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Internal Audit Report
Risk Management

Date of fieldwork: November 2009
Date of draft report: November 2009
Date of final report: November 2009

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Executive Summary

This report details the Internal Audit of the procedures and controls in place over Risk Management and has been undertaken in accordance with the 2008/2009 Internal Audit Plan. Our audit approach and a summary of the work undertaken are provided in the audit framework in Appendix A.

Background

The Trust has currently been reviewing many of its key processes as part of its ongoing aim to address its key risks. At the time of the audit the Trust had approximately 94 key risks recorded on its risk register. The Trust is also currently restructuring its governance arrangements to provide better accountability and less duplication of effort which has meant that the current Risk Management Committee has been disbanded and is to be replaced by the Risk and Governance Executive that will meet for the first time early in the New Year.

Audit Opinion

Substantial   While there is a basically sound system there are weaknesses which put some of the control objectives at risk and/or there is evidence that the level of non-compliance with some of the controls may put some of the systems objectives at risk.

Summary of findings

The risk management process at the Trust is well established, the risk register integrates with the organisation's key objectives and the assurance framework. As a result of this audit, six recommendations have been raised, all of which deal with issues regarding the clarity of information and reporting. Our findings are detailed in the paragraphs below.

Risk Management Strategy:

The Trust has a combined risk management strategy and policy document which deals with all areas of the risk management process, this document has recently been updated and the Board approved the new version on the 25th October 2008. The policy section identifies both the individuals with executive responsibility for risk management and also the key stakeholders in the process. Audit confirmed that training on Risk Awareness is provided to the Board of Directors and Senior Management, however only 55% of Senior Managers had received relevant training; a recommendation has been raised to address this issue.

Maintenance of Risk Register:
Risks to the organisation are identified using a number of different methods and sources, however, the current key risks to the organisation were identified during risk identification and evaluation exercises that were part of developing the new integrated business plan that was completed in June 2006. All risks that have been identified outside of this process have been reviewed, scored and ranked by the Risk Management Committee, which was at the time responsible for maintaining the risk register. However Audit found that there is currently no link between the risks in the risk register and those within the Assurance Framework. Further the methods of prioritising the risks were different between both documents.

At the time of the audit it was identified that the review of current risks and action plans was the responsibility of the Risk Management Committee, however, it was difficult to determine whether this Committee was reviewing all risks and action plans in a systematic way as the quality and style of the minutes meant that discussions could not be directly linked to specific risks. Further, action had not commenced on some plans.

Risk Management Framework:
The risk management framework currently in place at the Trust is a centrally managed operation, which gathers information from a number of sources and then collates these into a single risk register which is then monitored by the Risk Management Committee and to a lesser extent by the Board. The Trust is planning to extend its risk management processes down to its Directorates both to improve general risk identification for inclusion in the corporate risk register but to help identify specific risks which may be given insufficient attention at the moment. This process requires significant time and resources and it is planned that this process will be phased in across the different Directorates. At the time of the audit a number of risk awareness exercises using the Manchester Patient Safety Framework (MaPSaF) had been undertaken with a number of departments that will help staff identify risks when the new system is in place.

Risk Reporting:
The main body responsible for reviewing the risks faced by the organisation was the Risk Management Committee. Before it was disbanded, the Risk Management Committee, which has now been superseded by the Risk and Governance Executive, met five times during 2008/09 the last time being in November 2008. This risk management process had also been reviewed during October 2008 by the full Board and had also been discussed by the Quality and Risk Management Committee during November 2007. It was identified that although the Risk Management department has agreed key performance indicators defined within the risk management strategy, aspects of its performance had been reviewed only at the first two Risk Management Committee meetings this financial year.

Acknowledgement
We would like to thank the management and staff of the Risk Management Department for all their assistance during the audit.

Section 1 – Observations and Recommendations

In order to assist management in using our reports:

a) We categorise our **audit opinion** according to our assessment of the controls in place and the level of compliance with these controls:

🟢	**Full Assurance**	There is a sound system of control designed to achieve the system objectives and the controls are being consistently applied.
🟢	**Substantial Assurance**	While there is a basically sound system, there are weaknesses which put some of the system objectives at risk, and / or there is evidence that the level of non-compliance with some of the controls may put some of the system objectives at risk.
🟡	**Limited Assurance**	Weaknesses in the system of controls are such as to put the system objectives at risk, and/or the level of non-compliance puts the system objectives at risk.
🔴	**Nil Assurance**	Control is generally weak, leaving the system open to significant error or abuse, and/or significant non-compliance with basic controls leaves the system open to error or abuse.

b) We categorise our **recommendations** according to their level of priority.

High	*Priority 1*	Major issues that we consider need to be brought to the attention of senior management and the audit committee.
Medium	*Priority 2*	Important issues which should be addressed by management in their areas of responsibility.
Low	*Priority 3*	Detailed problems of a minor nature resolved on site through discussions with local management.

1. Systematic Review of Risks and Action Plans   (Priority 2)

Recommendation	Rationale	Responsibility
It is recommended that the Trust ensures it takes a systematic approach to the review of key risks and action plans including how this is recorded within Risk and Governance Executive minutes.	A systematic approach to recording the review of key risks and action plans by the Risk and Governance Executive will help to ensure that the Trust maintains an up to date risk register and manages these risks appropriately. The Trust's key risks and action plans were reviewed at the Risk Management Committee meetings, however, it was determined that the evidence of this review was often difficult to link to specific risks. It was noted that the new Ciris system will improve the recording of information and reporting within the Trust. If risks to the Trust are not reviewed regularly, there is a risk that key risks change or develop further, exposing the Trust to new threats that the Trust is not prepared for.	Associate Director of Risk Management

Management Response		Deadline
This is a relevant and valid recommendation and should be managed through the RGE agenda – ensuring regular review and reassessment of risks on a rotating basis. Action planning should also coincide with these reviews.		Every quarters agenda to include a review of risk register. June 2007

2. Regular Performance Reporting   (Priority 3)

Recommendation	Rationale	Responsibility
It is recommended that the risk management performance is reviewed on a regular basis.	Regular monitoring of the key performance indicators that relate to the Trust's risk management process will help to ensure that the risk management process provides a value added service. The risk management strategy includes a section which identifies the key performance indicators for risk management. A review of the Risk Management Committee minutes identified that although key performance indicators were reviewed in the first two meetings of the year, the subsequent minutes did not contain any evidence that they were being reviewed. If the performance of the risk management process in place within the Trust is not monitored, there is a risk that risk may not be appropriately monitored and controlled within the organisation.	Associate Director of Risk Management

Management Response	Deadline
Key performance indicators are to be included in the agenda for RGE to ensure that ongoing monitoring is in place.	Quarterly meetings June 2007

3. Links between the Risk Register & Assurance Framework   (Priority 2)

Recommendation	Rationale	Responsibility
An extra column should be inserted into the Assurance Framework in which to record the corresponding/linking risk numbers from the Risk Register. Similarly, the Risk Register should have an extra column in which to record the associated risk from the Assurance Framework.	Risks identified within the Assurance Framework should be clearly linked to the risks included within the Trust-wide risk register to ensure that all risks are incorporated in the Assurance Framework. There is currently no link between the risk register and the Assurance Framework. No references are made between the top risks identified in the Trust's risk register and the risks identified in the Assurance Framework. Further, the audit noted that the method of scoring risks in the Assurance Framework and the risk register were different. There is an increased risk of the Assurance Framework failing to incorporate all high priority risks stated in the organisation-wide risk register which could result in an assurance gap.	Associate Director of Risk Management

Management response		Deadline
Agreed		Immediately

4. Risk Scoring / Prioritisation   (Priority 2)

Recommendation	Rationale	Responsibility
A consistent method of prioritising / scoring risk should be utilised in both the risk register and the Assurance Framework. The top risks in the Risk Register should feature in all Assurance Framework and Trust Board reporting.	The risks in the Trust- wide register and the Assurance Framework should be prioritised using a consistent risk assessment framework. This helps to ensure effective risk management and reporting. The audit identified that the methods of scoring risks in the Assurance Framework and the risk register were different. Where inconsistent methods / basis of risk prioritisation are in place there is the risk that the Assurance Framework might fail to incorporate all high priority risks stated in the Trust-wide risk register which could result in an assurance gap.	Associate Director of Risk Management

Management response		Deadline
Agreed		Immediately

6. Risk Management Action Plans (Priority 2)

Recommendation	Rationale	Responsibility
Timely action should be undertaken on those areas of the Risk Management Action Plan noted as 'Not Started'.	Mitigation activity should be undertaken immediately to address identified risks. Audit noted that the Action Plan worksheet was regularly updated by the Risk Manager at the monthly meetings with the Risk Owners. However, there were a number of areas where action had 'Not Started' and the action deadline had been moved forward. Where action does not commence to mitigate identified risks, such risks might materialise.	Risk Owners / Risk Manager

Management Response	Deadline
Agreed.	Immediate

Appendix A – Audit Framework

Audit Objectives

The audit was designed to ensure that management have implemented adequate and effective controls over risk management.

Audit Approach and Methodology

The audit approach was developed with reference to the Internal Audit Charter and by an assessment of risks and management controls operating within each area of the scope.

The following procedures were adopted: -

- ∞ identification of the role and objectives of each area;
- ∞ identification of risks within the systems, and controls in existence to allow the control objectives to be achieved; and
- ∞ testing of controls within the systems.

From these procedures we have identified weaknesses in the systems of control, produced specific proposals to improve the control environment and have drawn an overall conclusion on the design and operation of the system.

Areas Covered

Audit work was undertaken to cover the following areas and control objectives: -

- ∞ The risk management strategy, policy and procedures are regularly reviewed and approved by the Trust Board.
- ∞ The risk register is reviewed and updated on an ongoing basis, to identify and address all risks that the Trust is exposed to, and that this process has been formally embedded in regular and routine management processes;
- ∞ The appropriateness of the present risk management structure as a framework, and its effectiveness in practice; and
- ∞ A reporting framework to monitor risks and the risk management is established and is working effectively.

Appendix B – Staff Interviewed

- ∞ XXXXX XXXXXX – Associate Director of Risk Management
- ∞ XXXXX XXXXXX – Head of Governance
- ∞ XXXXX XXXXXX – Head of Clinical Governance
- ∞ XXXXX XXXXXX – Risk Manager

An exit meeting was held with the Associate Director of Risk Management on 10th June 2009.

Section C – Management Action Plan

Ref	Recommendation	Priority	Management Response	Responsibility	Deadline
1.1	It is recommended that the Trust ensures it takes a systematic approach to the review of key risks and action plans including how this is recorded within Risk and Governance Executive minutes.	2	This is a relevant and valid recommendation and should be managed through the RGE agenda – ensuring regular review and reassessment of risks on a rotating basis. Action planning should also coincide with these reviews.	Associate Director of Risk Management	Every quarterly agenda to include a review of risk register. June 2007
1.2	It is recommended that the risk management performance is reviewed on a regular basis.	3	Key performance indicators are to be included in the agenda for RGE to ensure that ongoing monitoring is in place.	Associate Director of Risk Management	Quarterly meetings June 2007
1.3	An extra column should be inserted into the Assurance Framework in which to record the corresponding/linking risk numbers from the Risk Register. Similarly, the Risk Register should have an extra column in which to record the associated risk from the Assurance Framework.	2	Agreed	Associate Director of Risk Management	Immediate
1.4	A consistent method of prioritising / scoring risk should be utilised in both the risk register and the Assurance Framework. The top risks in the Risk Register should feature in all Assurance Framework and Trust Board reporting.	2	Agreed	Associate Director of Risk Management	Immediate
1.5	Senior Managers should be encouraged to attend Risk Management training.	2	Agreed	Senior Managers / Risk Manager	May 2009
1.6	Timely action should be undertaken on those areas of the Risk Management Action Plan noted as 'Not Started'.	2	Agreed	Risk Owners / Risk Manager	Immediate

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Internal Audit Progress Report

Quarter 3- 2009/10

December 2009

INTRODUCTION

This progress report has been prepared for the Members of the Audit Committee for the Trust. The report outlines the work performed by Deloitte & Touche Public Sector Internal Audit Ltd to date for the 2009/2010 Internal Audit Plan, which has been performed in accordance with the NHS Internal Audit Manual and Standards.

PERFORMANCE

The following table details the Internal Audit Service performance for the year to date measured against the key performance indicators set out in the Internal Audit Quality Plan, agreed with the Audit Committee.

No.	Key Performance Indicator	Target	Actual 2009/10
1	Audit brief to be issued to auditee at least ten days prior to commencement of fieldwork	100% of audits	100% of Audits
2	A close out meeting to be held for each audit	100% of audits	100% of audits
3	Average period between the close out meeting and issue of the draft report	15 days	12 days
4	Average period between the receipt of final management responses and issue of the final report	10 days	1 day
5	Average customer satisfaction score (measured by survey) (5=Excellent, 4 = Good, 3 = Satisfactory, 2 = Poor, 1 = Very Poor)	85% at 3 or above (Satisfactory)	100%

PROGRESS AGAINST THE 2009/2010 INTERNAL AUDIT PLAN

As at the 21st December 2009, progress against the 2009/2010 plan is as follows:

Number of audits in plan	25	
Number of audits finalised	8	32% of plan
Number of reports issued at draft	4	16% of plan
Number of audits in progress	1	4% of plan

At the time of this report, approximately 60% of the 2009/2010 Internal Audit Plan has been completed (See Appendix One - Days Delivered). Audits have been completed in accordance with the timings agreed with the Audit Committee and we are on target to complete the planned programme of work by 31 March 2010.

Appendix One details the updated 2009/2010 Internal Audit Plan and outlines the status of work to date, the number of days delivered, together with the assurance level at the time of this report and the number of recommendations raised (for finalised reports only).

AUDIT ACTIVITY

Since the last Audit Committee, the following final reports have been issued with the stated assurance levels:

- ∞ Local Clinical Governance   -   Substantial Assurance
- ∞ Debtors and Sundry Income   -   Substantial Assurance
- ∞ Estates & Facilities: Job Costing   -   Substantial Assurance
- ∞ Payroll (Stage 1)   -   N/A: Fact Finding Exercise – No Assurance Level Provided

Summary details of the recommendations contained in the above reports together with the management responses are contained in Appendix Two of this report.

Changes to the Audit Plan

At the request of the Director of Finance and Planning, an additional ten days have been added to the 2009/2010 Internal Audit Plan to complete work on the new payroll system. This is in addition to the five days utilised from contingency within the 2009/10 Internal Audit Plan. A total of fifteen days have been used for the Internal Audit Work.

The Audit Committee is asked to note and approve the following two amendments to the 2009/10 Internal Audit Plan:

∞ Treasury Management – Following changes within the auditable area in November and December 2009, at the request of the Head of Finance, the audit has been rescheduled to be undertaken in January 2010.
∞ Quality Accounts – Following a meeting with the Associate Director of Clinical Governance, it was determined that the audit would be more suitable for completion in March 2010 when work has progressed within the Trust on producing the Quality Accounts for the 2009/2010 financial year.

Significant Control Weaknesses

Based on the work we have undertaken within Quarter Three, there have been no major internal control issues (Priority One Recommendations) to be brought to the attention of the Audit Committee.

Draft Reports

As at the 21st December 2009, the following audits have been issued as draft:

∞ Clinical Governance and Risk;
∞ Asset Management;
∞ Non Pay Expenditure;
∞ Payroll; and
∞ Payroll (Stage Two).

2009/2010 Internal Audit Plan - Status as at 21st December 2009   **Appendix 1**

No.	Audit Title	Lead Executive Director	Days in Plan	Days Delivered	Assurance Level	Recommendations (Priority)			Status
						1	2	3	
1	Local Clinical Governance (CF 0809)		10	10	Substantial	0	8	2	Final
2	Business Continuity Planning (CF 0809)		8	8	Limited	3	8	0	Final
3	Location/Unit Visit 1		5	5	Substantial	0	1	2	Final
4	Location/Unit Visit 2		5	5	Limited	1	6	0	Final
5	Location/Unit Visit 3		5	5	Substantial	0	4	2	Final
6	Human Resources 08/09 Follow Up		4	4	Substantial	0	5	2	Final
7	Compliance HR Policies & Procedures		10	10	Substantial	0	7	2	Final
8	Clinical Governance & Risk		6	5.5					Draft
9	Estates & Facilities : Job Costing		4	4	Substantial	0	6	3	Final
10	Asset Management		5	4.5					Draft
11	Debtors and Sundry Income		5	5	Substantial	0	0	1	Final
12	Financial Ledger & Budgetary Control		8	6					WIP
13	Non Pay Expenditure		5	4.5					Draft
14	Payroll		7	6					Draft
15	Treasury Management		5	0					Jan 10
16	Quality Account		8	0					March 10
17	Standards for Better Health		6	0					March 10
18	IT Audit: Data Quality and Dashboard Reporting		7	0					March10
19	Estates & Facilities: Planned Maintenance		4	0					Feb 10
20	Assurance Framework		6	0					Feb 10
21	Compliance with FT Code of Governance		3	0					March 10
22	IT Audit: RIO Implementation		6	1					Ongoing
23	IT Audit: Data Warehouse Implementation		6	0					March 10
24	Follow Up of Recommendations		3	0					March 10

25i	Contingency – Payroll System (Stage 1)		5	5	N/A				Final
25ii	Payroll System (Stage 2)		5	4.5					Draft
	Audit Management		12	8.5					
	TOTAL		**168**	**101.5**		**4**	**45**	**14**	

Internal Audit Recommendations from Final Reports issued since last Audit Committee   Appendix 2

Ref.	Recommendation	Priority	Management Response	Deadline	Responsible Officer	Responsible Director
1. Local Clinical Governance						
1.1	Directorates should report to the Learning and Development Team on budgetary performance regarding training and development.	2	Agreed	January 2010	Directorate Clinical Governance Leads / Training Leads	Director of Nursing and Governance
1.2	Terms of Reference should be subject to regular review and update. The Terms of Reference should detail the date of last review and date of next review.	3	Agreed	January 2010	Clinical Governance Chairs	Director of Nursing and Governance
1.3	Regular meetings should be taking place for the Local Clinical Governance Groups.	2	Agreed	January 2010	Local Clinical Governance Group Chairs	Director of Nursing and Governance
1.4	Regular reporting should be completed to the Directorate Clinical Governance Groups.	2	Agreed	January 2010	Local Clinical Governance Group Chairs	Director of Nursing and Governance
1.5	A representative from each Locality Clinical Governance Group should be present at the Directorate Clinical Governance Meetings.	2	Agreed	January 2010	Local Clinical Governance Group Chairs	Director of Nursing and Governance
1.6	Directorate Clinical Governance reports should be cascaded and discussed at locality level on a regular basis.	2	Agreed	January 2010	Local Clinical Governance Group Chairs	Director of Nursing and Governance

Ref.	Recommendation	Priority	Management Response	Deadline	Responsible Officer	Responsible Director
1. Local Clinical Governance						
1.7	A formal working arrangement should be in place between the Directorate Clinical Governance Groups (DCGG) and the Directorate Risk, Health and Safety Groups (DRHSG). This should be documented within the Terms of Reference for the Groups. A representative from the DCGG should attend the DRHSG meetings and vice versa.	2	Agreed	January 2010	Directorate Clinical Governance Leads & Directorate Health and Safety Leads	Director of Nursing and Governance
1.8	The results of the Staff Attitude Survey should be communicated to the Trust Clinical Governance Group.	3	Agreed	January 2010	Director of Human Resources	Director of Nursing and Governance
1.9	Clear and transparent arrangements should be established to facilitate the regular discussion of Clinical Audit and Effectiveness at Local Clinical Governance Groups.	2	Agreed	January 2010	Local Clinical Governance Group Chairs	Director of Nursing and Governance
1.10	Regular discussions of risk and adverse incidents should take place at the Local Clinical Governance meetings.	2	Agreed	January 2010	Local Clinical Governance Group Chairs	Director of Nursing and Governance

Ref.	Recommendation	Priority	Management Response	Deadline	Responsible Officer	Responsible Director
2. Debtors and Sundry Income						
2.1	An Invoice Request Form should be completed for all invoices raised. In line with procedures, the form should be evidenced as authorised by the budget holder. All staff should be reminded to comply with the approved policy.	3	Agreed.	December 2009	Head of Finance (Financial Accounts, Systems & Governance).	Director of Finance and Planning
3. Estates and Facilities: Job Costing						
3.1	Minor Works Costing and Approval Forms should be completed and retained on file. The appropriate cost centre should always be completed on the Minor Works Costing and Approval Form.	2	Agreed	November 2009	Head of Estates and Capital	Director of Information and Performance
3.2	A breakdown of labour charges for capital projects should be sent to Finance on a regular basis in order to be charged to the Trust's capital budget.	3	Agreed	November 2009	Head of Estates and Capital	Director of Information and Performance
3.3	An authorised signatory list should be developed for those people able to authorise the Minor Works Costing and Approval Form.	2	Agreed	December 2009	Head of Estates and Capital	Director of Information and Performance
3.4	The costs for minor works entered onto QFM should be checked for accuracy.	2	Agreed	November 2009	Head of Estates and Capital	Director of Information and Performance

Ref.	Recommendation	Priority	Management Response	Deadline	Responsible Officer	Responsible Director
3. Estates and Facilities: Job Costing						
3.5	A detailed breakdown of the individual elements should be provided in support of each quotation for minor improvement works.	2	Agreed	November 2009	Head of Estates and Capital	Director of Information and Performance
3.6	A reconciliation should be performed on a monthly basis in order to confirm that the value of events recharged is consistent with the value listed on QFM as 'finance invoiced'	2	Agreed	November 2009	Directorate Accountant Specialised Services	Director of Finance and Planning
3.7	Guidance should be in place on the application of the 15% mark up on the cost of minor works to reflect management and administration time spent on the projects.	2	Agreed	December 2009	Head of Estates and Capital	Director of Information and Performance
3.8	All service units should be sent a detailed breakdown of their monthly recharges from Facilities and Estates each month.	3	Disagreed - Agreed Agreed.	N/a	Directorate Accountant Specialised Services	Director of Finance and Planning
3.9	User access reports should be run on a quarterly basis and checked in order to confirm that all users are still employed at the Trust and access rights remain appropriate.	3	Agreed	November 2009	QFM Systems Administrator	Director of Information and Performance

Full details concerning the above recommendations and management responses are contained in our final reports, which are available upon request.

<u>Statement of Responsibility</u>

We take responsibility for this report which is prepared on the basis of the limitations set out below.

The matters raised in this report are only those which came to our attention during the course of our internal audit work and are not necessarily a comprehensive statement of all the weaknesses that exist or all improvements that might be made. Recommendations for improvements should be assessed by you for their full impact before they are implemented. The performance of internal audit work is not and should not be taken as a substitute for management's responsibilities for the application of sound management practices. We emphasise that the responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management and work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, nor relied upon to identify all circumstances of fraud or irregularity. Auditors, in conducting their work, are required to have regards to the possibility of fraud or irregularities. Even sound systems of internal control can only provide reasonable and not absolute assurance and may not be proof against collusive fraud. Internal audit procedures are designed to focus on areas as identified by management as being of greatest risk and significance and as such we rely on management to provide us full access to their accounting records and transactions for the purposes of our audit work and to ensure the authenticity of these documents. Effective and timely implementation of our recommendations by management is important for the maintenance of a reliable internal control system. The assurance level awarded in our internal audit report is not comparable with the International Standard on Assurance Engagements (ISAE 3000) issued by the International Audit and Assurance Standards Board.

Deloitte & Touche Public Sector Internal Audit Limited

South West Region

December 2009

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