# MILTON KEYNES UNIVERSITY HOSPITAL NHS FOUNDATION TRUST

## Risk Management

Internal audit report 7.20/21

Final

3 August 2021

# 1. EXECUTIVE SUMMARY

## Why we completed this audit

With the use of secure portals for the transfer of information, and through electronic communication means, remote working has meant that we have been able to complete our audit and provide you with the assurances you require. It is these exceptional circumstances which mean that 100 per cent of our audit has been conducted remotely. Based on the information provided by you, we have been able to sample test, or complete full population testing.

An audit of Risk Management was undertaken as part of the approved internal audit plan for 2020/21. The audit was completed to enable the Trust to take assurance around the effectiveness of controls, processes, and governance arrangements in relation to risk management. The Trust has a Risk Management Strategy which governs how the Trust responds to and manages risks, with these risks recorded through the Datix risk management system.

Risk management at the Trust is overseen by the Risk and Clinical Governance team. Risks are identified at a departmental and divisional level, added to Datix, and then discussed at each Divisional Board. Any risks that are graded 15 or above are automatically escalated by Datix to the Significant Risk Register for review by the Integrated Governance Board (formerly the Risk and Compliance Board) and the Trust Executive Group (formerly the Management Board). Risks are also escalated to the Board Assurance Framework is reviewed by the Board, and Audit Committee and Finance and Investment Committee.

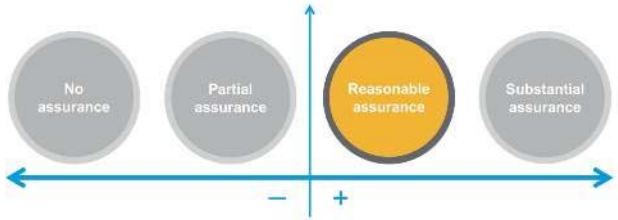
As part of the review we also undertook a questionnaire to assess the views of directors and the senior management team with regards to risk management.

## Conclusion

The COVID-19 pandemic has had a major impact on the Trust with a shift in focus to responding to it and this has been reflected in the compliance with controls in relation to the management of risks, but we were unable to test the compliance of clinical risk owners with the training. In addition, risks on Datix did not consistency record key information such as assurances and gaps in controls, and there was a lack of evidence of challenge and scrutiny of risk registers by Divisional Boards, the Integrated Governance Board, and the Trust Executive Group.

**Internal audit opinion:**

Taking account of the issues identified, the Board can take reasonable assurance that the controls in place to manage this risk are suitably designed and consistently applied. However, we have identified issues that need to be addressed in order to ensure that the control framework is effective in managing the identified risk(s).



## Key findings

**We identified the following weakness resulting in the agreement of 4 medium priority management actions:**

**Identification and Assessment of Risks**

Risk Content

Against each risk on Datix information is recorded, such as initial, current and target scores, controls, and actions. Through review of our sample of 20 risks on Datix we found the following:

- 5/20 risks had initial and current scores that were equal, despite having controls documented against them;
- 9/20 risks did not have assurances documented against them and one was noted as "to be confirmed";
- 3/20 risks did not have gaps in controls recorded and were either blank or noted that gaps were to be confirmed;
- 12/29 risks did not have actions, despite their current and target scores being different, indicating there was a need for action(s); and
- For 4/20 risks where actions had been noted against, one was SMART, however the remaining three were not.

We raised a management action as part of the 2019/20 review to undertake a review of all risks to confirm their content was appropriate; however, the Head of Risk and Clinical Governance confirmed this had not been implemented. This could mean that risks are not being appropriately managed. **(Medium)**

**Divisional and Departmental Risk Review**

The four clinical divisions within the Trust hold Divisional Board meetings on a monthly basis where risks relevant to those divisions are reviewed. Non-clinical departments, such as Finance, maintain their own risk registers and have their own forums for reviewing their registers. We obtained the terms of reference and the minutes for the following meetings:

- Medicine – September 2020;
- Surgery – January 2021 (action log);
- Women and Children – September and November 2020, and January 2021;
- Core Clinical – October and November 2020;
- Workforce and Development Assurance Committee – May and October 2020; and
- Finance and Investment Committee – November 2020, January and February 2021.

As part of the audit we requested the last three minutes and risk registers for each of the groups listed above, however, these were not provided in full for the Medicine, Surgery and Core Clinical Divisions, and the Workforce Department. We were advised by the Head of Risk and Clinical Governance that this was likely because the Divisional Boards were not meeting due to the demand placed on the divisions by the COVID-19 pandemic.

We were provided with a limited number of minutes to the Core Clinical, Medicine and Surgery Divisions, and the Workforce and Development Assurance Committee, and as such we were unable to confirm that these groups were meeting in accordance with the frequency outlined in their terms of reference.

Through review of the minutes that we were provided with, we found the following:

- Medicine Divisional Board: the minutes for September 2020 did not record that a risk register had been reviewed, but did note a governance report which was requested; however, the report was not provided;
- Surgery Divisional Board: an action log was provided from the January 2021 meeting; however, this did not show review of the risk register; and

Furthermore, during review of the minutes received for the Women and Children's Divisional Board and for the Core Clinical Divisional Board meeting in October 2020, we found that there was a lack of evidence of challenge and scrutiny, particularly in relation to risks that were overdue for review and their current scores were above target.

We were advised by the Head of Risk and Clinical Governance that where risk registers were not presented and sufficient challenge had not taken place, this was likely to be due to the pressure of the COVID-19 pandemic and that risk review processes should return to normal once the effect of the pandemic had reduced. Where risks are not adequately scrutinised, as a result of registers not being presented or insufficient challenge, there is a risk that action is not taken to reduce the likelihood of the risks occurring. **(Medium)**

**Integrated Governance Board (IGB)**

The IGB does not have terms of reference so its remit and responsibilities have not been clearly defined. We understand the IGB has been introduced to replace the Risk and Compliance Board (RCB) and in practice it is responsible for review of the Significant Risk Register and each divisional and non-clinical departmental registers. We confirmed the following through review of the minutes for the IGB's only meeting in November 2020 that:

- Risk registers from the four clinical divisions had not been reviewed and therefore there were no risks noted to be escalated to 15 or above; and
- Whilst the Significant Risk Register and risks scored over 15 were noted as being reviewed and discussed extensively, the minutes did not show specific discussion and clearly evidence this.

The impact is that risks that have become significant may not be escalated from divisional and non-clinical departmental registers, and the IGB is not meeting its responsibility to have oversight of the Trust’s key risks. **(Medium)**

### Trust Executive Group (TEG)

The Trust Executive Group reviews the Significant Risk Register (SRR) on a monthly basis with a cover report and a Risk Management Upwards Report.

We confirmed the following through review of a sample of five risks on the latest version of the SRR from January 2021:

- The current score for one had not been lowered despite extensive controls documented on the SRR;
- Assurances had not been documented for one risk;
- Gaps in assurance had not been documented for all five risks;
- Actions had not been documented for three risks, however, those risks had a current score that was higher than the target score; and
- For the two with actions, only one was written in a SMART format.

As part of the 2019/20 Risk Management review we found that there were 65 risks on the SRR, which at the time of this audit was down to 18. However, there was still key information missing from the SRR and the Head of Risk and Clinical Governance advised us that this was due to the COVID-19 pandemic and less focus on risk management. There is a risk that action is not taken to reduce the likelihood and impact of risks occurring is actions are not SMART and/or gaps in assurances are not identified . **(Medium)**

**We noted the following controls to be adequately designed and operating effectively:**

### Incident Reporting Policy

The Trust has an Incident Reporting Policy which has been approved. Through review of the Policy we noted the following:

- It was approved in June 2015 by the Management Board;
- It was last reviewed in January 2019;
- It was due for review in March 2021; and
- It included key information such as links to the Risk Management Strategy, how to identify lessons learnt from incidents and the transfer of risks identified as part of incidents to risk registers.

We confirmed through review of a screenshot of the Trust's intranet that the Strategy and Incident Reporting Policy had been made available to staff.

### Risk Assessment Template

A risk assessment form is used when a risk is identified, and this is available to staff via the Trust’s intranet. We confirmed through review of the risk assessment template that it included the following fields:

- Cause and impact;
- Inherent and current scores;

- Controls and gaps;
- Actions; and
- A scoring table.

**Escalation of Risks**

Any risks rated 15 or above by a divisional or non-clinical department are automatically escalated to the Significant Risk Register. We confirmed through review of the following minutes that there had been no risks raised to 15 or above and therefore we did not test whether any risks discussed had been escalated to the significant risk register at the subsequent Trust Executive Group:

- Women and Children – September and November 2020, and January 2021;
- Core Clinical – October and November 2020;
- Workforce and Development Assurance Committee – May and October 2020; and
- Finance – January and February 2021.

**Board Assurance Framework**

The Audit Committee reviews the BAF on a quarterly basis and the Board on a bi-monthly basis. We confirmed through review of the last two minutes for the Audit Committee, for June and September 2020, and two of the last three for the Board, for November and January 2021, that the BAF had been presented, reviewed and challenge and scrutiny had taken place, particularly in the September 2020 Audit Committee meeting on the new proposed format, with suggestions made on what should be included.

Through review of the September 2020 minutes for the Board we found that the BAF was not presented and we were not provided with a reason for this. However, as the BAF had been reviewed in the subsequent two meetings, we have not agreed an action in relation to this finding.

We undertook a comparison of feedback provided by the Head of Internal Audit and the January 2020 version of the Board Assurance Framework and found that aspects of the feedback had been considered and implemented, for example:

- Where gaps in control read like actions but had been amended;
- Incorporation of additional detail to reflect real risks;
- Addition of finance and workforce risks; and
- Reflection of digital transformation and change programmes.

A further **10 low priority** management actions were agreed, and this was detailed in section 2 of the report.

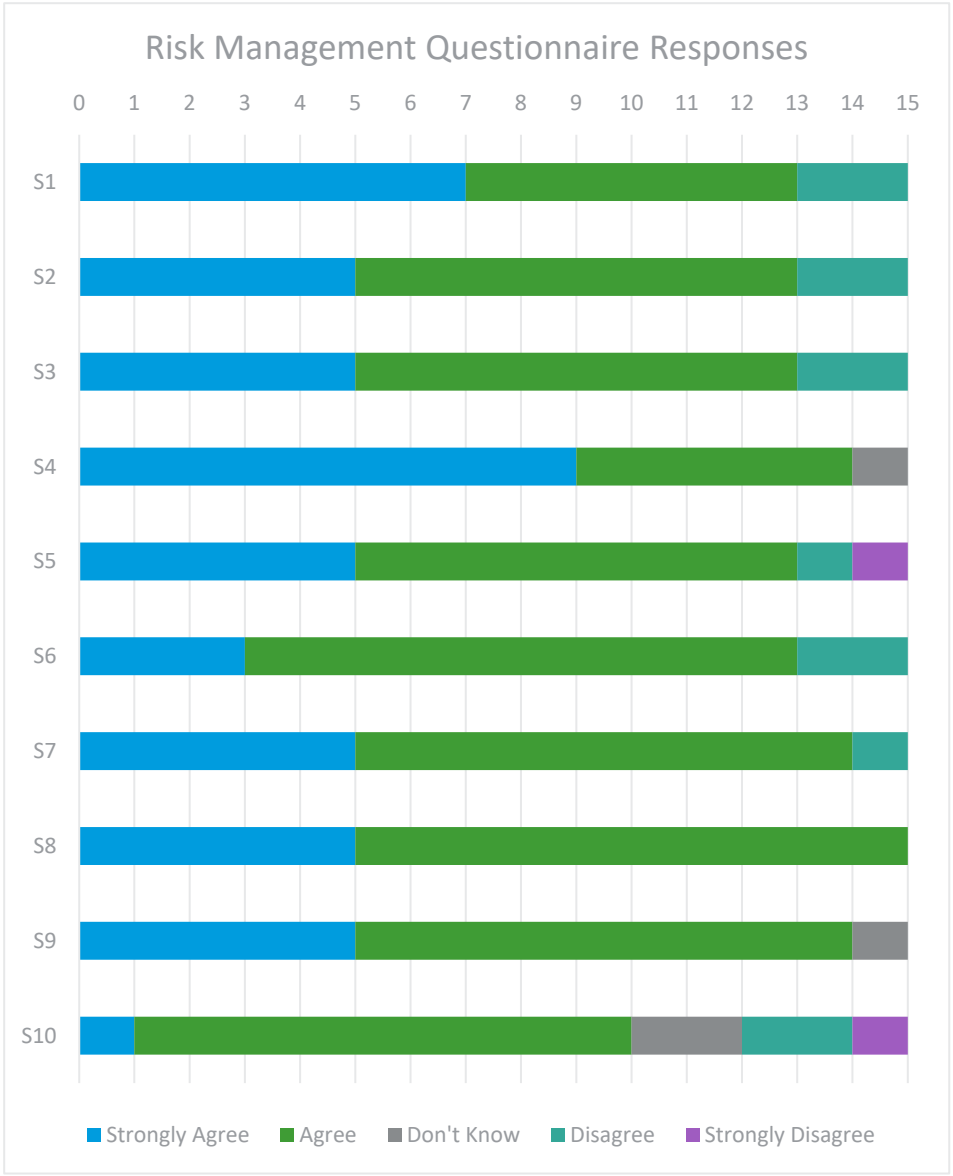
## Risk Management Questionnaire

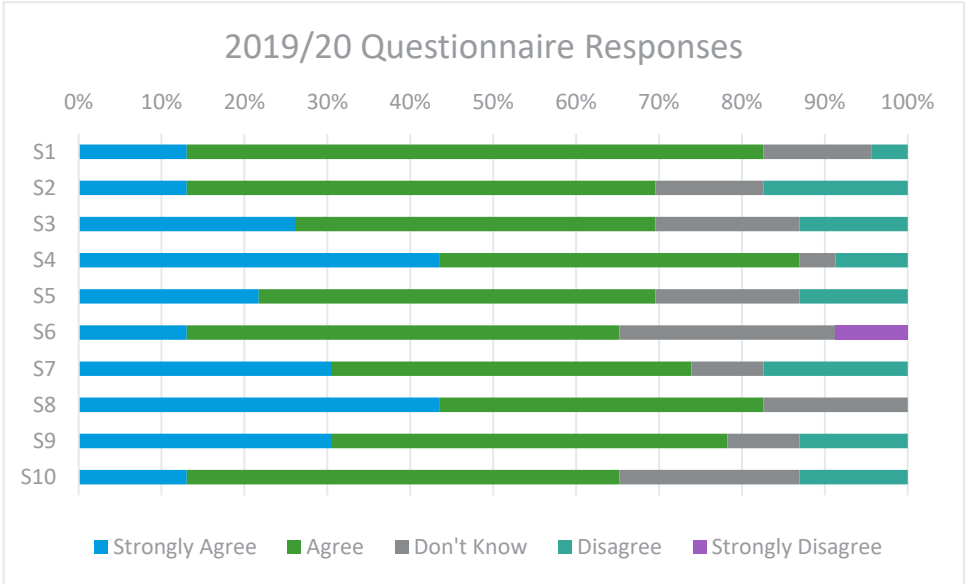
We circulated a questionnaire to the directors and senior management team at the Trust to determine their views on the Trust's approach to risk management and received 15 responses. We asked whether respondents strongly agree, agree, do not know, disagree or strongly disagree with the statements below. The results can be found in chart form on the next page, as well as the results as a proportion of the total responses from the 2019/20 (for which there were 23 responses) and 2020/21 reviews.

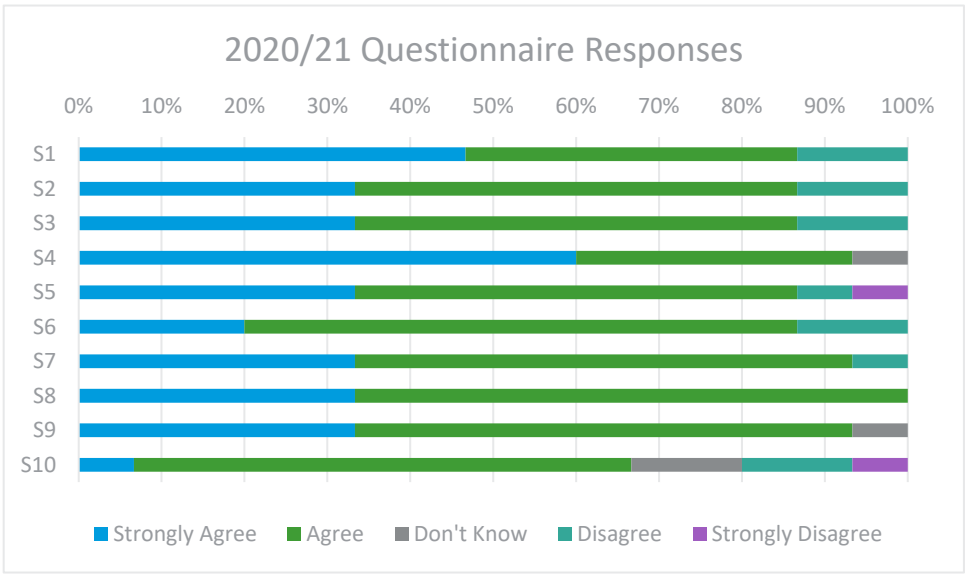
1. There is a consistent tone for risk management set from the top.
2. The Board provides consistent, coherent, sustained and visible leadership in terms of how the organisation expects people to behave and respond when dealing with risk.
3. The organisation has clear leadership in terms of risk management.
4. I am aware of the Risk Management Policy and associated procedural guidance.
5. Roles and responsibilities for managing risks have been well defined.
6. Risk management is well embedded in the organisation.
7. Individuals can talk openly about risks, without fear of consequences or being ignored.
8. Significant risks are identified and brought to the attention of Senior Management and the Board.
9. I have had sufficient training with respect to my responsibilities for risk management.
10. Risks are promptly de-escalated when controls have been applied.

The responses to our questionnaire were mostly positive for all statements. General narrative feedback received from respondents suggesting improvements, included:

- *We do not have a corporate risk register to identify aggregated risk and the Exec team do not appear to understand what that should look like. The risk register has been changed so many times it is now confused and unwieldy, it doesn't follow a logical pathway such as that used on the risk assessment template.*
- *There is no current appetite to foresee risk, it is apparent risk is identified mainly through incidents that happen rather than using knowledge and intelligence to look at what could go wrong.*
- *[Risk management] is well embedded, discussed routinely at key management committees and staff have a good opportunity to raise issues.*
- *I believe there are relatively good processes in place, with good support available from the Risk Team; however risks are often put onto the Risk Register either as the event is about to occur or after the event, rather than following proactive risk identification sessions.*
- *In some areas, the timeliness of [risk] review is very good - however some areas do not regularly update the risks on Datix and therefore the data is not always as up to date as it should be.*


Risk Management Questionnaire Responses
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15
S1
S2
S3
S4
S5
S6
S7
S8
S9
S10
Strongly Agree
Agree
Don't Know
Disagree
Strongly Disagree


2019/20 Questionnaire Responses
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
S1
S2
S3
S4
S5
S6
S7
S8
S9
S10
Strongly Agree
Agree
Don't Know
Disagree
Strongly Disagree


2020/21 Questionnaire Responses
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
S1
S2
S3
S4
S5
S6
S7
S8
S9
S10
Strongly Agree
Agree
Don't Know
Disagree
Strongly Disagree

# 2. DETAILED FINDINGS AND ACTIONS

This report has been prepared by exception. Therefore, we have included in this section, only those areas of weakness in control or examples of lapses in control identified from our testing and not the outcome of all internal audit testing undertaken.

| **Risk Management Strategy** | | | |
|---|---|---|---|
| **Control** | The Trust has a Risk Management Strategy which has been approved and includes the following guidance and key information:<br>• Roles and responsibilities;<br>• The Trust's risk scoring methodology and risk appetite;<br>• Escalation and de-escalation of risks; and<br>• Training.<br>The Strategy and Policy have been approved, specify a previous and next review date and have been made available to staff via the Trust's intranet. | **Assessment:**<br>**Design** | ✓ |
| | | **Compliance** | × |
| **Findings / Implications** | **Review of the Strategy**<br>We noted that the strategy was approved by the Management Board in June 2019 and last reviewed in October 2019. It was due for review in October 2020, however, this review had not been completed at the time of audit in February 2021.<br>As such, we found that it had not been updated since the 2019/20 Risk Management review and included out of date guidance, such as references to, and the responsibilities of, the Risk and Compliance Board. The Head of Risk and Clinical Governance advised us that the Board no longer existed and was replaced by the Integrated Governance Board.<br>We were informed by the Head of Risk and Clinical Governance that the strategy had not been reviewed and updated as all staff had been focussed on the Trust's response to the pandemic and a planned date to review the strategy had not been agreed.<br>As part of the 2019/20 Risk Management review we agreed an action to communicate policy documents to staff following their most recent update. We were also advised that the Risk Management Strategy and Incident Reporting Policy had not been distributed to staff, however, this would be completed via the Chief Executive Newsletter.<br>The questionnaire undertaken as part of the audit found that 14 of the 15 respondents either strongly agreed or agreed with the statement that they were aware of the Risk Management Strategy and associated guidance, whilst one chose "Don't Know".<br>There is a risk that staff are following out of date guidance in relation to risk management which could mean that risks are not being adequately managed. | | |

| Risk Management Strategy | | | | |
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| | We noted during review of the Risk Management Strategy that it defined review frequencies for each grading of risk, for example risks graded 8 to 12 and, 15 and over. However, we found through review that it did not include a review frequency for risks graded five to seven.<br><br>We were advised by the Head of Risk and Clinical Governance that this had likely been missed and risks with a score of between five and seven would likely be reviewed on annual basis or somewhere between monthly and annual.<br><br>There is a risk that any risks graded five to seven will not be subject to review, which could mean that action is not taken to maintain controls. | | | |
| **Management Action 1** | The Director of Corporate Affairs will ensure the Risk Management Strategy is reviewed and any updates necessary are implemented, including amending references to the Risk and Compliance Board to reflect the new Integrated Governance Board and a frequency review for risks rated between five and seven.<br><br>Following this, it will be approved by the Trust Executive Group and communicated to staff via the Chief Executive Newsletter. | **Responsible Owner:**<br><br>Kate Jarman, Director of Corporate Affairs | **Date:**<br><br>31 August 2021 | **Priority:**<br><br>Low |

| Risk Management Training | | | |
|---|---|---|---|
| **Control** | A risk assessment eLearning course is provided for staff, which includes training on assessing and documenting risks.<br><br>All staff are required to refresh this training annually. | **Assessment:** | |
| | | **Design** | ✓ |
| | | **Compliance** | × |
| **Findings / Implications** | We confirmed through review of the training materials for 2020/21 that they included guidance on risk management and completing risk assessments. More specifically, we found they included guidance on the following:<br><br>• Identifying the cause and impact of a risk;<br>• Scoring the risk both with and without controls;<br>• Identifying and assessing controls; and<br>• References to the Risk Management Strategy. | | |

| Risk Management Training | | | | |
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| | However, we found that identifying and documenting assurances had not been included. In addition, it was confirmed that the training materials stated that risk grading without controls had been labelled as current, whereas grading with controls had been labelled as inherent, which is incorrect.<br><br>It should be noted that an action was agreed as part of the 2019/20 Risk Management review to include guidance in the training on identifying and documenting assurances, as well as monitoring compliance with the training.<br><br>We were advised by the Head of Risk and Clinical Governance that guidance on assurances should have been included and that the references to inherent and current risk grading was an error.<br><br>We were also advised by the Head of Risk and Clinical Governance that compliance with training was monitored by line managers through the ESR system and staff will not receive a pay increment if they are non-compliant with their training at the date of their at least six monthly appraisals.<br><br>There is a risk that staff who are responsible for managing risk do not have the skills necessary to fulfil their risk management responsibilities. | | | |
| **Management Action 2** | The Risk Management Team will update the current risk management training material to include guidance on identifying, assessing and documenting assurances. Following this, the training materials will be amended to label grading of risks without controls as inherent and with controls as current.<br><br>Compliance with training will be monitored by line managers through the ESR system. | **Responsible Owner:**<br>Risk Management Team | **Date:**<br>30 April 2021 | **Priority:**<br>Low |

| Identification and Assessment of Risks | | | |
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| **Control** | Once a risk is identified, staff must complete a risk assessment form which is available to them via the Trust's intranet.<br><br>The risk assessment is reviewed and approved to be added to Datix by a Clinical Improvement Group within the relevant division. If the risk is related to a non-clinical department, the owner of the relevant register will approve the risk to be added; for example, finance risks are approved by the Finance and Investment Committee. | **Assessment:**<br>**Design**<br><br>**Compliance** | <br>✓<br><br>× |

| Identification and Assessment of Risks | |
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| **Findings / Implications** | **Risk Assessments**<br><br>We confirmed the following through review of a sample of 20 risks added to Datix since February 2020:<br><br>• A risk assessment form had been completed in full for 10;<br>• A risk form had been completed for four, however, the "Escalate onto Risk Register?" field had not been completed; and<br>• For six a risk assessment form had not been completed.<br><br>We were advised by the Head of Risk and Clinical Governance that the 'escalate to risk register' column was not required to be completed as any risk assessments input to Datix are added to a risk register depending on the area they relate to and their score. As such, we have not agreed an action in relation to this finding.<br><br>For the six in our sample of 20 where a risk assessment had not been completed, we were advised by the Head of Risk and Clinical Governance that due to the pandemic and the urgency to document the risks so that they could be subject to review meant that risk assessments were not consistently produced. We were also advised that for the six in our sample it was likely a risk assessment should have been produced and this should be done, if the risks remain a concern, once the impact of the COVID-19 pandemic on the Trust has been reduced.<br><br>The impact is that risks without a risk assessment may not be subject to adequate oversight, and action to reduce the impact and likelihood of occurrence has not been fully considered.<br><br>**Approval of Risks**<br><br>We confirmed the following through review of a sample of 20 risks added to Datix since February 2020:<br><br>• Two had been approved by the relevant Clinical Improvement Group or non-clinical departmental group;<br>• The remaining eighteen had not been approved by a Clinical Improvement Group.<br><br>We noted the following during testing and discussion with the Risk and Systems Manager of the 18 not approved by a Clinical Improvement Group or non-clinical departmental group:<br><br>• One had been approved by the Women's and Children's Clinical Improvement Group, however, minutes were not provided;<br>• Six had been approved by an individual member of staff, this included (but is not limited to) the Associate Director of Operations or their PA, a Divisional Director and the Imaging Services Lead;<br>• Seven had been approved by a meeting group; however, this was not the relevant Clinical Improvement Group (for example the relevant Triumvirate or the Clinical Imaging Group); and<br>• Two IT risks had been approved by an informal meeting group which did not maintain minutes;<br>• One finance risk had been approved by the Finance and Investment Committee; however, this was not stated clearly within the minutes; and<br>• Evidence was not provided for the approval of the remaining risk. |

| Identification and Assessment of Risks | | | | |
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| | For the 15 risks that were not approved by the relevant Clinical Improvement Group or evidence was not provided, we were advised by the Head of Risk and Clinical Governance that due to the COVID-19 pandemic, risks had been approved outside of the process outlined in the Risk Management Strategy in order to expedite risks onto Datix and to be reviewed by the relevant Divisional Governance Group.<br><br>The Trust is non-compliant with its Risk Management Strategy, which could mean that key risks are not subject to sufficient oversight where risks are incorrectly added to Datix and presented within each division's risk register. | | | |
| **Management Action 3** | The Head of Risk and Clinical Governance will ensure that each Divisional Governance Group reviews all of their risks with an aim to remove any that are no longer a concern or were incorrectly approved and entered into the related risk register.<br><br>Following this, a risk assessment for any that remain, will be produced, where this is not already in place and is required. | **Responsible Owner:**<br>Tina Worth, Head of Risk and Clinical Governance | **Date:**<br>31 August 2021 | **Priority:**<br>Low |
| **Findings / Implications** | **Approval of IT Risks**<br><br>Where the two IT risks in our sample had been approved by an informal meeting group, we were advised by the Head of Risk and Clinical Governance that at the time of the audit there was no group responsible for reviewing the IT risk register. This responsibility could rest with the IGB or an alternative IT forum.<br><br>There is a risk that risks are not subject to sufficient oversight where risks are incorrectly added to Datix and presented within a department's risk register. | | | |
| **Management Action 4** | The Director of Corporate Affairs will ensure that the Integrated Governance Board's (IGB) terms of reference reflect that they will have oversight of IT related risks and will review the IT risk register at each meeting, removing any which are no longer valid.<br><br>Following this, all IT risks will be approved by an appropriate IT forum. | **Responsible Owner:**<br>Kate Jarman, Director of Corporate Affairs | **Date:**<br>31 August 2021 | **Priority:**<br>Low |
| **Findings / Implications** | **Approval of Finance Risks**<br><br>For the remaining one finance risk in our sample (risk 2932) we noted during review of the May 2020 Finance and Investment Committee minutes that discussion of risks had taken place, however, approval of the risk was not clearly stated.<br><br>There is a risk that risks are not subject to sufficient oversight where risks are incorrectly added to Datix and presented within a department's risk register. | | | |

| Identification and Assessment of Risks | | | | |
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| **Management Action 5** | The Director of Corporate Affairs will ensure that the Finance and Investment Committee (FIC) formally document within their minutes where risks have been approved to be included on the finance risk register.<br><br>The committee will also review risk 2932 and formally document within their minutes that it has been approved. | **Responsible Owner:**<br>Kate Jarman, Director of Corporate Affairs | **Date:**<br>31 August 2021 | **Priority:**<br>Low |
| **Findings / Implications** | **Risk Content**<br><br>Through review of our sample of 20 risks on Datix we found the following in relation to information documented against them:<br><br>• 5/20 risks had initial and current scores that were equal, despite having controls documented against them;<br>• All 20 risks were described in a cause and effect format;<br>• 9/20 risks did not have assurances documented against them and one was noted as "to be confirmed";<br>• 3/20 did not have gaps in controls recorded and were either blank or noted that gaps were to be confirmed;<br>• 12/20 risks did not have actions, despite their current and target scores being different, indicating there was a need for action; and<br>• For 4/20 risks where actions had been noted, one was SMART and the remaining three were not.<br><br>We raised an action as part of the 2019/20 review to undertake a review of all risks to confirm their content is appropriate. We were advised by the Head of Risk and Clinical Governance that this action had not been implemented. If risk registers are not completed as appropriate, this increases the likelihood of risks not being appropriately managed. | | | |
| **Management Action 6** | The Trust will perform an exercise where individual risks on Datix will be reviewed to confirm their content is appropriate and in line with guidance from the Risk Management Strategy and Risk Assessment Form Guidance Document. | **Responsible Owner:** Head of Risk and Clinical Governance | **Date:**<br>31 August 2021 | **Priority:**<br>Medium |
| **Findings / Implications** | **Overdue Actions**<br><br>We obtained a report of overdue actions relating to individual live risks across the Trust as at 1 March 2021 and identified a total of 125 overdue actions, with this ranging between one day overdue and five years and 11 months. In comparison to the 2019/20 Risk Management review, this position has improved from 287 overdue actions linked to live risks, which is a substantial change considering the effects of COVID-19.<br><br>An analysis of these overdue actions by division/area as well as an aged analysis can be found within the appendix of the report. | | | |

| Identification and Assessment of Risks | | | | |
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| | We were advised by the Head of Risk and Clinical Governance, and as we found in the 2019/20 Risk Management review, that the Datix system does not enable individual actions to have implementation dates and the implementation date is set by risk, therefore all actions under a single risk have the same date. As such, action implementation due dates do not form part of the risk registers presented to divisions and departments.<br><br>If actions are overdue there is an increased likelihood that risks could materialise and impact on the achievement of organisational objectives.<br><br>As part of the 2019/20 Risk Management review we found that there was a lack of challenge around overdue actions within divisional governance meetings as well as non-clinical departmental meetings and agreed an action to undertake a systematic review of overdue actions and present a report to each governance meeting for discussion. We made the same finding through review of divisional and non-clinical departmental meeting minutes as part of this review.<br><br>We were advised by the Head of Risk and Clinical Governance that this action had not been implemented due to the Trust's shift in focus to addressing the COVID-19 pandemic. | | | |
| **Management Action 7** | The Head of Risk and Clinical Governance will ensure that a systematic review of overdue actions will be conducted to assure the Trust that actions are being taken as appropriate.<br><br>Following this, a report of overdue actions will be discussed at each divisional/departmental risk management meetings, with this monitored at each meeting. | **Responsible Owner:**<br>Tina Worth, Head of Risk and Clinical Governance | **Date:**<br>31 August 2021 | **Priority:**<br>Low |

| Divisional and Departmental Risk Review | | | |
|---|---|---|---|
| **Control** | The four divisions each hold a Divisional Governance meeting on a monthly basis which is responsible for identifying, reviewing and reporting on risks relevant to their division.<br><br>Non-clinical departments, such as Finance, maintain their own risk registers and have their own forums for reviewing their registers.<br><br>Risks scored 15 or above are automatically escalated to the Significant Risk Register (SRR) by Datix when it is next reviewed by the Trust Executive Group.<br><br>The Trust Executive Group receive the SRR with a report which outlines risks escalated to the SRR since the last meeting. | **Assessment:**<br>**Design** | ✓ |
| | | **Compliance** | × |

| Divisional and Departmental Risk Review | | | | |
|---|---|---|---|---|
| **Findings / Implications** | We obtained the terms of reference and a sample of minutes for the following divisions and departments:<br>• Medicine – September 2020;<br>• Surgery – January 2021 (action log);<br>• Women and Children – September and November 2020, and January 2021;<br>• Core Clinical – October and November 2020;<br>• Workforce and Development Assurance Committee – May and October 2020; and<br>• Finance – November 2020, and January and February 2021.<br><br>We confirmed through review that quorum requirements had been outlined and during review of the Women and Children, Core Clinical, Workforce and Finance ToR that responsibilities in relation to risk management had been included. However, we found that the Medicine and Surgery ToR did not include responsibilities in relation to review of risks.<br><br>As part of the 2019/20 Risk Management review we agreed an action to document risk review responsibilities within the Medicine Divisional Board and Risk Management and Governance Group ToR. We found through review of the Risk Management and Governance Group ToR that risk review responsibilities had been included, however, as noted above, this had not been implemented for the Medicine Divisional Board.<br><br>There is a risk that forums may not be performing the responsibilities required as per the Risk Management Strategy. | | | |
| **Management Action 8** | The Head of Risk and Clinical Governance will ensure that responsibilities of the Medicine and Surgery Divisional Boards in relation to risk management and scrutiny of risk registers will be formally documented within their Terms of Reference, with these reviewed periodically. | **Responsible Owner:**<br>Head of Risk and Clinical Governance | **Date:**<br>31 August 2021 | **Priority:**<br>Low |
| **Findings / Implications** | **Risk Register Review**<br><br>As part of the audit we requested the last three minutes and risk registers for each of the groups listed above, however, these were not provided in full for the Medicine, Surgery and Core Clinical Divisions, and the Workforce Department. As such, we were unable to confirm that risks related to those divisions and departments that had been sufficiently reviewed.<br><br>We were advised by the Head of Risk and Clinical Governance that this was likely because the Divisional Boards were not meeting due to the demand placed on the divisions by the COVID-19 pandemic.<br><br>There is a risk that risks at a divisional level are not being sufficiently scrutinised, which could mean that action is not taken to reduce the likelihood or impact of the risks occurring.<br><br>**Quoracy and Meeting Frequency** | | | |

## Divisional and Departmental Risk Review

Through review of the minutes received for our sample, we found in all cases that the meetings were quorate and for the Women and Children Divisional Board and Finance and Investment Committee that meetings had taken place in accordance with the groups' terms of reference (ToR).

However, for the Core Clinical, Medicine and Surgery divisions, and the Workforce and Development Assurance Committee, we were sent limited minutes. As a result, we were unable to confirm that these groups were meeting in accordance with the frequency set out in their ToR.

If Divisional Boards and departmental governance groups do not meet in line with their ToR there is a risk that risks are not being sufficiently scrutinised, which could mean that action is not taken to reduce the likelihood or impact of the risks occurring.

**Presentation of Risk Registers**

Through review of the minutes and action logs received for our sample of divisional boards and non-clinical departments, we found that a risk register had been reviewed for the Women and Children and Core Clinical divisional boards, and the Workforce and Development Assurance Committee, and by the Finance and Investment Committee at their January and February 2021 meetings. However, we found that the Finance and Investment Committee had not reviewed their register at the November 2020 meeting due to COVID-19 pandemic pressures. As the register had been reviewed in their subsequent meetings, we have not agreed an action in relation to this finding.

However, for the remaining minutes and action logs, we found the following:

- Medicine Divisional Board: the minutes for September 2020 did not record that a risk register had been reviewed but did note a governance report which was requested. However it was not provided during the audit; and
- Surgery Divisional Board: an action log was provided from the January 2021 meeting; however, this did not evidence review of a risk register.

For the Medicine and Surgery Divisional Boards, we were advised by the Head of Risk and Clinical Governance that they had likely not reviewed a risk register due to the time pressure on their meetings as a result of the COVID-19 pandemic.

If divisional boards do not review a risk register at each meeting there is a risk that risks are not being sufficiently scrutinised, which could mean that action is not taken to reduce the likelihood or impact of the risks occurring.

**Challenge and Scrutiny of Risk Registers**

As a risk register was not reviewed by the Medicine and Surgery Divisional Boards, and by the Finance and Investment Committee (FIC) in November 2020, they are excluded from this finding.

We found through review of the following risk registers and minutes that challenge and scrutiny had taken place of risks, where required:

- Core Clinical Divisional Board – November 2020;
- Workforce and Development Assurance Committee – May and October 2020; and
- FIC – January and February 2021.

| Divisional and Departmental Risk Review | | | | |
|---|---|---|---|---|
| | However, during review of the minutes received for the Women and Children's Divisional Board and for the Core Clinical Divisional Board meeting in October 2020, we found that challenge and scrutiny had not taken place where required, particularly in relation to risks that were overdue for review and their current scores were above target.<br><br>We were advised by the Head of Risk and Clinical Governance that this was likely because, whilst risks were reviewed, due to the COVID-19 pressures it was unlikely the Divisional Boards would have the time to challenge those which were overdue for review.<br><br>Where risks are not adequately scrutinised this could mean that actions are not taken to reduce the likelihood or impact of the risks occurring. | | | |
| **Management Action 9** | The Director of Corporate Affairs will, following a reduction in the pressure of the COVID-19 pandemic, issue a formal instruction to divisional boards and non-clinical departmental meeting groups that are responsible for reviewing risk registers that they must:<br>• Meet in line with the frequencies set out in their terms of reference;<br>• Review their risk registers at each meeting;<br>• Challenge and scrutinise risks which are due for review and are scored above their target. | **Responsible Owner:**<br>Kate Jarman, Director of Corporate Affairs | **Date:**<br>31 August 2021 | **Priority:**<br>Medium |
| **Findings / Implications** | **Review of Overdue Risk Actions**<br><br>Through review of the minutes received for all Divisional Boards and non-clinical departments, we found that a report of overdue risk actions had not been presented during the period examined. As part of the 2019/20 Risk Management review we agreed an action for a report of overdue risk actions to be presented as there were 287 outstanding actions linked to live risks. As part of the 2020/21 review we found this had decreased, however, there were still 125 outstanding.<br><br>We were advised by the Head of Risk and Clinical Governance that due to the COVID-19 pandemic the action had not been implemented.<br><br>There is a risk that action is not being taken to reduce the impact and likelihood of risks occurring.<br><br>Management action seven has been agreed in relation to this finding. | | | |

| Integrated Governance Board | | | |
|---|---|---|---|
| **Control** | There are no terms of reference for the Integrated Governance Board (IGB) that has replaced the Risk and Compliance Board (RCB). | **Assessment:**<br>**Design** | × |

| Integrated Governance Board | | | |
|---|---|---|---|
| | In practice, the IGB is responsible for reviewing the risk registers of each division and non-clinical department to ensure risks are being escalated where required.<br><br>A greater focus is placed on those scored 15 or above and these are challenged in greater detail.<br><br>Where risks are de-escalated by reducing their score to below 15, they appear on the relevant divisional or non-clinical departmental risk review group's risk register output from Datix. | **Compliance** | - |
| **Findings / Implications** | We confirmed the following through review of the minutes for the IGB's only meeting in November 2020 that risk registers for the four divisions had not been reviewed and therefore there were no risks noted to be escalated to 15 or above. The Significant Risk Register was reviewed by the IGB but the minutes did not show evidence of specifically what discussions took place, but recorded that risks over 15 were reviewed and discussed extensively.<br><br>We were advised by the Head of Risk and Clinical Governance that the IGB had been set up to replace the RCB, however, they did not yet have terms of reference setting out membership and responsibilities.<br><br>If the IGB does not review clinical and non-clinical risk registers, either in their entirety or on a rolling basis, this could mean that risks that become significant are not escalated for the review of senior and executive management.<br><br>Furthermore, without terms of reference the membership may not fully understand the role of the IGB and/or key duties in relation to risk management may not be completed. | | |
| **Management Action 10** | The Director of Corporate Affairs will ensure that Terms of reference is produced for the Integrated Governance Board. These will include:<br>• Responsibilities, including to review clinical and non-clinical risk registers in their entirety or on a rolling basis;<br>• Meeting frequency;<br>• Quorum requirements;<br>• Reporting arrangements;<br>• Membership; and<br>• A date of last and next review.<br><br>Following this, the IGB's minutes will document challenge and scrutiny of the significant risk register in full. | **Responsible Owner:**<br>Kate Jarman, Director of Corporate Affairs | **Date:**<br>31 August 2021 | **Priority:**<br>Medium |

| Trust Executive Group | | | | |
|---|---|---|---|---|
| **Control** | The Trust Executive Group (TEG) reviews the Significant Risk Register (SRR) on a monthly basis. The TEG receives a Risk Management Upwards Report and accompanying report cover sheet including risks that have been escalated to and de-escalated from the SRR since the last meeting.<br><br>The TEG can escalate risks, where required, to the Board Assurance Framework (BAF) for the attention of the Board.<br><br>Where risks are de-escalated by reducing their score to below 15, they appear on the relevant divisional or non-clinical departmental risk review group's risk register output from Datix. | | **Assessment:**<br>**Design** ✓<br>**Compliance** × | |
| **Findings / Implications** | **Terms of Reference**<br>We confirmed through review of the TEG terms of reference that the document was last reviewed in June 2020 but a further date for its review had not been set.<br><br>There is a risk that the TEG's terms of reference will not be subject to regular review which could mean that become out of date and may not reflect current responsibilities. | | | |
| **Management Action 11** | The Trust Executive Group will update their terms of reference to include a date of next review. | **Responsible Owner:**<br>Kate Jarman, Director of Corporate Affairs | **Date:**<br>30 April 2021 | **Priority:**<br>Low |
| **Findings / Implications** | **Review, Challenge and Scrutiny of the Significant Risk Register (SRR)**<br>We reviewed the last three sets of minutes and reports for the TEG for November and December 2020, and January 2021. We found that:<br>• Risk Management Upwards reports had been presented;<br>• The SRR had been presented with its covering reports;<br>• The covering reports included escalated and de-escalated risks since the last meeting;<br>• Overdue risks scored 15 or above from divisional or departmental risk registers had also been noted on the report, however, this did not include reasons why or actions being taken; and<br>• Risks with both no actions against them and overdue actions had been included.<br><br>We also found during review of the minutes that there was limited evidence of challenge and scrutiny taking place and the reports had only been noted in December 2020. For November 2020 and January 2021 there was limited commentary. This is despite between six and nine risks on each of the registers presented that were overdue for review and the current risk score was above the target score. | | | |

| Trust Executive Group | | | | |
|---|---|---|---|---|
| | We were advised by the Director of Corporate Affairs that TEG meetings have been brief due to the hospital being in significant escalation with the COVID-19 pandemic. We were also advised that the Trust would be returning to normal scrutiny arrangements as the hospital returns to more normal activities.<br><br>If significant risks are not subject to adequate challenge and scrutiny, there is a risk that action is not taken to reduce the likelihood or impact of the risks occurring. | | | |
| **Management Action 12** | The Director of Corporate Affairs will ensure that the Trust Executive Group sufficiently challenges significant risks at each of their meetings, highlighting those that are overdue for review and where scores remain above their target, following the Trust's return to normality after the COVID-19 pandemic. | **Responsible Owner:**<br>Kate Jarman, Director of Corporate Affairs | **Date:**<br>31 August 2021 | **Priority:**<br>Low |
| **Findings / Implications** | **Significant Risk Register (SRR) Content**<br><br>We reviewed a sample of five risks on the SRR for January 2021 (2570, 2955, 2953, 2791 and 2182) and found the following:<br><br>• The current score for one risk had not been lowered despite extensive controls documented on the SRR (2182);<br>• All five had been described in a cause and effect format;<br>• Assurances had not been documented for one risk (2953);<br>• Gaps in assurance had not been documented for all five risks;<br>• Actions had not been documented for three risks (2955, 2953 and 2791); however, those risks had a current score that was higher than the target score; and<br>• For the two with actions, one was not written in a SMART format (2570).<br><br>We found through comparison of our findings to those from the 2019/20 Risk Management review that there were now only 18 risks on the SRR, down from 65.<br><br>However, there was still key information missing from our sample of SRR risks and as such there is a risk that action is not taken to reduce the likelihood and impact of risks occurring.<br><br>We were advised by the Head of Risk and Clinical Governance that the COVID-19 pandemic had caused risk management processes to be paused, which may be why all the required information has not been included. | | | |
| **Management Action 13** | The Trust Executive Group will undertake a review of all risks on the Significant Risk Register to ensure that they include:<br><br>• Current scores which reflect that controls have been applied i.e. lowered following application; | **Responsible Owner:**<br>Kate Jarman, Director of Corporate Affairs | **Date:**<br>31 August 2021 | **Priority:**<br>Medium |

| Trust Executive Group | |
|---|---|
| | • Assurances on controls in place and gaps in those assurances;<br>• Actions are identified and documented where the risk's current score is higher than the target; and<br>• Actions written in a SMART format. |

| Board Assurance Framework | | |
|---|---|---|
| **Control** | The Board Assurance Framework (BAF) includes the Trust's highest rated and strategic risks which are aligned to the corporate objectives.<br><br>Risks on the BAF include the following:<br><br>• Cause and effect;<br>• Current and target risks;<br>• Existing controls and gaps;<br>• Assurances; and<br>• Actions to reduce current scores to their target. | **Assessment:**<br><br>**Design** ✓<br><br>**Compliance** × |
| **Findings / Implications** | **BAF Content**<br><br>We selected a sample of risks on the BAF. These were risks 1917, 2501, 2896, 940 and 2932. We confirmed the following was in place for each of our sample:<br><br>• The current score had been lowered following application of controls;<br>• Risks had been documented in a cause and effect format;<br>• Assurances had been documented;<br>• Actions were in place, where required; and<br>• The actions in place were SMART.<br><br>However, we found that gaps in assurance had not have been identified on the document, despite the new format incorporating this information. Where gaps in assurance are not identified this could mean that the Trust is unaware as to the sources of assurance that are needed over its key controls. | |

| Board Assurance Framework | | | | |
|---|---|---|---|---|
| **Findings / Implications** | **Assurances on the BAF**<br>Through review of our sample of five risks, we found during testing that the assurances documented on the BAF for four were in place. However, for the remaining one (risk 940) we requested evidence of the monthly performance reports to divisions and evidence of escalation to senior managers for the last three months. However, this was not provided.<br>There is a risk that assurances on the BAF do not exist, which could mean that risk likelihood and impact scores are incorrect. | | | |
| **Management Action 14** | The Director of Corporate Affairs will ensure that gaps in assurance are identified for all risks on the Board Assurance Framework or note is added stating that there are no gaps.<br>Following this, a review of the assurances for risk 940 will be undertaken to confirm that assurances recorded exist. Where they are found to not exist, an assessment will be completed as to whether there are gaps in assurance for this risk. | **Responsible Owner:**<br>Kate Jarman, Director of Corporate Affairs | **Date:**<br>31 August 2021 | **Priority:**<br>Low |

| Risk Review | | | |
|---|---|---|---|
| **Control** | The Risk Management Strategy outlines the following requirements with regard to risk review:<br>• All green/low risks (graded 1-4) should be reviewed at least annually unless otherwise dictated by the risk assessment, or when there is significant change to process/the identified hazard, accident incident;<br>• All amber/moderate (graded 8-12) risks should be reviewed monthly; and<br>• All red/high risks (graded 15+) best practice should be for a review two weekly unless appropriate actions are in place and there is agreement that the risk can be tolerated at that level and no less than one month. | **Assessment:**<br>**Design** ✓<br>**Compliance** × | |
| **Findings / Implications** | We obtained a report of all live risks from Datix as at 11 February 2021 and analysed this to identify whether risks were being reviewed in line with the Trust's Risk Management Strategy. Through our analysis we noted the following:<br>• There were 386 risks on Datix and 118 of these were overdue for review (31%), ranging from three days to two years overdue. This had improved since the 2019/20 review where 41% were overdue;<br>• Of the seven very low / acceptable risks on Datix, all had been reviewed within the last 12 months (100%) and therefore were compliant with the Risk Management Strategy; | | |

## Risk Review

- There were 220 moderate / unacceptable risks and 172 of these (78%) had not been reviewed within the last month, as required by the strategy. In addition, 101 of these had not been reviewed for more than 60 days with the longest being two years and three months; and
- 27 of the 41 high / significant risks (65%) had not been reviewed within the last month, as required by the strategy as a minimum, and 13 of these had not been reviewed for over 60 days, with the longest being two years and three months.

Through comparison of the proportion of risks not reviewed within their timeframes required by the Risk Management Strategy to our findings last year, we found that those that were moderate / unacceptable had worsened from 69% in the 2019/20 review to 78% and those that were high / significant had worsened from 53% in the 2019/20 review to 65%

As the Risk Management Strategy did not specify a review frequency for risks rated as low / acceptable (which has been covered as part of our Risk Management Strategy finding) we were unable to test whether they had been reviewed in line with a set frequency. However, we did find that of the 118 low / acceptable risks, 33 were overdue for review between three days and two years and one month, according to their next review dates input to Datix.

If risks are not reviewed in a consistent, periodic manner, there is a risk that changes to the existing risk are not identified, with adequate mitigating actions not put in place.

Management action 9 has been agreed in relation to this finding for divisional governance meetings to review and challenge overdue risks, and management action 12, for the Trust Executive Group to do the same.

Please refer to other management actions made in this report.

# APPENDIX A: ANAYLSIS OF RISK REGISTERS

The table and charts below show the number of overdue risks and actions at 11 February and 1 March 2021, respectively.

| | Total Risks | Total Overdue Risks | Overdue Days (minimum) | Overdue Days (maximum) |
|---|---|---|---|---|
| Women's and Children's | 41 | 17 | 42 | 287 |
| Core Clinical | 96 | 41 | 13 | 785 |
| Operations | 6 | 6 | 94 | 439 |
| IT | 18 | 0 | 0 | 0 |
| Finance | 15 | 0 | 0 | 0 |
| Corporate Affairs | 15 | 1 | 72 | 72 |
| Estates | 55 | 5 | 42 | 134 |
| Medical Director | 4 | 3 | 42 | 72 |
| Directorate of Patient Care | 18 | 16 | 11 | 767 |
| Workforce (HR) | 12 | 1 | 73 | 73 |
| Performance & Information | 4 | 3 | 6 | 6 |
| Patient Services | 4 | 2 | 134 | 226 |
| Surgical | 60 | 12 | 3 | 13 |
| Medicine | 38 | 11 | 10 | 97 |
| **Trust Total** | **386** | **118** | **-** | **-** |

# APPENDIX B: CATEGORISATION OF FINDINGS

| Categorisation of internal audit findings | |
|---|---|
| **Priority** | **Definition** |
| Low | There is scope for enhancing control or improving efficiency and quality. |
| Medium | Timely management attention is necessary. This is an internal control risk management issue that could lead to: Financial losses which could affect the effective function of a department, loss of controls or process being audited or possible reputational damage, negative publicity in local or regional media. |
| High | Immediate management attention is necessary. This is a serious internal control or risk management issue that may lead to: Substantial losses, violation of corporate strategies, policies or values, reputational damage, negative publicity in national or international media or adverse regulatory impact, such as loss of operating licences or material fines. |

The following table highlights the number and categories of management actions made as a result of this audit.

| Area | Control design not effective* | | Non Compliance with controls* | | Agreed actions | | |
|---|---|---|---|---|---|---|---|
| | | | | | Low | Medium | High |
| Risk Management | 1 | (8) | 7 | (8) | 10 | 4 | 0 |
| **Total** | | | | | **10** | **4** | **0** |

* Shows the number of controls not adequately designed or not complied with. The number in brackets represents the total number of controls reviewed in this area.

# APPENDIX C: PROGRESS MADE WITH PREVIOUS AUDIT FINDINGS

| Implementation status by management action priority | Number of actions agreed | Status of management actions | | | | | |
|---|---|---|---|---|---|---|---|
| | | Implemented (1) | Implementation ongoing (2) | Not implemented (3) | Superseded (4) | Not yet due (5) | Completed or superseded (1) + (4) |
| Low | 4 | 2 | 1 | 1 | 0 | 0 | 2 |
| Medium | 5 | 0 | 2 | 3 | 0 | 0 | 0 |
| **Totals** | **9** | **2** | **3** | **4** | **0** | **0** | **0** |

Our testing of the implementation of those actions agreed as part of previous reviews undertaken found the following actions had not been implemented in full:

- Three **(Medium)** actions had not been implemented regarding review of departmental and divisional risk registers to ensure risk content is in line with the Risk Management Strategy, a review of overdue actions relating to risks and reporting to divisional and departmental risk review meetings, and a review of all risks on the Significant Risk Register to ensure their content was in line with the Risk Management Strategy.
- Two **(Medium)** actions were partially implemented; these were in relation to amendments to the risk management training and the monitoring of training compliance, and scrutiny of risks by divisional and departmental meetings to ensure content and frequency of review was in line with the Risk Management Strategy.
- One **(Low)** action had not been implemented; this related to communicating all policies, procedures and strategies to staff when updates are applied to them.
- One **(Low)** action had been partially implemented; this was in relation to the documenting of roles and responsibilities in relation to risk management in the Medicine Divisional Board's terms of reference.

# APPENDIX D: SCOPE

The scope below is a copy of the original document issued.

## Scope of the review

The scope was planned to provide assurance on the controls and mitigations in place relating to the following risks:

| Objective of the risk under review |
| --- |
| Ensure the timely management and reporting of risk within the Trust to contribute to the achievement of corporate objectives. |

**When planning the audit the following areas for consideration and limitations were agreed:**

- Risk Management Strategy and associated policies and procedures.
- The provision of training and the assignment of roles and responsibilities for risk management.
- Arrangements for identifying and assessing risks linked to strategic and operational objectives.
- Processes for review and updating of the BAF / Corporate Risk Register.
- Processes at a Divisional level for reviewing and reporting on risks in these areas.
- The arrangements for escalating, de-escalating and reporting risks for the attention of senior management, either via the Audit Committee, Trust Board or other committee.
- How controls and assurances are captured on the relevant risk registers, and whether feedback on risks are fed back to committees and groups for assurance purposes.

As part of the review, we will issue a culture survey to staff in the Trust to gauge the understanding of risk management within the Trust.

We will also consider all actions raised as part of the 19/20 audit in this area where these have not been covered in follow up audits.

**Limitations to the scope of the audit assignment:**

- This review will not comment on whether individual risks are appropriately managed, or whether the organisation has identified all of the risks and opportunities facing it.
- We do not endorse a particular means of risk management.
- It remains the responsibility of the Board and senior management to agree and manage information needs and to determine what works most effectively for the organisation.

- Our review did not cover compliance with training requirements for Risk Management, although we did comment on the content of the training provided.
- The results of our work are reliant on the quality and completeness of the information provided to us.
- Our work does not provide absolute assurance that material errors, loss or fraud do not exist.

| | | | |
|---|---|---|---|
| **Debrief held** | 16 March 2021 | **Internal audit Contacts** | **Head of Internal Audit** |
| **Draft report issued** | 7 April 2021 | | |
| **Responses received** | 3 August 2021 | | |
| | | | **Client Manager** |
| | | | Kate Jarman, Director of Corporate Affairs |
| **Final report issued** | 3 August 2021 | **Client sponsor** | Kate Jarman, Director of Corporate Affairs |
| | | **Distribution** | |

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The matters raised in this report are only those which came to our attention during the course of our review and are not necessarily a comprehensive statement of all the weaknesses that exist or all improvements that might be made. Actions for improvements should be assessed by you for their full impact. This report, or our work, should not be taken as a substitute for management's responsibilities for the application of sound commercial practices. We emphasise that the responsibility for a sound system of internal controls rests with management and our work should not be relied upon to identify all strengths and weaknesses that may exist. Neither should our work be relied upon to identify all circumstances of fraud and irregularity should there be any.

Our report is prepared solely for the confidential use of Milton Keynes University Hospital NHS Foundation Trust and solely for the purposes set out herein. This report should not therefore be regarded as suitable to be used or relied on by any other party wishing to acquire any rights from RSM Risk Assurance Services LLP for any purpose or in any context. Any third party which obtains access to this report or a copy and chooses to rely on it (or any part of it) will do so at its own risk. To the fullest extent permitted by law, RSM Risk Assurance Services LLP will accept no responsibility or liability in respect of this report to any other party and shall not be liable for any loss, damage or expense of whatsoever nature which is caused by any person's reliance on representations in this report.

This report is released to you on the basis that it shall not be copied, referred to or disclosed, in whole or in part (save as otherwise permitted by agreed written terms), without our prior written consent.

We have no responsibility to update this report for events and circumstances occurring after the date of this report.

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