been a number of risk management training sessions held, but to date there is no training plan in place identifying who within the Health Board should be trained. Recently the need for a training needs analysis and the roll out of risk training to Corporate Functions, ILGs and CSGs, has been added to the 'Risk Management Implementation Plan'. However, this has had to be put on hold and will be reviewed in January 2021. (Finding 3)

Objective 4: A consistent risk scoring approach is applied at each level within the Health Board. Where the recorded mitigating actions reduce an inherent risk score to a much lower residual score, those actions are robust. Where risk scores increase or decrease especially at organisational or strategic levels, decisions can be evidenced.

We note the following areas of good practice:

- We are aware of the peer review process that has been set up at an ILG level to ensure consistency of scoring of those risks scoring 15 and above. We also saw evidence of a peer review taking place within Facilities to ensure that scoring was adequate, consistent and the controls were effective.
- Any changes to the risk scores are reviewed by the Assistant Director of Governance and Risk.
- We reviewed risks on the Merthyr and Cynon (M&C) and RTE Surgery risk registers and it was evident that the scoring of risks were consistent.

We identified the following finding:

- At the time of the audit there was no specific guidance to how risks scoring one to eight should be recorded, apart from on a local risk register which is outside of the Datix system. We understand this will be included in the Risk Assessment Procedure due to be approved in January 2021. (Finding 4)

Objective 5: An effective process is in place for the escalation and de-escalation of risks through the Health Board.

We note the following areas of good practice:

- Management have reviewed the risks on the old Corporate Risk Register to determine if they should be incorporated into the new ORR.
- An ORR report is taken to the Board, Board Committees and Management Board confirming risks that have been added onto the ORR, where the scores have increased and decreased and closed risks. Reasons are provided and approval is required.

We identified the following finding:

- We reviewed a sample of areas to ensure that where risks had scored 15 or more, they had been escalated onto an ILG risk register and the ORR. However, there were some instances where risks were not being recorded on the ORR. In addition, we saw instances where risks on the RTE Surgery CSG risk register were not on the RTE ILG risk register and vice versa. (Finding 1)

Objective 6: Consideration has been given to the development of a board assurance framework with a plan in place for how this will be populated with the Health Board's strategic risks.

We note the following areas of good practice:

- There are a number of tasks detailed within the 'Risk Management Improvement Plan' relating to Board Assurance. Tasks cover agreeing principal risks to include in the Board Assurance Framework (BAF) with controls, assurance and gaps to be identified and to further develop the Board Assurance Report (BAR) - triangulating performance, assurance and risk information.

- Whilst there have been some delays due to the pandemic, the principal risks were agreed by the Board in September 2020. We note that work has also started on the BAR.
- As detailed previously, the Risk Management Strategy has been updated and included within it are the steps to be taken to develop the BAR, including the roles of the Board, the Management Board, the Executive Leads and the Audit and Risk Committee.

We did not identify any findings under this objective.

Objective 7: Effective monitoring and reporting of risks takes place at the various tiers within the Health Board, including at committee level.

We note the following areas of good practice:

- The Risk Management Strategy provides detail on the monitoring role of the Board, Audit & Risk Committee, and other Board Committees and the Management Board.
- We confirmed that the ORR was reviewed at all Board meetings. In addition, the Board receive a report confirming new risks to the ORR, where the risk rating has increased or decreased during the period, and any closed risks.
- The Audit & Risk Committee also received the ORR and update reports at each of their meetings.
- The Quality & Safety Committee, Digital & Data Committee, Primary, Community, Population Health & Partnerships Committee and People & Culture Committee all receive reports on their allocated risks at regular points throughout the year.
- The Management Board receive the ORR and ORR report.

We identified the following finding:

- For three of the four Planning, Performance and Finance Committee meetings that took place in 2020, ORR assigned risks were not received. (Finding 2)

7. Summary of Recommendations

The audit findings and recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**1**	**2**	**2**	**5**

Finding 1- Escalating risk (Operating effectiveness)	Risk
Risks scoring 15 or more are escalated from the Clinical Service Group risk registers to the relevant ILG Risk Register and the Organisational Risk Register. We intended reviewing risks scoring 15 or more at the surgery and CAMHS CSGs to confirm that they had been escalated through their respective ILG risk register to the Organisational Risk Register. We found that: • Bridgend ILG - Surgery CSG Risk Register – Due to the pandemic we were unable to meet with the ILG and so we were unable to obtain a copy of the register to test. • Merthyr and Cynon ILG - The Surgery CSG risk register contains four risks scoring 15 or more. Again, due to the pandemic we were not provided with a copy of the Merthyr ILG risk register, so could not test to confirm appropriate escalation. However, we note that three of the four risks had not been escalated to the Organisational Risk Register despite their scores being 15 or more. • Rhondda Taf Ely ILG - The Surgery CSG risk register contains nine risks scoring 15 or more. The ILG risk register contains three of these and two others that were not on the CSG risk register. None of the risks had been escalated to the Organisational Risk Register, although we acknowledge that this may be a timing issue. • We have previously undertaken a review in the CAMHS CSG and identified three risks scoring 15 or more that the CSG were monitoring. As part of this current review we had hoped to trace these risks to the relevant ILG	Risks are not being escalated and de-escalated within the Health Board

risk register and the ORR. However, as CAMHS sits within the Bridgend ILG, we have not been sighted on their risk register. The three risks are not on the ORR.	
Recommendation	**Priority level**
Management should ensure that all risks that are scored 15 or more are escalated up to the Organisational Risk Register to enable the Executives to view all risks within their areas. Management should also ensure that all risks recorded on the Rhondda Taf Ely (RTE) ILG Risk Register and the RTE Surgery CSG Risk Register are aligned and all risks scoring over 15 are escalated to the ILG Risk Register.	**High**
Management Response	**Responsible Officer/ Deadline**
ILGs are committed to undertaking a review of all risks within the three locality groups. This work has been significantly impacted by the impact and response to the Covid-19 pandemic with operational focus quite rightly directed to clinical service provision. This work is still planned, however the timeline for this is dependent on the Covid-19 pandemic response and the impact of post Covid recovery of planned care. The work will be approached as follows:	Chief Operating Officer / ILG Directors Deadline: 30.09.2021

1.1	Review of risks and Clinical Service Group (CSG) risk registers ensuring it continues to be embedded in the ILG via a standing agenda item for the CSG and ILG Quality, Safety & Experience meetings.	
1.2	ILG Heads of Quality & Safety will continue to work with CSG's to both rationalise and standardise the CSG risk register.	
1.3	Through the delivery of dedicated monthly training slots ensure that CSG's have awareness/training in the Service to Board Escalation process and align their risk management approach to the recently revised Health Board Risk Management Strategy.	

Finding 2 – Risk monitoring at committees (Control Design)	Risk
The Risk Management Strategy states that all Board Committees should '*receive and scrutinise risks and provide onwards assurance to the Board in relation to risks assigned to them to provide oversight and scrutiny*'. We reviewed the terms of reference (ToR) and minutes of the Board Committees to ensure alignment with the Risk Management Strategy and we found the following: • The Planning, Performance & Finance Committee ToR were approved in July 2020. The ToR state that the committee 'monitor risk to financial delivery including mitigating actions to appropriately manage the risks', which does not align with the Risk Management Strategy. Furthermore, there is no reference to reviewing risks from the Organisational Risk Register assigned to the Committee. • The Population, Health & Partnerships Committee ToR were approved in November 2020, but there is no specific reference to risk management arrangements detailed within them. • While we saw evidence of risk reports at the, Population Health and Partnerships Committee, we saw no evidence of risk monitoring at the three Planning, Performance and Finance committee meetings that we reviewed. However, it appears that active monitoring of the five risks allocated to the committee resumed in December 2020.	There is no risk management strategy and associated framework in place within the Health Board. There is insufficient reporting and monitoring of risks undertaken within the Health Board.

Recommendation	Priority level
1. Management should ensure that the terms of reference for Board Committees are all aligned with the Risk Management Strategy and make reference to scrutinising risks that have been assigned to them. 2. Management should ensure that all risks assigned to the specific Board Committees are reviewed and discussed on a regular basis by these Committees.	**Medium**
Management Response	**Responsible Officer/ Deadline**
1. All Committee Terms of Reference will ensure reference to their review of assigned risks. 2. Review of the Organisational Risk Register is already a standing agenda item on all Board Committee meetings. It is also being captured in the Committee Cycles of Business which are being developed by the end of March 2021.	Director of Corporate Governance / Assistant Director of Governance & Risk Deadline: 31.1.2021

Finding 3- Risk management training plan (Operating effectiveness)	Risk
We have evidenced a number of risk management training sessions that have been held with staff from, amongst others, the Executive team, ILG management and CSG leads. Where requested, training has been provided to other managers and leaders in some CSGs and directorates, for example CAMHS and Facilities. Furthermore, a Board Members session was held to review risk, risk appetite and principal risks. Management note that training is not complete as it is yet to be rolled out to all CSGs and the Corporate functions. The roll out has been affected by the pandemic. At the time of our review the implementation plan states that a training needs analysis is yet to be undertaken and as such, there is no specific training plan in place outlining when other departments and areas will receive it.	Training has been not been provided on the new risk management approach for staff at all levels within the Health Board.
Recommendation	**Priority level**
Whilst we acknowledge that compiling a Training Needs Analysis is a new task that has been included on the Risk Management Improvement Plan, Management need to ensure that all departments and staff are provided with training on the new Risk Management Strategy, and the use Datix to record risks, as soon as possible. This will help ensure consistency of approach across the organisation.	**Medium**

Management Response	Responsible Officer/ Deadline
A training needs analysis will be undertaken early in 2021. In the interim monthly risk training sessions via Microsoft Teams has been scheduled with an open invite for staff across ILG's to attend.	Director of Corporate Governance / Assistant Director of Governance & Risk Deadline: 31.3.2021 – completion of the TNA may be impacted by the Covid-19 response.

Finding 4- Management of low scoring risks (Operating effectiveness)	Risk
The Risk Management Strategy states '*any risks identified and evaluated as having a low/moderate rating, i.e. a score of between one and eight, can be managed locally within the relevant area and do not require formal recording on the Datix Risk Management System. These risks are recorded locally in the local risk register within each service area / department*'. Whilst the Risk Management Policy and Procedure have been revised, there is no specific guidance to how the low scoring risks should be recorded. As such, there could be a number of systems in place to record these risks and therefore inconsistencies in the reporting of these risks or the monitoring of them to ensure appropriate escalation up to the CSG risk register.	There is no consistent approach for scoring risks within the Health Board.
Recommendation	**Priority level**
Guidance should be incorporated within the Risk Management Procedure detailing the format or system that should be used for the CSGs or directorates to record the risks scoring one to eight, so that there is consistency with reporting these risks.	**Low**

Management Response	Responsible Officer/ Deadline
There are templates in the Risk Assessment Procedure which will be approved by the Management Board at the end of January 2021 that can be used for all risks scoring 1-8.	Director of Corporate Governance / Assistant Director of Governance & Risk 31.1.2021

Finding 5- Department risk management plans (Operating effectiveness)	Risk
There is an overall Health Board 'Risk Management Improvement Plan' in place that covers a number of tasks to embed and improve the new risk management process, some of which involve the departments within the Health Board. We read the Facilities risk management plan that identifies key actions with target dates of what they need to do to review their current risk registers and bring their processes in line with the Health Board wide process. We also saw evidence of the planned approach to work being undertaken in the RTE ILG to review their registers. We deem having such action plans as good practice. As such, we feel that where they do not already exist, similar plans should be developed within other departments across the Health Board in order to support the tasks and timeframes outlined in the overall 'Risk Management Improvement Plan' If departments are not proactive in reviewing their current risks, then the ORR, and the tiers of registers that sit below it, will not be up to date for some time. The development of action plans may be linked to training provision, with some departments unaware of the actions they are required to carry out until they have received training on the new process.	There is no plan in place for reviewing the risk management system in the short term and longer term.

Recommendation	Priority level
Management should ensure that departments have suitable plans in place to review their current risk registers and risk management arrangements, so that there is an alignment with the overall Health Board Risk Management Improvement Plan that enables the development of complete ILG risk registers and a comprehensive Organisational Risk Register.	**Low**
Management Response	**Responsible Officer/ Deadline**
This has been established through an established mechanism with ILG's and Corporate Functions to align with the Management Board reporting timeframes. It will be an ongoing reminder to ensure that this is undertaken but the mechanisms and system for doing so has been established. The process is also escalated within the Service to Board Escalation pathway that is incorporated into the Risk Management Strategy and Risk Assessment Procedure.	Director of Corporate Governance / Assistant Director of Governance & Risk Deadline: 31.1.2021

Appendix B - Assurance opinion and action plan risk rating

Audit Assurance Ratings

 **Substantial assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.

 **Limited assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No assurance** - The Board can take **no assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

* Unless a more appropriate timescale is identified/agreed at the assignment.