Risk Management Review
Final Assignment Report 2018/19

NHS Wirral Clinical Commissioning Group

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ASSURANCE

Contents

1. Introduction, Background and Objective

A review of the CCG's Risk Management systems was conducted in accordance with the requirements of the 2018/19 Internal Audit Plan, as approved by the Audit Committee.

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 considered the specific risk management processes operating within the CCG.

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 CCG's risk management structures as documented within the Risk Management Strategy.

2. Executive Summary

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.

Moderate Assurance

The following provides a summary of the key themes.

Scope Area	Key Themes
Risk Strategy	Wirral Clinical Commissioning Group (CCG) has a Risk Management Strategy and Policy in place which was ratified by the Quality & Performance Committee in September 2018 and is available to staff on the intranet and the public website. This outlines the risk management processes, defines roles and responsibilities and monitoring arrangements.
	The Risk Management Strategy and Policy states that it should be reviewed on a biennial basis. The policy was in date, however it is noted that the specified date for review 3 years following last update.
	Overall responsibility for risk management is held by the Chief Officer. The Director of Corporate Affairs, Director of Quality and Patient Safety, Chief Financial Officer and Director of Commissioning are leads for identified areas of risk.
	Lay members are included in the membership of key committees. This ensure they have oversight of current CCG risks and management action being undertaken in relation to their specific areas of responsibility.

	The strategy details the responsibilities of all employees including reporting risks, participating in risk assessment processes and attending training. However, it is not clear how this operates in practice and we recommend that the strategy is updated to provide firmer guidance on the risk assessment and escalation processes. The inclusion of a simple flow diagram would assist. There are also some outdated references in the strategy e.g. Section 8.2 refers to NHSLA Risk Management Standards and the Audit Commission. In addition, due to the recent developments in Programme Management Office arrangements and the use of VERTO software the strategy should be refreshed to align with the current practices in the CCG. **(Medium Risk).**
	It would also be beneficial to update the Risk Strategy to reflect how the CCG's partnership and collaboration arrangements link in to the risk and governance requirements through the Joint Commissioning/ Section 75 and the Healthy Wirral Programme**. (Medium Risk)**
Risk grading, scoring and training	The risk grading and scoring mechanism is clearly defined in the Risk Management Strategy. This includes the use of the best practice 5x5 risk matrix for the scoring of risks. A risk scoring table is appended to the policy for reference, along with examples for each area of what may constitute a minor or catastrophic risk.
	Whilst Information Governance training is part of the mandatory training programme, which covers elements of risk management, there is no specific training in place within the CCG for risk management. Interviews confirmed that the CCG has not commissioned any risk management training for Managers and staff, nor has there been any recent Governing Body development training in relation to risk management.
	Apart from a recent (Jan 2019) PWC facilitated workshop to support the development of a risk register for the Section 75/ joint commissioning (Wirral Health and Care Commissioning) there has been no dedicated development work in relation to risk.
	We recommend that the Risk Management Strategy is strengthened to specify the training staff are required to undertake in relation to risk management, the frequency and how this will be delivered and monitored. **(Medium Risk)**
Identifying, recording, monitoring and managing risks	Risks can be identified and reported by any staff member, however, as noted above, the Risk Management Strategy does not clearly identify how staff members should report risks and this should be strengthened Although anyone can report risks, access is restricted for raising risks to the risk register as a quality control measure. In practice, risks are raised through line management to either the Associate Director or Director Lead and risks are brought forward through the subcommittee structure for consideration before being added to the strategic risk register. The CCG does not operate a system of operational risk registers.
	Review of Governing Body minutes indicated that updates on the risk

	register are regularly presented, however, there is limited evidence within the Governing Body minutes of challenge and debate to support the decisions put forward by the Director of Corporate Affairs. **(Medium Risk)**
	All sub-committees of the Governing Body are responsible for identifying, assessing, evaluating, treating, monitoring and recording risks relating to their respective areas. In addition to this, the Quality & Performance Committee also has delegated responsibility to review the strategic risk register on a monthly basis and escalate key risks to the Governing Body. MIAA review of minutes for the Quality & Performance Committee highlighted that the committee reviews and discusses risks on the risk register. A recent development in undertaking deep dives on long-standing risks is commended, the outcomes have yet to be formally documented in Quality & Performance Committee minutes.
	The Governing Body also receive an annual report from each sub-committee. The annual report for the Quality and Performance Committee lacks depth as it only includes composition of the committee, the types of reports received by the committee and a very brief work plan. Given that this committee plays a key role in risk management we would expect the Chairs annual report to provide assurance in relation to this duty and how it has been discharged in year. **(Low Risk)**
	Audit testing of the minutes of the Finance Committee between July and December 2018 found that 2 of 6 meetings were not quorate as per the Committee's Terms of Reference as the Medical Director was not in attendance. **(Low Risk)**
	Reports submitted to committees often include a covering sheet detailing the purpose of the report. However, these do not link back to specific risks and therefore assurances and supporting information for risks are often unclear. The covering sheet should also identify whether the risk is for consideration for addition to the risk register. **(Low Risk)**
	The CCG Risk Management Strategy states that the Audit Committee are responsible for ensuring that the risk assurance processes are being followed and reviewed on an annual basis. Audit review of the Audit Committee minutes confirmed review of the Risk Management System occurred in September 2018 through the provision of an assurance report from the Director of Corporate Affairs.
Risk Register	At the time of this review, the CCG had 13 risks recorded on the risk register. It is noted that some sections of the risk register lack clarity, specifically, movement between previous and current scoring columns.
	A number of the risks are not clearly articulated and should be reviewed, there is no target risk rating or reference to risk appetite for each risk and the assurance is not sufficiently detailed. There are instances where the risk has morphed into another over time, whereas

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	it may have been more appropriate to formally amend or close the original risk and add a new one.
	Audit testing of the risk register found that risks were marked as discussed at recent Finance Committee and Quality & Performance Committee meetings. Review of the corresponding minutes found that they did not always reference the risks that were shown as discussed on the risk register. Testing also highlighted that action plans do not consistently include specific target achievement dates and actions are assigned to Directors rather than operational leads. A number of risks had been on the register for years, although the CCG has recently instigated deep dives into these long standing risks.**(High Risk)**
	The CCG should also consider how the strategic risk register will integrate system wide risks in relation to Healthy Wirral and WHaCC, especially where the CCG may want a watching brief on emerging/ developing risks.

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	1	3	3	7

Other detailed findings and recommendations are set out below.

4. Detailed Recommendations

1. Risk Register	Risk Rating: High

Operating Effectiveness

Issue Identified – At the time of this review, the CCG had 13 risks recorded on the risk register. It is noted that some sections of the risk register lack clarity, specifically, movement between previous and current scoring columns.

A number of the risks are not clearly articulated and should be reviewed, there is no target risk rating or reference to risk appetite for each risk and the assurance is not sufficiently detailed. There are instances where the risk has morphed into another over time, whereas it may have been more appropriate to formally amend or close the original risk and add a new one.

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The CCG should also consider how the strategic risk register will integrate system wide risks in relation to Healthy Wirral and WHaCC, especially where the CCG may want a watching brief on emerging/ developing risks.

Specific Risk – Risks and the requirements to mitigate them are vague and so risks are not mitigated in a timely manner.

Committee minutes may not accurately reflect the discussion and updates taking place.

Risk register may not accurately reflect the discussions taking place at committee level.

Recommendation – The risk register should be updated and refreshed to ensure that :

- The terminology of risk descriptors are updated so that they are clear on what the actual risk is.

- Assurance and key control requirements should be more clearly defined to show details of report, meetings, accountability etc. a

- Target risk rating and risk appetite should be documented.

- Action plans should include a target date for implementation and include an operational lead to drive forward progress.

- The CCG should ensure that all risk discussed are formally referenced in the relevant committee minutes and that updates to the risk register correspond to the information detailed in the committee minutes.

- Healthy Wirral system, WHaCC collaboration and partnership risks should be included in the risk register to ensure there is one repository for risk.

Management Response (Remedial Action Agreed) – Agree with recommendations and will use Quality and Performance committee meetings to refresh the Risk Register, which may spread over successive meetings,

Responsibility for Action – Paul Edwards, Director of Corporate Affairs

Deadline for Action – October 2019

2. Risk Management Strategy	Risk Rating: Medium

Operating Effectiveness

Issue Identified – The strategy details the responsibilities of all employees including reporting risks, participating in risk assessment processes and attending training. However, it is not clear how this operates in practice and we recommend that the strategy is updated to provide firmer guidance on the risk assessment and escalation processes. The inclusion of a simple flow diagram would assist. There are also some outdated references in the strategy e.g. Section 8.2 refers to NHSLA Risk Management Standards and the Audit Commission. In addition, due to the recent developments in Programme Management Office arrangements and the use of VERTO software the strategy should be refreshed to align with the current practices in the CCG.

It would also be beneficial to update the Risk Strategy to reflect how the CCG's partnership and collaboration arrangements link in to the risk and governance requirements through the Joint Commissioning/ Section 75 and the Healthy Wirral Programme.

Specific Risk – Operational risk management processes are not clear, therefore employees may not be aware of how to raise risks.

Recommendation – The CCG should refresh the Risk Management Strategy and Policy to ensure it reflects current practices in the CCG, including the PMO arrangements and that risk management processes are more clearly detailed so that staff can use as a reference document/ operating procedure.

Management Response (Remedial Action Agreed) – Agree with recommendation.

Responsibility for Action – Paul Edwards, Director of Corporate Affairs

Deadline for Action – September 2019

3. Risk Management Training	Risk Rating: Medium

Operating Effectiveness

Issue Identified – Whilst Information Governance training is part of the mandatory training programme, which covers elements of risk management, there is no specific training in place within the CCG for risk management. Interviews confirmed that the CCG has not commissioned any risk management training for Managers and staff, nor has there been any recent Governing Body development training in relation to risk management.

Apart from a recent (Jan 2019) PWC facilitated workshop to support the development of a risk register for the Section 75/ joint commissioning (Wirral Health and Care Commissioning) there has been no dedicated development work in relation to risk.

Specific Risk – Staff are not appropriately trained to identify and manage risks.

Recommendation – MIAA recommends that a review of training needs is undertaken across all cohorts of staffing groups, specifically considering Governing Body and management tier.

Subsequently, this should be clearly documented within the Risk Management Strategy.

Management Response (Remedial Action Agreed) – Agree with recommendation. Will arrange a number of sessions for staff groups, incorporating changes to Policy and links to PMO approach

Responsibility for Action – Paul Edwards, Director of Corporate Affairs

Deadline for Action – December 2019

4. Governing Body and Committee Challenge of Risk	Risk Rating: Medium

Operating Effectiveness

Issue Identified –Review of Governing Body minutes indicated that updates on the risk register are regularly presented, however, there is limited evidence of challenge on risk status and risk mitigation activities other than that recommended by the Director of Corporate Affairs and the minutes/ cover reports do not fully demonstrate assurances received from the Governing Body sub committees.

Evidence of challenge is also limited in the Quality and Performance Committee minutes, although it is noted that this had improved in the most recent minutes.

Specific Risk – Risks may not be adequately challenged and so progress to mitigate risks is not driven forward.

Minutes may not adequately record discussions taking place at meetings.

Recommendation – The CCG should ensure that minutes appropriately evidence any

discussions and challenge in relation to risk, escalation and mitigation action plans.

Management Response (Remedial Action Agreed) – Director of Corporate Affairs will work with lead Director for Quality and Performance Committee (Director of Quality and Patient Safety) to ensure minutes of the Quality and Performance Committee capture challenge and discussions.

Responsibility for Action – Paul Edwards, Director of Corporate Affairs and Lorna Quigley, Director of Quality and Patient Safety

Deadline for Action – June 2019

5. Quality & Performance Committee Annual Report	Risk Rating: Low

Operating Effectiveness

Issue Identified – The Governing Body receive an annual report from each sub-committee. The annual report for the Quality and Performance Committee lacks depth as it only includes composition of the committee, the types of reports received by the committee and a very brief work plan. Given that this committee plays a key role in risk management we would expect the Chairs annual report to provide assurance in relation to this duty and how it has been discharged in year.

Specific Risk – Governing Body do not receive adequate assurance that the committee are fulfilling their roles and responsibilities.

Recommendation – All committee annual reports should provide an update on how they have discharged their duties but in particular the Quality and Performance Committee annual report should provide assurance in relation to its risk management duty and how it has been discharged in year.

Management Response (Remedial Action Agreed) – Agree with recommendation

Responsibility for Action – Committee Chairs

Deadline for Action – June 2019

6. Finance Committee Quoracy	Risk Rating: Low

Operating Effectiveness

Issue Identified – Audit testing of the Finance Committee minutes between July and December 2018 found that 2 of 6 meetings were not quorate as per the Committee's Terms of Reference, as the Medical Director was not in attendance.

Specific Risk – Committee terms of reference do not reflect actual expectations. Required attendance is not in line with terms of reference.

Recommendation – MIAA recommends that the CCG review the required attendees stated on the terms of reference and ensure that this reflects actual attendance expectations.

Management Response (Remedial Action Agreed) – Agree with recommendation

Responsibility for Action – Lesley Doherty, Chair of Finance Committee/Mike Treharne, Chief Finance Officer

Deadline for Action – June 2019

7. Report Covering Sheets	Risk Rating: Low

Operating Effectiveness

Issue Identified – Reports submitted to committees often include a covering sheet detailing the purpose of the report. However, these do not link back to specific risks and therefore assurances and supporting information for risks are often unclear. The covering sheet should also identify whether the risk is for consideration for addition to the risk register.

Specific Risk – Assurance trail relating to specific risks cannot be followed.

Recommendation – Cover sheets should include a clearer reference to risk and where the report is providing assurance this also needs to be clearly noted.

Management Response (Remedial Action Agreed) – Agree with recommendation and will revise cover sheets guidance to make requirements more explicit

Responsibility for Action – Paul Edwards, Director of Corporate Affairs

Deadline for Action – July 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 CCG's risk management structures as documented within the Risk Management Strategy.

The following sub-objectives were identified:

- The CCG has an up-to-date Risk Management Strategy underpinned by policies and procedure notes, which have been appropriately approved and communicated to all staff;

- Appropriate risk grading and scoring mechanisms have been developed and relevant staff have been trained accordingly;

- There are adequate and established methods for identifying, recording, monitoring and managing risks from a range of sources 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 to mitigate risks in line with the Risk Management Policy;

- The CCG Audit Committee and the Senior Management Team monitor aspects of risk management as defined within the Risk Management Policy; and

- There are reporting arrangements in place to inform the Governing Body of risks as appropriate.

Limitations inherent to the internal auditor's work

We have undertaken the review of the process, subject to the following limitations.

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 Risk Management process is that at February 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

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- 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: • the efficient and effective use of resources • the safeguarding of assets • the preparation of reliable financial and operational information • compliance with laws and regulations.
High	Control weakness that has or is likely to 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: • has a low impact on the achievement of the key system, function or process objectives; • 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.

Report Distribution

Name	Title	Report Distribution
Paul Edwards	Director of Corporate Affairs	Draft & Final
Grace Price-Jones	Acting Corporate Affairs Manager	Draft & Final
Mike Treharne	Chief Finance Officer	Final

Discussion meeting held with

Name	Title	Date
Paul Edwards	Director of Corporate Affairs	8th March 2019
Grace Price-Jones	Acting Corporate Affairs Manager	8th March 2019

Review Completion

Name	Planned Date	Actual Date
Fieldwork Starts	February 2019	February 2019
Discussion Document to Client	March 2019	March 2019
Responses by Client	March 2019	March 2019
Final Report	March 2019	March 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