Risk Management
Final Internal Audit Report

July 2022

Cwm Taf Morgannwg University Health Board

GIG CYMRU NHS WALES
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Audit and Assurance Services

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

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Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

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Executive Summary

Purpose

The overall objective of this audit is to evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to risk management.

Overview

We have issued reasonable assurance on this area.

The matters requiring management attention include:

- There were no records of actions and decisions made in relation to the escalation and de-escalation of risks between the Surgery Clinical Service Group, Bridgend Integrated Locality Group and the Organisational Risk Register.
- Risk management training record information is limited, and enhancements could be made to better use the information for targeting future training.
- Management risk reviews were overdue for a number of risks in our sample.

Further matters arising concerning the areas for refinement and further development have also been noted (see Appendix A).

Report Classification

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	 2020/21

Assurance summary[1]

Assurance objectives		Assurance
1	Effective processes for escalation and de-escalation	Reasonable
2	Training provision	Reasonable
3	Risk identification process	Reasonable
4	Consistency in capturing, scoring and mitigation of common risks	Reasonable

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising		Assurance Objective	Control Design or Operation	Recommendation Priority
1	Risk monitoring meetings within Bridgend ILG	1 & 4	Design	Medium
3	Training Records	2	Design	Medium
4	Review of Risks	3	Operation	Medium

1. Introduction

1.1 Our audit of risk management was completed in line with the 2021/22 Internal Audit plan for Cwm Taf Morgannwg University Health Board (The 'Health Board').

1.2 Effective risk management is a key component of corporate and clinical governance and is integral to the delivery of organisational objectives. Risk management consists of defined steps which help us understand risks and their impact. Good risk management awareness and practice at all levels is a critical success factor for any organisation and needs to be seen as integral to effective management practice.

1.3 In January 2021 the Health Board approved a revised risk management policy and strategy. Our 2020/21 risk management audit took place at a time when the revised approach was being rolled out, with relevant staff undergoing training and work being undertaken to refine the risk registers that Integrated Locality Groups (ILGs) and Clinical Service Groups (CSGs) had adopted as a result of the implementation of the new operating model. We provided reasonable assurance of the controls in place at that time. However, we identified some issues in relation to the availability of risk registers due to the ongoing review process. Furthermore, where registers were available, the escalation of risk from CSG registers to ILG registers, and onto the organisational risk register was not always in line with the process outlined in the policy. As such, we focused on this area in our 2021/22 review.

1.4 In recent months the Health Board has undertaken work to develop its Board Assurance Framework (BAF). A revised BAF was presented at the May Board meeting and will form part of a future audit review.

1.5 Our audit testing focussed on the arrangements in place within:

- Facilities directorate central hub, and the facilities teams based in the three ILGs.
- Bridgend ILG, with a specific focus on the Surgery CSG.
- the central Corporate Governance team.

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

1.7 The risks considered in the review were:

- Risks are not managed in line with the approved policy where there is lack of awareness of the Health Board's risk management policy and procedure.
- Risk becomes an issue if they are not identified, assessed or included on the relevant risk registers.
- Appropriate action is not taken if risks are not being escalated through the Health Board as appropriate.
- Risks to the achievement of the Health Board's objectives are not being actively managed.

- Risk management operates in silos and fails to provide a comprehensive risk profile of the Health Board, through a lack of collaboration.

Detailed Audit Findings

Objective 1: In line with the Risk Management Policy, effective processes are in place for the escalation and de-escalation of risks through the Health Board, including within CSGs and ILGs and Corporate directorates.

2.1 The Health Board's Risk Management Policy and associated documents provide clear guidance on the processes around escalation and de-escalation of risks.

2.2 The facilities directorate review their risk register every three months, focusing on risks that were due for review in that period. Prior to updating the Datix system that is used to record the risks, the Facilities Governance and Compliance Manager meets with the Facilities Leads in each of the ILGs and will also communicate with all the Heads of Service in the central Facilities team to review and note the status of the risks that they are responsible for.

2.3 Following the quarterly update process, we saw the Facilities Governance and Compliance Manager producing risk management exception reports for the Central Facilities Hub and each of the ILGs. These reports will include details of any risks that need to be considered for escalation. The reports will then be used to inform discussions on risk at the Facilities Performance meetings, Central Facilities Hub Assurance meetings and also the appropriate ILG meetings.

2.4 Bridgend ILG has recently drawn up a flow chart setting out the arrangements for monitoring risks and the approach to escalation and de-escalation, which is in line with the Health Board policy. The flowchart was due for approval at the time of our audit.

2.5 We understand that the Bridgend ILG risk register is reviewed at a monthly risk meeting chaired by the ILG's Head of Quality & Safety and attended by the ILG Triumvirate and CSG mangers. However, we did not see any documentation to confirm this process, so we were unable to evidence the process for escalation and de-escalation. **(Matter Arising 1)**

2.6 Furthermore, we understand that the Surgery CSG in Bridgend has a weekly governance meeting which includes risk discussions. These meetings are informal so it was not possible to evidence the risk discussions around escalation and de-escalation. **(Matter Arising 1)**

2.7 At an ILG level, risk is discussed at the ILG performance meetings with the Chief Operating Officer and at the CSG performance meetings with the ILG triumvirate.

2.8 The Assistant Director of Governance & Risk has a monthly meeting with the ILG Heads of Quality & Safety to review the ILG risk registers and determine where risks need to be considered for escalation to the Organisational Risk Register (ORR). As these meetings are informal, no record is kept of the actions taken or arising from them. **(Matter Arising 2)**

2.9 The ORR is reviewed every other month by the Health Board's Strategic Leadership Group (SLG), where changes to the ORR are formally approved. The SLG also receive an update report that includes:

- risks to be considered for escalation to the ORR;
- risks to be closed;
- risks to be de-escalated;
- changes to risk scores; and
- updates on the risk position for each of the ILGs.

2.10 The entire ORR is currently received at each meeting of the Audit & Risk Committee, and every meeting of the Health Board.

2.11 We can confirm that the recommendation made in our previous audit about ensuring all risks are allocated to a relevant Board Committee for monitoring, that committee terms of reference reflect this, and monitoring takes place, has been implemented. Where there are assigned risks on the Organisational Risk Register these are received at every meeting of the respective Board Committees.

2.12 An action identified in our previous audit related to all areas of the Health Board undertaking a full review of risks in order to 'cleanse' their risk registers. For the areas that we reviewed we were informed that this exercise had been completed. Updates on the cleansing process have been provided to the Audit & Risk Committee by the ILG Heads of Quality & Safety.

Conclusion:

2.13 There is clear guidance and processes in place for the escalation within the Health Board. For those areas that were reviewed while we saw appropriate escalation and de-escalation, evidence supporting the discussions that took place was not always in place. We have provided reasonable assurance against this objective.

Objective 2: Training in relation to the revised risk management approach continues to be delivered to relevant staff at all levels within the Health Board, including those recording risks on Datix.

2.14 Risk management training sessions are scheduled monthly and are available to all Health Board staff. The sessions are led by the Assistant Director of Governance & Risk, assisted by the ILG's Heads of Quality & Patient Safety. Sessions are also delivered to individual departments when requested.

2.15 The Audit & Risk Committee and the Board are regularly updated on the number of staff that have attended training. During the period January 2021 to April 2022 307 members of staff attended a risk management training session. Whilst a register of attendees is maintained (auto generated record from Teams), information relating to the department they represent is not captured. As such, there is no ability to undertake analysis of attendance across the Health Board to identify areas where attendance is low, or where no-one has been trained. Discussions with managers in the departments we visited confirmed that they do not keep any records of staff attendance on risk management training, but felt that

attendance information would be useful as a means to developing a training needs assessment and ensuing the correct people are being trained. **(Matter Arising 3)**

Conclusion:

2.16 There is a schedule in place for risk management training sessions that are available to all staff to attend. Whilst a register is maintained of staff that have attended the training sessions the information recorded is limited. We have provided reasonable assurance against this objective.

Objective 3: Processes for the identification of risks are in place, with risk assessments completed by suitably experienced and trained staff, and in line with the Health Board's Risk Assessment procedure.

2.17 For the areas reviewed, we were advised that when a risk is identified all details are entered directly into Datix, there are no supporting paper or electronic risk assessments. Any risks recorded on Datix are subject to approval by senior staff within the department. In the case of the Facilities Directorate, we saw a clear process in place for adding new risks to the register that included appropriate challenge and final approval by the Facilities Governance and Compliance Manager.

2.18 We undertook testing on a sample of 30 risks recorded on the Organisation, Facilities, Bridgend ILG and Surgery CSG risk registers to assess the appropriateness of details recorded, scoring and timeliness of review of risk. The results of testing found that whilst the details and scores of risks were appropriate, six of the risks had passed their review date. **(Matter Arising 4)**

2.19 The Risk Management Policy states that low scoring risks (8 and below) do not need to be captured on Datix and instead departments should have their own systems for recording and then monitoring these risks. A revised Risk Management Policy was approved during the course of audit review. In relation to this matter, the reference to Datix has been removed, suggesting departments could use Datix to capture low scoring risks, or alternative systems.

2.20 Our audit fieldwork identified a number of different approaches in place for recording and therefore monitoring low scoring risks, including the use of Datix. It is clear there are inconsistencies in approach not just across departments, but also within departments. **(Matter Arising 5)**

Conclusion:

2.21 Testing undertaken on a sample of risk found that a number of risks review dates were overdue. Inconsistencies were also noted in the management of low scoring risks. We have provided reasonable assurance against this objective.

Objective 4: Mechanisms are in place to ensure consistency in capturing, scoring and mitigation of common risks across ILGs.

2.22 As noted in 2.8 there are monthly informal meetings between the Assistant Director of Governance & Risk and the ILG Heads of Quality & Risk. We were informed that discussions take place on the scoring of risks to ensure consistency and consideration given to the merging of risks if circumstances were deemed possible.

2.23 As part of the risk management process in place for the Facilities Directorate, discussions take place around common risks and whether the risks can be 'merged' if appropriate. This was evidenced through the risks on the Facilities risk register that are recorded as relating to all three ILG's.

2.24 Within Bridgend ILG we were advised that discussions would take place regarding 'common' risks and whether such risks should be merged. However, we have been unable to evidence if such discussions took place as no records are kept of these meetings. **(Matter Arising 1)**

2.25 The Assistant Director of Governance & Risk's role includes undertaking a 'peer' review of the Health Board's risks to ensure that there is consistency in the scoring of risks and mitigation actions recorded.

Conclusion:

2.26 Whilst we have been advised that discussions around identification of common risks takes place within and across ILGs, the absence of any records has meant that we have been unable to confirm this. The arrangements in place within Facilities did mean we could confirm that consistency is reviewed. We have provided reasonable assurance against this objective.

Appendix A: Management Action Plan

Matter Arising 1: Risk monitoring meetings within Bridgend ILG (Design)	**Potential Impact**
Bridgend ILG As part of the process for managing risk within Bridgend ILG there is a monthly risk management meeting chaired by the ILG's Head of Quality & Safety and attended by the ILG Triumvirate and CSG management. The purpose of the meeting is to review the risks on the ILG's risk register in order of risk priority. Part of this process is to consider escalation and de-escalation of risks to the ORR. While this is a key meeting in the risk management process within the ILG, we were unable to determine if any meeting records are kept of the actions and decisions made regarding the risks reviewed. Furthermore, we understand that attendance at these meetings has declined recently, which may mean proper scrutiny is not taking place, but we have been unable to confirm this. Surgery CSG Weekly governance meetings take place between key members of the CSG and the governance lead for the CSG. We understand that high and moderate risks relevant to the CSG are reviewed. However, these meetings are informal, so no records are kept of actions or decisions that have been agreed. While we have seen the Surgery CSG and Bridgend ILG risk registers and can see they capture risks of the relevant score, we have not been able to evidence the process that takes place to support the movement of risks through the risk registers.	Risks are not managed in line with Health Board guidance.
Recommendations	**Priority**
ILG and CSG management should consider maintaining an action log of key actions / decisions that are made regarding ILG and CSG risks. This would allow for an appropriate trail of decisions made and ensure that any actions identified are completed.	**Medium**

Agreed Management Action	Target Date	Responsible Officer
BILG will set up monthly meetings with the Triumvirate and maintain a running action log from the meetings. As a team, BILG retain action logs for the CSG meetings which indicate which risks require review, updating or reformatting etc. These are actions which are taken away from the meetings and revisited the following week. If the responsible clinician is not in attendance at the meeting, the governance officer will send a communication through the risk via Datix advising that action is required. To provide some additional assurance going forwards, the Head of Quality will also request that the CSG governance leads escalate to them any issues after two weeks if the action has not been completed.	September 2022	Nurse Director & Head of Quality in BILG

Matter Arising 2: Recording actions from ILG monthly meetings (Design)		**Potential Impact**
We understand that a monthly informal meeting takes place between the Assistant Director of Governance & Risk and the Heads of Quality & Safety for the ILGs. The purpose of the meeting is to review progress on the individual ILG risk registers in order of risk priority. The discussions allow the opportunity to discuss whether risks should be considered for escalation to the ORR and likewise the de-escalation of any ORR risks back to the ILG risk registers. It is also an opportunity to identify common risks within the ILGs that could be merged and ensure consistent scoring. Some of the points discussed will be actioned in Datix during the meeting and the outcomes from these meetings will be reflected in the risk update report that is submitted to the Health Board's Senior Leadership Team. However, whilst emails may be exchanged after the meeting, there is no formal record of any actions that were taken or need to be taken.		Actions proposed at the meeting may not be completed. Inaccurate changes in risk scores resulting in inappropriate escalation or de-escalation.
Recommendations		**Priority**
Following the monthly meeting held between the Assistant Director of Governance & Risk and the Heads of Quality & Safety for the ILGs, management should consider producing an action log to record key actions that have been 'actioned' during the meeting, such as merger of risks, escalation/ de-escalation of risks, and any actions required to be taken outside of the meeting.		**Low**
Agreed Management Action	**Target Date**	**Responsible Officer**
Where there are any recommendations made in the meeting that could lead to changes to the Organisational Risk Register, the Assistant Director of Governance & Risk will follow this up with an email to those present noting the action agreed.	End of September 2022	Assistant Director of Governance & Risk

Matter Arising 3: Training records (Design)		**Potential Impact**
Between January 2021 and April 2022 307 members of staff were trained on the Health Board's revised risk management policy and process. Whilst a register is maintained of the staff that have attended training sessions, we understand that the register does not capture the staff member's department or their role. During our fieldwork we identified that local records of attendance are not held, with a common belief being that a central log is maintained. As such directorates and CSGs are not aware which members of their teams have received the training. While updates on the number of staff attending risk management training is reported to the Senior Leadership Team and Health Board, this information is limited and is not granulated to specific areas. As a result, management cannot provide data to target training in those areas where attendance rates may be low.		Lack of awareness of the Health Board's Risk Management policy and procedure leading to risk being realised.
Recommendations		**Priority**
Management should enhance the information that is recorded for staff that have undertaken risk management training to include their department. This would allow enhanced reporting on risk management training which could be used to target areas where the uptake of risk management training is poor.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
Currently due to limited administrative support being available the automated attendance record from Teams is relied upon. Going forward the Department will be captured for those staff present.	End of September 2022	Assistant Director of Governance & Risk

Matter Arising 4: Review of Risks (Operation)		**Potential Impact**
We reviewed a sample of 30 risks from risk registers within the Facilities Directorate, Surgery CSG, Bridgend ILG and the ORR to establish the appropriateness of the information recorded, the appropriateness of scoring, and the timeliness of review. We identified: • Organisational Risk Register – 2/5 risks had passed their review dates. Both were due to be reviewed in December 2021. • Bridgend ILG Risk Register – 3/10 risk had passed their review dates, with one due for review in mid-2019 and two in mid-2021. • Surgery Clinical Services Group – 1/5 risk had passed its review date. The risk should have been reviewed in September 2021. In all cases while the risk may have been reviewed, Datix has not been updated to reflect this.		Risks are not managed in line with Health Board guidance.
Recommendations		**Priority**
Management should ensure that for those risks highlighted, a review is undertaken as soon as practicable and the Datix system updated. Management should ensure that staff are reminded of the requirement to review and update risks in Datix in line with the timescales detailed in the Health Board guidance.		**Medium**
Agreed Management Action	**Target Date**	**Responsible Officer**
Risk Leads will be asked to ensure that Datix is updated to reflect the updates on the risks identified as being passed their review dates. Reminders to ensure risks are regularly updated will be included in the CTM Staff update and more prominently on the Risk Intranet Pages. Messaging will also continue via the training and regular meetings with risk leads.	End of September 2022	Assistant Director of Governance & Risk

Matter Arising 5: Management of Low Scoring risks (Operation)	**Potential Impact**
From the fieldwork undertaken and discussions held we identified a number of approaches for capturing low scoring risks: • Facilities Directorate - were capturing all risks on Datix regardless of score. This means low scoring risks are reviewed as part of their routine risk review process. • Bridgend ILG - we were informed that the policy was followed and only risks above eight were input on Datix, however we were also told that some CSGs do put lower scoring risks onto Datix. • Surgery CSG – While we understand that low scoring risks would be managed locally, our testing identified a small number of risks scoring less than eight on the register. The iteration of the Risk Management Strategy in place at the time of the audit states that low scoring risks are to be managed locally and do not have to be captured on Datix. However there appears to be inconsistent practice across the Health Board for capturing low scoring risks, and where low scoring risks were not being captured on Datix, we could not confirm what oversight was taking place of those risks. We raised a finding in our previous Risk Management report that the absence of any specific guidance as to how low scoring risks should be recorded, could result in a number of systems being used to record these risks. This could then result in inconsistencies in the reporting and monitoring of such risks.	There is no consistent approach for the management of low scoring risks
Recommendations	**Priority**
Management should consider the use of Datix for capturing all risks, this would allow for a consistent approach throughout the Health Board and provide greater effectiveness of monitoring.	**Low**

Agreed Management Action	Target Date	Responsible Officer
The ability to maintain a consistent approach to recording low level risks will be considered with a suggestion to align with the implementation of the new All Wales Risk Module on Datix where low level risks can be added to the system without generating the more detailed steps higher level risks require.	End of October 2022	Assistant Director of Governance & Risk.

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

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

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