REPORT TO: East Lothian IJB – Audit and Risk Committee

MEETING DATE: 5 December 2023

BY: Chief Internal Auditor

SUBJECT: Internal Audit Update of NHS Lothian 2023/24 Audit Reports

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1 PURPOSE

1.1 To inform the Audit and Risk Committee of the recently issued audit reports relevant to IJB Governance, Internal Control and Risk Management processes submitted to the NHS Lothian Audit & Risk Committee.

2 RECOMMENDATION

2.1 That the Audit and Risk Committee note the contents of the audit report and consider any risk management implications.

3 BACKGROUND

3.1 The NHS Lothian Internal Audit team reports key audit findings, conclusions and recommendations to the NHS Lothian Audit & Risk Committee. Some of this internal audit work will provide assurances that should be considered by the East Lothian IJB.

3.2 All audit reports are available publicly for review at the following link for NHS Lothian at Audits (nhslothian.scot).

3.3 One audit review is considered appropriate to bring to the attention of the East Lothian IJB Audit & Risk Committee, being the Audit Review of Complaints Handling (Appendix 1). This review was provided with a Limited Assurance grading.

4 ENGAGEMENT

4.1 Engagement with management will have been undertaken in accordance with the procedures in place for the relevant Internal Audit team.

5 POLICY IMPLICATIONS

5.1 None

6 INTEGRATED IMPACT ASSESSMENT

6.1 The subject of this report does not affect the wellbeing of the community or have a significant impact on equality, the environment or economy.

7 DIRECTIONS

7.1 The subject of this report does not require any amendment to or creation of Directions.

8 RESOURCE IMPLICATIONS

8.1 Financial - None

8.2 Personnel - None

8.3 Other - None

9 BACKGROUND PAPERS

9.1 None

Appendix 1: Audit Review of Complaints Handling

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DATE	29 November 2023

NHS Lothian

Internal Audit 2023/24

Complaints Handling

August 2023

FINAL REPORT

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It is the responsibility solely of NHS Lothian's management and directors to ensure there are adequate arrangements in place in relation to risk management, governance, control and value for money.

Report Distribution

Executive Lead:

- Executive Director of Nursing, Midwifery and Allied Health Professionals

For action:

- Head of Patient Experience
- Deputy Director of Nursing

For Information:

- Director Of Finance
- Audit and Risk Committee

Executive summary

Background

NHS Lothian's definition of a complaint is: 'An expression of dissatisfaction by one or more members of the public about the Board's action or lack of action, or about the standard of service provided by or on behalf of the Board.'

NHS Lothian values listening to the opinions and feedback of those making use of their services and are committed to ensuring stakeholder complaints and feedback shapes the work that they do. NHS Lothian has an ambition to ensure that they routinely collect and learn from patients, the public, and health and social care staff. NHS Lothian has a responsibility to acknowledge where things go wrong, put things right as quickly as possible, to learn lessons, prevent reoccurrence, and identify improvements.

The effective management of complaints enables the organisation to provide a better experience to service users. In particular, guidance states the requirement for NHS Scotland organisations to welcome feedback and use to it improve services, to address complaints in a person-centred way, and to respect the rights of patients and the public.

Over the last 2 years there has been significant development and improvement work carried out and the operational arrangements and process for handling complaints was redesigned during 2022 and new protocols introduced across the organisation.

Objectives

The objective of this review is to provide an independent assessment of the design and operational effectiveness of NHS Lothian's Complaints Handling Arrangements. We reviewed and assessed the controls in place within the updated complaints handling process and considered the progress being made to implement and embed the new processes, ensuring a robust and timely investigation & clear roles and responsibilities .

Our review focussed on the following key risks:

- The new roles and responsibilities and protocols for resolving complaints has not been documented clearly and/or there is no clear mapping or communication of the process resulting in staff being unaware of process requirements and ultimately complaints being mis-managed by NHS Lothian.
- There is ineffective oversight of complaints received across NHS Lothian resulting in the Board not having assurance that all complaints received have been dealt with appropriately.
- There is no feedback loop for lessons learned, and a lack of assurance that teams are acting on recommendations from complaints. As a result, relevant improvements are not identified and shared across the wider organisation where relevant.

Due to the early delivery of this audit in the financial year, and the implementation of updated processes in January 2023, our testing covered the period of January 2023 – April 2023 to ensure we considered a representative sample. We have confirmed with management that processes have remained consistent from January 2023 to present.

Executive summary

Limitations in scope

Please note that our conclusion is limited by scope. It is limited to the risks outlined above. Other risks exist in this process which our review and therefore our conclusion has not considered. Where sample testing has been undertaken, our findings and conclusions are limited to the items selected for testing.

During our testing we were unable to review a sample of complaint investigation reports therefore, we cannot provide assurance over the quality of these.

This report does not constitute an assurance engagement as set out under ISAE 3000.

Acknowledgement

We would like to take this opportunity to thank your staff for their co-operation during this internal audit.

Headline messages

Conclusion

Limited Assurance

We have reviewed the processes and controls around complaints handling and have concluded that the processes have provided a **LIMITED LEVEL OF ASSURANCE**. This was confirmed through testing in specific areas of the organisation and through discussions with management.

The risks reviewed are set out on the following page with the assurance rating we have assessed for each one and the number of recommendations raised. We have reported by exception against the areas where we consider that Management and the Audit and Risk Committee should focus their attention.

We reviewed NHS Lothian's processes in place for handling complaints, including, recording, managing, investigating, monitoring progress and responding to complaints received. In January 2023 there were updates made to the roles and responsibilities within the services for complaints; whilst this is being embedded into the ways of working, there are improvements which can be taken forward.

As part of this review, we completed sample testing of both stage 1 and stage 2 complaints, held discussions with services and reviewed processes and reporting.

Our testing of 10 stage 1 complaints identified that 50% of those selected had achieved the required response time, However, from our further high level analysis of all complaints received in the same period, we noted that 208 out of 317 did not comply. This is equivalent to 66%.

Our testing of a sample of 13 stage 2 complaints, identified that lessons learned, and action plans are not consistently created and are not re-visited to confirm that mitigating actions have been put in place. Full details are included within the Detailed Findings and Action Plan of this report.

The Datix system used for the recording of complaints records progress made and maintains a log of uploaded documentation relevant to the complaint which is helpful in managing responses. However, management explained that the reports that Datix provide are not always useful, and further analysis is required. We have therefore considered this to be a low-level recommendation.

We will review progress made as part of our recommendation tracking during the 2023/24 year and summarise progress against these recommendations in our Head of Internal Audit Opinion.

Headline messages

Conclusion

We have raised 12 recommendations. The grading of these recommendations based on risk, is summarised in the table below.

Risks	Assurance rating	Number of recommendations			
		High	Medium	Low	Imp
The new roles and responsibilities and protocols for resolving complaints has not been documented clearly and/or there is no clear mapping or communication of the process resulting in staff being unaware of process requirements and ultimately complaints being mis-managed by NHS Lothian.	Moderate Assurance	-	1	4	1
There is ineffective oversight of complaints received across NHS Lothian resulting in the Board not having assurance that all complaints received have been dealt with appropriately	Significant Assurance	-	-	1	-
There is no feedback loop for lessons learned, and a lack of assurance that teams are acting on recommendations from complaints. As a result, relevant improvements are not identified and shared across the wider organisation where relevant.	No Assurance	3	2	-	-

Summary of findings

Examples of where recommended practices are being applied

- NHS Lothian has up to date process flow charts in place which include sufficient information to allow services to handle complaints relevant to them. The flow charts use colour coding to separate the responsibilities of the services and the patient experience team.
- There is guidance available for those required to investigate complaints, which includes the right knowledge, no conflicts of interest and free from bias. We confirmed the guidance includes links to templates which should be used during the complaints process.
- All complaints policy and process documents are readily available to staff via the intranet.
- For our sample of Stage 1 complaints, we confirmed that all complainants had been contacted throughout the process and contacted via telephone or letter with an outcome/apology.
- The patient experience team are readily available to answer questions or queries from services on the process and have provided training sessions to employees where requested.
- During conversations with the sites across NHS Lothian, it was confirmed that Datix is the single point of reference for complaints.
- There is weekly reporting to the management team which reports open actions with data taken from Datix on the same day and therefore is timely and provides management with accurate figures.
- Fortnightly reporting to the Patient Safety and Action Group includes complaints over 40 days old. During the meeting the relevant Director is invited to attend to explain why the complaint is delayed.
- Annual complaints reporting includes KPI's which have been defined by Scottish Government.

Summary of findings

Areas requiring improvement

- There is poor compliance with the Complaints Policy with regard to timeframes (set by Scottish Government) for responding to stage 1 complaints. We analysed the completion dates for all complaints (partially upheld, upheld and not upheld) from January 2023 - April 2023. This confirmed that 65% of complaints were not completed within the target timescales.
- Within our sample of 10 stage 1 complaints from January 2023 - April 2023, where a complaint had not been completed within the timescales the service did not contact the patient experience team to request an extension or contact the complainant to inform them of the delay.
- Datix reporting does not include details required for directorates to act on the information. The reports show clearly the status of complaints by manager, open complaints by stage, and number of days. Through discussions with services, it became apparent that the dashboards do not provide sufficient detailed information for the services to act upon these.
- NHS Lothian does not consistently identify actions for remediation following the investigation of a complaint. We selected a sample of stage 2 complaints made between January and April 2023. For the 13 stage 2 complaints tested, we found that:
  - Where lessons learned and actions were identified, these actions were not SMART.
  - Five complaints had no lessons learned or actions recorded on Datix.
- Whilst the complaints process and flowcharts include establishing lessons learned and actions following a complaint, there is no feedback loop process in place to ensure that actions from complaints have been embedded or sustained.
- There is no defined process in place to ensure the learning that has been identified by an investigation following a complaints investigation is shared across the health board where relevant.

Detailed findings & action plan

1.1	Moderate Assurance	The new roles and responsibilities and protocols for resolving complaints has not been documented clearly and/or there is no clear mapping or communication of the process resulting in staff being unaware of process requirements and ultimately complaints being mis-managed by NHS Lothian.

Finding and implication	Audit recommendation	Management response, including actions
<u>There is poor compliance with the Complaints Policy with regard to timeframes for responding to stage 1 complaints.</u> We selected a sample of stage 1 (Appendix 2) complaints to confirm that the documented process has been followed. Our sample covered the period from January 2023 to April 2023 to ensure we had a representative sample of complaints managed using the updated processes. Of the 10 stage 1 complaints selected: • Five complaints met the five-day response timescale set by the Scottish Government, and five complaints did not. – In two cases, the Patient Experience Team (PET) followed up with the service which resulted in a response being issued. The PET are responsible for monitoring, reviewing and issuing the services response to the complainant. – In one instance this was due to the complainant not responding to communications with the service. • Where a complaint had not been completed in five days the service did not contact PET or contact the complainant to inform them of the delay or when the next contact will be made as required by the process.	Recommendation 1 The services should be reminded of the timescales in place for dealing with complaints and the process which should be followed where this has not been achieved.	**Actions:** On issue of the initial communication to service PET will include clarification of the expected timescale (5+5 Days) for the service to issue their response to the complainant. On review at day 5 by the PET team will reiterate to service the operational process (as set out in the stage 1 flowchart) that they need to follow. **Responsible Officer:** Head of Patient Experience **Executive Lead: Executive** Nurse Director **Due Date:** 1 September 2023
	Recommendation 2 After the five-day timescale has been breached the Complaints Officer from the PET team should follow up with the service to understand why this is the case and encourage progress.	**Actions:** On review at day 5 when the PET team reiterate to service the operational process (as set out in the stage 1 flowchart) that they need to follow they will require service to provide an explanation and offer to support progress. **Responsible Officer:** Head of Patient Experience **Executive Lead:** Executive Nurse Director **Due Date:** 1 September 2023

Detailed findings & action plan

1.1	Moderate Assurance	The new roles and responsibilities and protocols for resolving complaints has not been documented clearly and/or there is no clear mapping or communication of the process resulting in staff being unaware of process requirements and ultimately complaints being mis-managed by NHS Lothian.

Finding and implication	Audit recommendation	Management response, including actions
We analysed the dates for all complaints (partially upheld, upheld and not upheld) from January 2023 - April 2023 to confirm how many Stage 1 complaints were not completed in the five-day timescale - 208 out of 317 (65%) were not completed within the target timescales. The PET are responsible for reviewing and issuing the services response to the complainant.	Recommendation 3 NHS Lothian should ensure that where a stage one complaint did not adhere to the five-day timeframe this is acknowledged when issuing the response.	**Actions:** On review at day 5 when the PET team engage with service the PET team will advise service to apologise if the timeframe for providing a response will exceed 10 days. (See below) **Responsible Officer:** Head of Patient Experience **Executive Lead:** Executive Nurse Director **Due Date:** 1 September 2023
	Improvement Action 1: Where a complaint requires more information from the complainant, NHS Lothian should consider implementing a process where they can 'stop the clock' until a response is received. This process should be made clear to the complainant.	**Management Response:** Whilst the standard is 5 days there is provision for an additional 5 day extension – when the complaint is received the complainant is advised of a 5 – 10 day expected turnaround The national Complaints Handling Procedure does not make provision for "stopping the clock" however it recognises that complaints cannot be logged or investigated without all of the pertinent details. The PET team currently contact complainants where there is insufficient information to progress the investigation. These complaints are categorised as "further details requested" and the 5 day timeframe does not commence until the necessary information is received.

Detailed findings & action plan

1.2	Moderate Assurance	The new roles and responsibilities and protocols for resolving complaints has not been documented clearly and/or there is no clear mapping or communication of the process resulting in staff being unaware of process requirements and ultimately complaints being mis-managed by NHS Lothian.

Finding and implication	Audit recommendation	Management response, including actions
<u>Potential to expand current controls in place around roles and responsibilities.</u> During discussions with directorates, we confirmed that directorates understand who their complaints commissioners are, however, this is not documented. One directorate had a matrix in place which allows them to identify the lead investigator for certain complaints. Whilst it may not always be possible for this person to fulfil this role, due to, for example being named in the complaint, it allows the commissioner to quickly assign complaints where this is not the case. A matrix to identify lead investigators could be adopted by each directorate to strengthen the assigning of complaints.	Recommendation 4 All directorates should define within their local delivery plan who will fulfil the complaints commissioner role as this currently varies across NHS Lothian.	**Management Response:** The Executive Nurse Director has requested that Business Units (at appropriate level for the part of the organisation) define their local complaints assurance process. **Actions:** CMT will be asked to complete a template setting out the complaints commissioner for each service within scope of responsibility **Responsible Officer:** Executive Nurse Director **Executive Lead:** Executive Nurse Director **Due Date:** 31 December 2023
	Recommendation 5 Local delivery plans for complaints should be updated to include a matrix which allows directorates to identify the lead investigator for sub-directorates.	**Actions:** CMT will be asked to complete a matrix identifying the role responsible as lead investigator for sub directorates. **Responsible Officer:** Executive Nurse Director **Executive Lead:** Executive Nurse Director **Due Date:** 31 December 2023

Detailed findings & action plan

2.1	Significant Assurance	There is ineffective oversight of complaints received across NHS Lothian resulting in the Board not having assurance that all complaints received have been dealt with appropriately.

Finding and implication	Audit recommendation	Management response, including actions
<u>Datix reporting does not include details required for directorates to act on the information.</u> The Datix system used within NHS Lothian for complaints has a dashboard functionality allowing management to easily view progress of open complaints. This is a live system where all additions, closures or amendments are instantly updated. These show clearly the status of: • complaints by manager, • open complaints by Stage, and • number of days, Through discussions with services, it became apparent that the dashboards do not provide sufficient detailed information for the services to act upon these. For example, who the complaint is currently sitting with. As a result, management within the services need to complete further analysis to obtain information required to follow up on overdue complaints.	Recommendation 6 A piece of work should take place with directorates to understand what information they require and what expectations they have to be able to access information from the Datix dashboard. This will allow the Patient Experience Team to understand and take action if Datix can be configured to meet these requirements.	**Management Response:** The ability to make changes to the Datix system is not within the scope of PET team and sits with Quality Improvement Support Team. **Actions:** 1) Invite DATIX to NHS Lothian to understand fully the complaints module and its full functionality **by 31 December 2023** 2) The PET Team & QIST will meet with each business unit to explain the functionality / possibilities of the Datix dashboard and to understand their individual requirements. This will be **by 31 December 2023** 3) The PET team will collate the responses and establish what as a minimum should be provided in each Dashboard **by 31 March 2024** 4) Where additional elements are required (eg reporting) these should be set out as options and feedback back to QIST as administrators of DATIX **by 31 July 2024** **Responsible Officer:** Head of Patient Experience **Executive Lead:** Executive Nurse Director **Due Date:** See above **Grant Thornton Comment:** We have discussed the above timescales with key contacts they are firm that these are the earliest dates they can work too – we suggest that management provide the ARC with a paper to explain in greater detail the process for taking this action forward.

Detailed findings & action plan

3.1	No assurance	There is no feedback loop for lessons learned, and a lack of assurance that teams are acting on recommendations from complaints. As a result, relevant improvements are not identified and shared across the wider organisation where relevant.

Finding and implication	Audit recommendation	Management response, including actions
<u>NHS Lothian does not consistently identify actions for remediation following the investigation of a complaint.</u> We selected a sample of stage 2 (Appendix 3) complaints made between January 2023 and April 2023. For the 13 stage 2 complaints we selected, we reviewed Datix to confirm that appropriate actions have been identified and an action plan is in place to implement the actions. We found that: • Eight complaints had lessons learned and subsequent actions identified. However, these actions were not SMART (specific, measurable, achievable, realistic, timely). • Five complaints had no lessons learned or actions recorded on Datix. As a result of a lack of action plans, there are common themes across complaints which are reoccurring, for example, within our sample three out of five complaints from the Acute Medicine directorate were focused on lack of discharge planning. Having action plans and lessons learned will enable themes to be identified and improvements to be made which should in turn reduce the number of complaints received.	Recommendation 7 Following an investigation of a stage 2 complaint, an action plan must be uploaded onto Datix as well as: EITHER – confirmation that it is in place prior to issuing a response to the complainant. OR – where an action plan is not relevant, this should also be recorded within Datix.	**Actions:** The lead investigator role will be further defined to include the development of the action plan (the investigation commissioner is currently responsible for ensuring this is done) CMT will instruct business units on the requirement to develop and upload action plans or record as not required PET will escalate to the relevant investigation commissioner where this has not been done **Responsible Officer:** Head of Patient Experience **Executive Lead:** Executive Nurse Director **Due Date:** 31 December 2023
	Recommendation 8 Training should be held with complaints commissioners, complaints investigators, and those with responsibility to review and sign off action plans, covering key elements of an effective action plan including SMART actions (specific, measurable, achievable, realistic, timely).	**Actions:** Training resources will be developed as part of a commissioned programme of work around learning from patient experience and outcomes. **Responsible Officer:** Head of Patient Experience **Executive Lead:** Executive Nurse Director **Due Date:** 31 March 2024

Detailed findings & action plan

3.1	No assurance	There is no feedback loop for lessons learned, and a lack of assurance that teams are acting on recommendations from complaints. As a result, relevant improvements are not identified and shared across the wider organisation where relevant.

Finding and implication	Audit recommendation	Management response, including actions
Finding 3.1 continued.	Recommendation 9 The investigation commissioner should ensure that actions arising from complaints are SMART (specific, measurable, achievable, realistic, timely) prior to approval of an action plan to assist in the clarity and monitoring.	**Actions:** Review toolkit to include details of action planning The investigation commissioner role will be further defined to include the review of the action plan **Responsible Officer:** Head of Patient Experience **Executive Lead:** Executive Nurse Director **Due Date:** 31 March 2024

Detailed findings & action plan

3.2	No assurance	There is no feedback loop for lessons learned, and a lack of assurance that teams are acting on recommendations from complaints. As a result relevant improvements are not identified and shared across the wider organisation where relevant.

Finding and implication	Audit recommendation	Management response, including actions
NHS Lothian has no established process to monitor the implementation and sustainability of actions identified following the investigation of a complaint. Whilst the complaints process and flowcharts include establishing lessons learned and actions following a complaint, there is no process in place to ensure that actions from complaints have been embedded or sustained, and there is a potential risk that similar complaints will re-occur if actions are not embedded and sustained. Without this in place, it is likely that incomplete actions may go undetected, and patients will experience the same issues going forward.	Recommendation 10 NHS Lothian should develop a process to monitor if actions identified and included within the action plan following the investigation of a complaint have been implemented and sustained following implementation.	**Actions:** CMT will be asked, as part of their local complaints assurance process flowchart, to identify the management oversight in place to follow up action plans for each service within scope of responsibility. **Responsible Officer:** Head of Patient Experience **Executive Lead:** Executive Nurse Director **Due Date:** 31 December 2023

Detailed findings & action plan

3.3	No assurance	There is no feedback loop for lessons learned, and a lack of assurance that teams are acting on recommendations from complaints. As a result relevant improvements are not identified and shared across the wider organisation where relevant.

Finding and implication	Audit recommendation	Management response, including actions
There is no defined process in place to ensure the learning that has been identified by an investigation following a complaints investigation to be shared across the health board where relevant. During discussions with directorates, it became apparent that lessons learned are not shared across NHS Lothian where relevant. Without this there is a risk there are missed opportunities for learning across NHS Lothian.	Recommendation 11 NHS Lothian should develop a standardised process to support directorates to cascade learning following complaints to other directorates across NHS Lothian.	**Actions:** Opportunities and processes will be developed as part of a commissioned programme of work around learning from patient experience and outcomes **Responsible Officer:** Head of Patient Experience **Executive Lead:** Executive Nurse Director **Due Date:** 31 March 2024

Appendices

Appendix 1:
Staff involved and documents reviewed

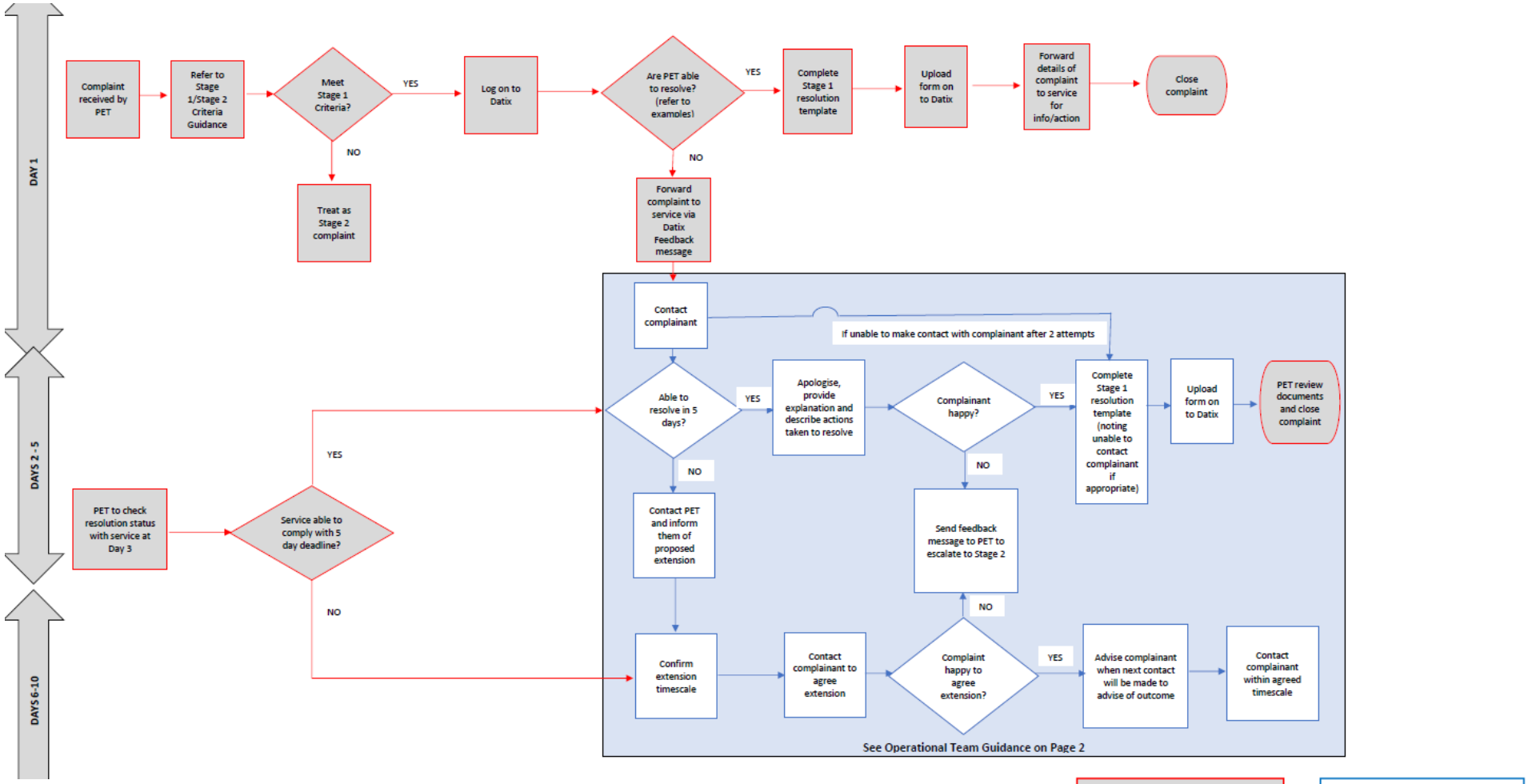
Staff involved

- Head of Patient Experience
- Deputy Director of Nursing
- Associate Nurse Director (Royal Infirmary of Edinburgh)
- Site Director (Royal Infirmary of Edinburgh)
- Director of Acute Services
- Nurse Director Acute Services
- Site Director (Woman and Childrens Services)
- Deputy Director of Midwifery (Woman's Services)
- Professional Lead (Children's Services)
- Site Director (Western General Hospital)
- Associate Nurse Director (Western General Hospital)
- Site Director (Royal Edinburgh Hospital)
- Nurse Director - Mental Health Services (Royal Edinburgh Hospital)

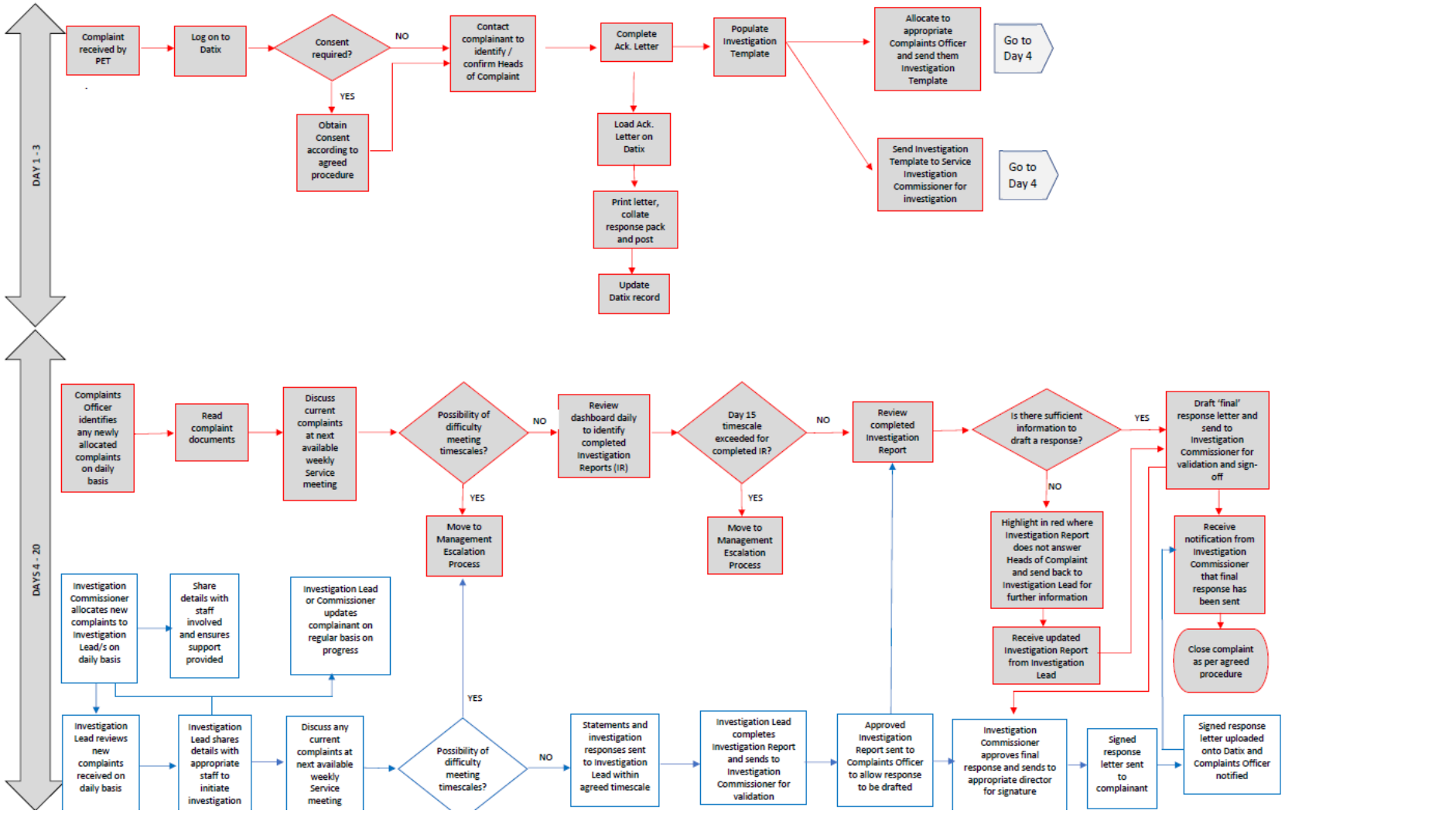
Documents reviewed

- Investigating a Complaint
- Stage 1 Flow Chart (Appendix 2)
- Stage 2 Flow Chart (Appendix 3)
- Concern Flow Chart
- SPSO Flow Chart
- Roles and responsibilities
- CMT – Complaints Handling Procedure
- Complaints training presentation
- Datix System
- Patient Experience Team weekly reporting
- Healthcare Governance Committee report – March 2023
- Patient Safety and Experience Action Group reporting
- Patient Experience Action Plan
- 2020/21 and 2021/22 Complaints Annual Report

Appendix 2:
Stage 1 Flowchart



Appendix 3:
Stage 2 Flowchart



Appendix 2:
Our assurance levels

The table below shows the levels of assurance we provide and guidelines for how these are arrived at. We always exercise professional judgement in determining assignment assurance levels, reflective of the circumstances of each individual assignment.

Rating*	Description
Significant Assurance	The Board can take reasonable assurance that the system(s) of control achieves or will achieve the control objective. There may be an insignificant amount of residual risk or none at all. There is little evidence of system failure and the system appears to be robust and sustainable. The controls adequately mitigate the risk, or weaknesses are only minor (for instance a low number of findings which are all rated as 'low' or no findings)
Moderate Assurance	The Board can take reasonable assurance that controls upon which the organisation relies to achieve the control objective are in the main suitably designed and effectively applied. There remains a moderate amount of residual risk. In most respects the "purpose" is being achieved. There are some areas where further action is required, and the residual risk is greater than "insignificant". The controls are largely effective and in most respects achieve their purpose with a limited number of findings which require management action (for instance a mix of 'medium' findings and 'low' findings)
Limited Assurance	The Board can take some assurance from the systems of control in place to achieve the control objective, but there remains a significant amount of residual risk which requires action to be taken. This may be used when: • There are known material weaknesses in key control areas. • It is known that there will have to be changes that are relevant to the control objective (e.g. due to a change in the law) and the impact has not been assessed and planned for. The controls are deficient in some aspects and require management action (for instance one 'high' finding and a number of other lower rated findings)
No assurance	The Board cannot take any assurance from the audit findings. There remains a significant amount of residual risk. The controls are not adequately designed and / or operating effectively and immediate management action is required as there remains a significant amount of residual risk (for instance a number of HIGH rated recommendations)

Appendix 4:
Our recommendation ratings

The table below describes how we grade our audit recommendations based on risks:

Rating	Description	Possible features
High	Findings that are fundamental to the management of risk in the business area, representing a weakness in the design or application of activities or control that requires the immediate attention of management	• Key activity or control not designed or operating effectively • Potential for fraud identified • Non-compliance with key procedures/standards • Non-compliance with regulation
Medium	Findings that are important to the management of risk in the business area, representing a moderate weakness in the design or application of activities or control that requires the immediate attention of management	• Important activity or control not designed or operating effectively • Impact is contained within the department and compensating controls would detect errors • Possibility for fraud exists • Control failures identified but not in key controls • Non-compliance with procedures/standards (but not resulting in key control failure)
Low	Findings that identify non-compliance with established procedures, or which identify changes that could improve the efficiency and/or effectiveness of the activity or control but which are not vital to the management of risk in the business area.	• Minor control design or operational weakness • Minor non-compliance with procedures/standards
Improvement	Items requiring no action but which may be of interest to management or which represent best practice advice	• Information for management • Control operating but not necessarily in accordance with best practice