Hywel Dda University Health Board

Bronglais General Hospital Directorate Governance Review

Final Internal Audit Report

February 2020

Private and Confidential

NHS Wales Shared Services Partnership

Audit and Assurance Services

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1. Introduction and Background

The governance review of the Bronglais General Hospital was completed in line with the approved 2019/20 Internal Audit Plan. The relevant Executive Director lead for the assignment was the Director of Operations.

2. Scope and Objectives

The overall objective of this audit was to confirm that Directorate governance structures follow the principles set out in the Health Board's system of assurance, and support the management of key risks and achievement of the Directorate's objectives.

The following objectives were reviewed as part of this audit:

- The Directorate has a clear organisational group structure with approved terms of reference;
- The terms of reference, meetings and work plans of Directorate groups are constructed in such a way as to provide assurance on key areas of Directorate business and performance (covers keys aspects, of performance, quality, compliance, finance and key risks);
- A risk management process is in place that ensures risks are appropriately identified, assessed, recorded and escalated;
- Look for assurance that staff in department visited have an awareness of the requirements of the Declarations of Interest, gifts and hospitality policy. Review level and nature of declarations made;
- The Directorate division has an appropriate and up to date scheme of delegation and a robust financial management arrangement are in place;
- The Directorate has appropriate processes in place to ensure compliance with appropriate actions are taken as a result of incidents are concerns raised; and
- Staff sickness absence management appropriate in line with policy and PADRs are undertaken in line with the policy.

3. Associated Risks

The following inherent risks were considered during this audit:

i. Governance structures, roles and responsibilities are not clear;

ii. Risks to achievement of the managed unit or Health Board objectives are not identified, managed or reported appropriately;

iii. Assurance against key areas of Directorate business, performance and compliance not received and acted upon;

iv. Incidents and concerns are not recorded and addressed;

v. Robust arrangements for financial management not in place; and

vi. Staff not managed appropriately.

OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

We are required to provide an opinion as to the adequacy and effectiveness of the system of internal control under review. The opinion is based on the work performed as set out in the scope and objectives within this report. An overall assurance rating is provided describing the effectiveness of the system of internal control in place to manage the identified risks associated with the objectives covered in this review.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Bronglais General Hospital Directorate Review is **Limited** assurance.

RATING	INDICATOR	DEFINITION
Limited Assurance		The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

The overall level of assurance that can be assigned to a review is dependent on the severity of the findings as applied against the specific review objectives and should therefore be considered in that context.

The Bronglais General Hospital (BGH) Directorate has an established management committee supported by a number of sub-groups, with performance scrutiny and monitoring evident within the management and supporting groups.

However, we identified a number of high priority findings that require addressing, including:

- A number of risks where actions had been identified as 'completed' but continued to remain on the register with no further actions recorded. We also noted that the inherent risk score and risk treatment status of these risks had not been amended to reflect completed actions. In addition, one risk identified on the corporate risk register was not evident on the Directorate or Services risk registers.
- Instances of non-compliance for the management of sickness absence including inaccurate or incomplete sickness documentation.
- A number of objectives listed within staff PADRs were not specific, measureable or timely across the departments audited, whilst a number of employees on the Ystwyth Stoke Ward did not have a PADR on their personal file.

We can confirm that the directorate is engaged with the Finance Department in delivering services against budget and the identification of saving targets were evident. However, the inherent risk of the directorate not achieving a breakeven position at year-end continues to exist.

In addition, a number of medium priority findings were identified in regard of the lack of a BGH Management Committee work plan, accessibility to some requested documents, supporting groups' terms of reference and declaration of interests.

5. Assurance Summary

The summary of assurance given against the individual objectives is described in the table below:

		Assurance Summary*			
Audit Objective					
1	The Directorate has a clear organisational group structure with approved terms of reference		✓		
2	The terms of reference, meetings and work plans of Directorate groups are constructed in such a way as to provide assurance on key areas of Directorate business and performance			✓	
3	A risk management process is in place that ensures risks are appropriately identified, assessed, recorded and escalated		✓		
4	Look for assurance that staff in department visited have an awareness of the requirements of the Declarations of Interest, gifts and hospitality policy. Review level and nature of declarations made			✓	
5	The Directorate division has an appropriate and up to date scheme of delegation and a robust financial management arrangement are in place			✓	
6	The Directorate has appropriate processes in place to ensure compliance with appropriate actions are taken as a result of				✓

		Assurance Summary*			
Audit Objective					
	incidents are concerns raised				
7	Staff sickness absence management appropriate in line with policy and PADRs are undertaken in line with the policy		✓		

** The above ratings are not necessarily given equal weighting when generating the audit opinion.*

Design of Systems/Controls

The findings from the review have highlighted **three** issues that are classified as weakness in the system control/design for Bronglais General Hospital Directorate Review. These are identified in the Management Action Plan as (D).

Operation of System/Controls

The findings from the review have highlighted **five** issues that are classified as weakness in the operation of the designed system/control for Bronglais General Hospital Directorate Review. These are identified in the Management Action Plan as (O).

6. Summary of Audit Findings

The key findings are reported in the Management Action Plan at Appendix A.

OBJECTIVE 1: The Directorate has a clear organisational group structure with approved terms of reference

The Bronglais General Hospital (BGH) Management Committee was been established as the directorate's management group. We can confirm that a terms of reference (TOR) for the BGH Management Committee has been produced that describes its purpose, objectives, membership, attendees and operating arrangements.

We can confirm that key issues such as finance, workforce, quality and performance were reported and addressed at the BGH Management Committee meetings for the period January to August 2019.

The BGH Management Committee TOR noted that all sub-groups are required to report to the management committee on a regular basis. Concluding a review of the sub-groups, we noted that the Theatre Users Group and Professional Nursing Forum had not been approved by the appropriate group/forum whilst there was no TOR in place for the Quality Forum.

Internal Audit requested BGH Management Committee agendas, minutes and papers for 2019. Whilst we were provided with some documents, not all were available at the time of fieldwork. This was due to long-term absence of an employee within the directorate that retained committee papers.

See Findings 4 & 5 at Appendix A.

OBJECTIVE 2: The terms of reference, meetings and work plans of Directorate groups are constructed in such a way as to provide assurance on key areas of Directorate business and performance

A review was undertaken of the BGH Management Committee agendas, minutes and papers since January 2019 to establish whether a work plan/cycle of business had been established. Whilst no work plan/cycle of business was evident, the standing items of the BGH Management Committee included the risk register, performance dashboard, finance, workforce and recruitment, and other key issue reports.

Testing was undertaken to establish whether other key business items listed in the Health Board and Quality, Safety & Experience Assurance Group (QSEAC) work plans had been aligned with the BGH Management Committee. Concluding a review of BGH Management Committee agendas for the period January to

August 2019, we noted that the following items had not been submitted or discuss at the directorate management meetings:

- Declaration of interests
- Matters arising
- Table of actions
- Review of terms of reference (TOR)
- Review of membership
- Review of other sub-committee/groups TORs
- Patient stories
- Internal & external audits
- Annual work plan

The Theatre User Group has a draft TOR in place; whilst the Professional Nursing Forum has a TOR dated 2013. To mitigate the lack of an approved and valid TOR for these supporting groups, we can confirm that at least one member of the management triumvirate is a member of these groups/forums. We also noted that the Quality Forum had replaced the Governance Committee in April 2019. However, no TOR has been produced or approved as at November 2019.

We can confirm that key issues such as workforce, quality and performance were being reported and scrutinised at supporting groups and forums with evidence of actions taken to address areas of risk or concern.

See Findings 6 at Appendix A.

OBJECTIVE 3: A risk management process is in place that ensures risks are appropriately identified, assessed, recorded and escalated

The BGH Directorate maintain Directorate and Services risk registers. We can confirm that following a review of the BGH Management Committee agendas and minutes for the period January to August 2019 the risk registers were regularly reviewed.

A corporate risk appetite has been set by the Health Board and implemented at directorate level with the BGH Management Committee reviewing all reported risks at every meeting. A review of the Directorate and Services risk registers as at October 2019 identified the following:

- We noted for a number of risks did not match, including two risks where the 'Target Risk Score' was higher than the 'Risk Tolerance Score'. This was due to the 'Risk Tolerance Score' being set by the Health Board, whilst

the 'Target Risk Score' is set based on the implementation of actions that can be met with the resource available.

- Where progress updates and deadline dates had been provided, we identified some instances where no follow-up actions had been provided since 17th August 2018.
- A number of risks where all actions had been noted as 'Completed' continued to remain on the register as 'treat'. Where no further actions to address the risks have been recorded, consideration should be given in amending the risk treatment to reflect their current status.

A review was also undertaken to ensure high priority risks had been submitted for inclusion on the Corporate Risk Register. Whilst we noted that three risks listed on the Corporate Risk Register were recorded on other directorate risk registers (Scheduled Care), noting the impact that could affect BGH, they were not evident on the Directorate or Service risk registers.

See Findings 1 at Appendix A.

OBJECTIVE 4: Look for assurance that staff in departments visited have an awareness of the requirements of the Declaration of Interest, gifts and hospitality policy

A review was undertaken to establish assurance that staff within the directorate were aware of the requirements of the declaration of interest, gifts and hospitality policy. We can confirm that entries on behalf of the directorate had been recorded in the Health Board Registers of Interests, Gifts, Sponsorship and Hospitality. However, the last entries recorded in the Registers of Gifts, Sponsorship and Hospitality were made in 2016.

See Finding 7 at Appendix A.

OBJECTIVE 5: The directorate division has an appropriate and up to date scheme of delegation and a robust financial management arrangement are in place

The BGH Directorate were fully engaged in the budget setting process for 2019/20 that included the adjustments to cost centre budgets based upon historical and workforce information.

The BGH Directorate management team regularly receive monthly Finance dashboard reports highlighting key areas of spend and savings, current performance levels and forecasted year-end positions. There was evidence of the Finance dashboard reports being submitted to the BGH Management Committee for review and scrutiny during 2019.

We can confirm that members of Finance are situated on site at least one day a week and liaise with the management team on a formal and informal basis. In addition, supplementary information is provided to the management team in regard of the Holding to Account meetings with Executive Directors and also in the form or ad hoc reports on key drivers such as bank and agency spend.

Both the Hospital General Manager and Finance Business Partner (Unscheduled Care) stated that there was positive engagement between to the functions with regular meetings to address current performance and achievement of the required financial savings. We also noted that finance was reported and discussed at the BGH Management Committee with actions to address areas of risk or concern evident.

At Month 7, the directorate's delivery of savings (at 3.7% of the annual budget equating to £0.785m) was on target. However, the directorate's performance had seen a cumulative adverse variance of £0.575m, with a year-end variance forecasted around £0.850m.

Whilst we noted the regular engagement between hospital management and the Finance function, the inherent risk of the directorate not achieving a breakeven position at year-end continues to exist.

We can confirm that the BGH Directorate has an Oracle approved hierarchy in place for 2019/20 that complies with Standing Orders and Scheme of Delegation. All requisitions are input through the Oracle system in line with the NHS Wales No Purchase Order No Pay Policy.

See Finding 8 at Appendix A.

OBJECTIVE 7: The Directorate has appropriate processes in place to ensure compliance with appropriate actions are taken as a result of incidents are concerns raised

All BGH Directorate incidents are recorded on the Datix reporting system. Following a review of the BGH Management Committee agendas and minutes for the period January to July 2019, we can confirm that redress and claims were regularly reported and scrutinised to ensure management actions mitigate the risks that led to the incident occurring.

No matters arising.

OBJECTIVE 8: Staff sickness absence management appropriate in line with policy and PADRs are undertaken in line with the policy.

An Electronic Staff Record (ESR) report was obtained from the Workforce Intelligence Team that detailed the PADR compliance levels of organisational cost centres (as at 12th August 2019) and periods of sickness recorded in 2019. The following departments were selected based on the ESR reports:

- Ceredig Ward
- Rhiannon Short Stay
- Ystwyth Stroke Ward
- Y Banwy

Sickness Management

A total of 46 sickness absences periods (from 20 employees) were reviewed and the following was noted:

- 22 instances where the self/medical certificate was not on file.
- 26 instances where the start date on ESR did not reconcile to the self/medical certificate.
- 25 instances where the end date on ESR did not reconcile to the self/medical certificate.
- 23 instances where the self/medical certificate did not cover the absence period.
- 23 instances where the reason for absence was not recorded
- 26 instances where a return to work (RTW) form was not on file.
    - Of the 20 instances where an RTW was on file:
        - One instance where the information recorded was inaccurate.
        - 10 instances where the RTW interview was undertake more than seven days after the absence end date.
        - Two instances where the RTW form had not been signed by the employee or manager.
- Seven employees where no action was evident of management intervention after periods of sickness would trigger an interview.

Performance Appraisal Development Reviews

A sample of 20 employees was selected from the sampled wards and tested to ensure a valid PADR was on file. We noted that four employees on the Ystwyth Stoke Ward did not have a PADR form on file, whilst the PADR form on file another employee was dated as being undertaken in May 2018.

Of the 16 employees where a PADR was on file, testing was undertaken to ensure personal objectives complied with the SMART (Specific, Measurable, Achievable,

Realistic & Timely) principle set out in the Performance Appraisal and Personal Development Plan Policy.

Of the 16 PADRs reviewed, 69 personal objectives had been set. We noted that there were a large number of objectives across the departments audited that were not specific or measureable – see Table A below for a breakdown of each cost centre tested.

We only noted two instances where an explicit timeframe had been included against objectives. Whilst the Health Board's PADR template specifies the setting of personal objective to be achieved over the year, in some instances this may take longer to complete, such as a professional qualification, and therefore a designated timeframe should be recorded.

See Findings 2 & 3 at Appendix A.

Table A – Breakdown of Sampled PADR Reviews

WARD/DEPT	NO. OF PADR REVIEWED	TOTAL OBJECTIVES REVIEWED	SPECIFIC		MEASURABLE		ACHIEVABLE		REALISTIC		TIMELY	
			Met	Not Met	Met	Not Met	Met	Not Met	Met	Not Met	Met	Not Met
Ceredigion Ward (0558)	5	25	6	19	6	19	24	1	24	1	0	25
Rhiannon Short Stay (1432)	5	21	5	16	6	15	16	5	16	5	2	19
Ystwyth Stroke Unit (0523)	1	4	1	3	0	4	4	0	4	0	0	4
Y Banwy (1505)	5	19	2	17	0	19	16	3	16	3	0	19
TOTAL	16	69	14	55	12	57	60	9	60	9	2	67

7. Summary of Recommendations

The audit findings and recommendations are detailed in Appendix A together with the management action plan and implementation timetable.

A summary of these recommendations by priority is outlined below.

Priority	H	M	L	Total
Number of recommendations	**3**	**5**	**0**	**8**

Finding 1 – Risk Register (O)	Risk
A review of the Directorate and Services risk registers identified a number of risks where actions had been identified as 'completed' but continued to remain on the register with no further actions recorded. We also noted that the inherent risk score and risk treatment status of these risks had not been amended to reflect completed actions. A review was also undertaken to ensure high priority risks had been submitted for inclusion on the Corporate Risk Register. Whilst we noted that three risks listed on the Corporate Risk Register were recorded on other directorate risk registers (Scheduled Care), noting the impact that could affect BGH, they were not evident on the Directorate or Service risk registers.	Risks to achievement of the directorate or Health Board objectives are not identified, managed or reported appropriately.
Recommendation 1	**Priority level**
Bronglais General Hospital Management should review the Directorate and Service risk registers to ensure the scoring of risks and the application of risk treatment is accurate and correct, and the identified corporate risks are considered for inclusion on the directorate registers.	**HIGH**
Management Response	**Responsible Officer/ Deadline**
On detailed review, in preparation for this submission, it is accepted that some adjustment of inherent risk score against risk treatment status was needed – this has now been addressed. The opportunity was also taken to update all	Hospital Services Manager Action complete – January 2020

actions for January 2020 and this should all now be satisfactory. We are also undertaking a review to ascertain if any other corporate or Scheduled Care risks exist which relate to BGH theatres which should be admitted and referenced to a generic theatres risk on the BGH Directorate Risk Register (but will remain the property of the Scheduled Care Directorate). We also noted that another corporate risk (696) was identified that is aligned to the Neurology Service – Specialist Epilepsy Nurse Service. This risk has also been accepted on to the BGH risk register.	Hospital General Manager & General Manager (Scheduled Care) 5th February 2020 Service Delivery Manager (Neurology) Action complete – January 2020

Finding 2 – Sickness Absence (O)	**Risk**
Of the 46 periods of sickness chosen within our sample, we noted a number of inaccurate and incomplete sickness documentation.	Staff not managed appropriately.
Recommendation 2	**Priority level**
Department managers and leads should ensure that the management of all periods of sickness complies with the NHS Wales Managing Attendance at Work Policy.	**HIGH**
Management Response	**Responsible Officer/ Deadline**

The Deputy Head of Nursing will have monthly meeting with the Ward Managers who are required to provide an update their ward improvement plans including sickness management.	Hospital Head of Nursing & Clinical Site Manager March 2020

Finding 3 – PADRs (D)	**Risk**
Of the 69 personal objectives reviewed, the majority of objectives were achievable and realistic. However, there were a large number of objectives across the departments audited that were not specific or measureable. We also noted that there was only two instances where an explicit timeframe had been included against objectives. In addition, of the five employees sampled for the Ystwyth Stoke Ward, a PADR was not on the personal file of four of the selected individuals, whilst the PADR form on file for the one employee was dated as being undertaken in May 2018.	Staff not managed appropriately.
Recommendation 3	**Priority level**
Bronglais General Hospital Management should ensure • **all objectives recorded in employee PADRs are consistent with the SMART principle set out in the Performance Appraisal and Personal Development Plan Policy; and** • **all employees on the Ystwyth Stroke Ward receive an annual personal development appraisal review that should be documented and retained on file.**	**HIGH**

Management Response	Responsible Officer/ Deadline
The Deputy Head of Nursing will have monthly meeting with the Ward Managers who are required to provide an update their ward improvement plans including PADRs. BGH also has three inexperienced development Band 7 Ward Managers who are receiving support and are also cohorted on to the STAR leadership programme to aid in the development of their management skills.	Hospital Head of Nursing & Clinical Site Manager March 2020

Finding 4 – BGH Management Committee Work Plan (D)	Risk
We noted that a work plan/cycle of business had not been implemented by the BGH Management Committee. No reference to a work plan/cycle of business was evident in the TOR nor agendas, minutes or papers. In addition, we noted that some key items listed in the Health Board and QSEAC work plans had not appeared in BGH Management Committee agendas for the period January to August 2019.	Governance structures, roles and responsibilities are not clear.
Recommendation 4	**Priority level**
The Bronglais General Hospital Management Committee should establish an annual work plan to ensure organisational business objectives and goals provided by supporting groups, committees and external sources are captured and reported.	**MEDIUM**
Management Response	**Responsible Officer/ Deadline**

A work plan will be developed by the BGH Management Committee to ensure key items are listed and reviewed throughout the year. In addition, the newly re-established Quality Forum, Chaired by the Head of Nursing, will operate as a formal sub-group of the BGH Hospital Management Committee. The QF will receive reports outcomes and review actions from QSEAC, external reviews – HIW etc., development of the BGH Clinical Strategy, capital projects and site improvements plan. The minutes and actions from the QF will be submitted to the HMC in order to provide assurance on delivery.	Senior Management Team & Hospital Directors March 2020

Finding 5 – Retention of Documents (O)	**Risk**
Internal Audit requested BGH Management Committee agendas, minutes and papers for 2019. Whilst we were provided with some documents, not all were available at the time of fieldwork. This was due to long-term absence of an employee within the directorate that retained committee papers	Governance structures, roles and responsibilities are not clear.
Recommendation 5	**Priority level**
Management should ensure all BGH Management Committee agendas, minutes and papers are made readily accessible.	**MEDIUM**
Management Response	**Responsible Officer/ Deadline**
BGH has been subject to an extraordinary situation where the only two members of the admin support team were absent long term for different reasons. The Management PA post has been re-appointed and going forward	Hospital General Manager March 2020

this individual will maintain a full document record, including version control, in a shared area that allows managed access.	

Finding 6 – Terms of Reference (D)	**Risk**
The is no terms of reference (TOR) in place for the Quality Forum; whilst the TOR for the Theatre Users Group and Professional Nursing Forum have not been approved by the appropriate group/forum.	Governance structures, roles and responsibilities are not clear.
Recommendation 6	**Priority level**
Management should ensure that approved terms of reference are in place for all supporting groups and forums of the BGH Management Committee.	**MEDIUM**
Management Response	**Responsible Officer/ Deadline**
The Quality Forum will agree the TOR at the first meeting in January 2020, whilst the TOR of the Professional Nursing Forum was recently updated. However, due to an oversight, the date was not changed on the document – this has been rectified. The Theatre User Group TOR and membership were reviewed and ratified by the HMC.	Head of Nursing & Chair of TUG Action Completed – January 2020

Finding 7 – Declaration of Interest, Gifts & Hospitality Registers (O)	Risk
A review of the Health Board Registers of Gifts and Sponsorship and Hospitality noted that no new entries of gifts, sponsorship or hospitality had been recorded since 2016 by staff at BGH.	Declarations of interest and/or gifts may not be made or may be incorrectly made, falling foul of Health Board policies.
Recommendation 7	**Priority level**
Bronglais Hospital Management should ensure the Health Board registers of gifts, sponsorship and hospitality are accurate and up-to-date, with staff reminded of their requirement to comply with the Standards of Behaviour Policy.	**MEDIUM**
Management Response	**Responsible Officer/ Deadline**
Staff are aware of the need for gifts declaration and the process to follow. The instances of this have been low in number but examples can be provided in order to assure that this is in place. However, to ensure future compliance with the Standards of Behaviour Policy, a reminder will be issue to employees at Bronglais General Hospital informing them of their requirement to declare and register gifts, sponsorships and hospitality on the Health Board registers.	Hospital General Manager February 2020

Finding 8 – Directorate Financial Performance (O)	Risk

The directorate's performance had seen a cumulative adverse variance of £0.575m, with a year-end variance forecasted around £0.850m. Whilst we noted the regular engagement between hospital management and the Finance function, the inherent risk of the directorate not achieving a breakeven position at year-end continues to exist.	Robust arrangements for financial management not in place.
Recommendation 8	**Priority level**
Directorate Management should liaise with Finance colleagues to identify further actions to address the financial challenges impacting on the forecasted year-end overspend.	**MEDIUM**
Management Response	**Responsible Officer/ Deadline**
The ability to manage and deliver within budget is impacted due to key drivers affecting Bronglais General Hospital – in the main agency premium costs (40% nurse vacancy rate) and variable pay for doctors to cover vacancies. BGH Management will continue to liaise regularly with Finance colleagues through regular on site meetings and monthly workshops to address overspends. Progress is being made where possible, e.g. the avoidance of using agency doctors, which has been in place for the past two years. Medium to long term plans have also been identified that will aid in the improved recruitment of staff (and therefore reduction in agency costs). This includes the 5-year nurse recruitment strategy that will see the establishment of a local School of Nursing & Faculty of Health Sciences at Aberystwyth University.	Hospital General Manager April 2020

Appendix B - Assurance Opinion and Action Plan Risk Rating

2019/20 Audit Assurance Ratings

 **Substantial Assurance** - The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.

 **Reasonable Assurance** - The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with **low to moderate impact on residual risk** exposure until resolved.

 **Limited Assurance -** The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.

 **No Assurance** - The Board has **no assurance** arrangements in place to secure governance, risk management and internal control, within those areas under review, which are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.

Prioritisation of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority as follows.

Priority Level	Explanation	Management action
High	Poor key control design OR widespread non-compliance with key controls. PLUS Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in control design OR limited non-compliance with established controls. PLUS Some risk to achievement of a system objective.	Within One Month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. These are generally issues of good practice for management consideration.	Within Three Months*

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

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