East Lothian
Integration Joint Board

REPORT TO: East Lothian IJB – Audit and Risk Committee

MEETING DATE: 7 December 2021

BY: Chief Internal Auditor

SUBJECT: Internal Audit Update of East Lothian Council and NHS Lothian 2020/21 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 services reported to the East Lothian Council Audit & Governance Committee and the NHS Lothian Audit & Risk Committee.

2 RECOMMENDATION

2.1 That the Audit and Risk Committee note the contents of the audit reports.

3 BACKGROUND

3.1 The East Lothian Council Internal Audit service reports key audit findings, conclusions and recommendations to the East Lothian Council Audit & Governance Committee. This includes audit reviews on the Health and Social Care Partnership (HSCP). 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 covers areas of interest to the East Lothian IJB.

3.2 All audit reports are available publicly for review at the following links; for East Lothian Council at Audit & Governance Committee | East Lothian Council and for NHS Lothian at Audits (nhslothian.scot).

3.3 Two audit reviews reported to the most recent meetings of the East Lothian Council Audit & Governance Committee and the NHS Lothian Audit & Risk Committee respectively are summarised in Appendices 1 and 2. These reports are:

- Corporate Appointeeship (Appendix 1)
- Risk Management at a Divisional/HSCP Level (Appendix 2)

4 ENGAGEMENT

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

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

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DATE	27 November 2021

Appendix 1: Executive Summary: Corporate Appointeeship

Conclusion: Reasonable Assurance

The HSCP has set up an in-house Corporate Appointeeship service and we found that clear and appropriate procedures and guidance documents are in place; comprehensive records and a clear audit trail of all actions taken are maintained; appropriate processes are in place for setting up client bank accounts and transferring responsibility for Corporate Appointeeship to the HSCP; and key financial controls are in place for client budgeting and for the creation, authorisation and recording of payments. Areas which will require focus going forward include the arrangements for ensuring that clients are receiving all the benefits to which they are entitled and the processes for identifying, and taking appropriate action, where clients have surplus funds.

Background

A Corporate Appointee is where an organisation has been appointed by the DWP to manage and look after a client's welfare benefits, to make sure they are receiving all the benefits to which they are entitled and to support clients who have no other means of accessing/managing their finances. Corporate Appointeeship and financial management services for clients in East Lothian have in recent years been provided by an external provider. Although staff and service user opinion of the external provider was generally very positive, there was uncertainty as to the external provider's ability to continue to provide the service going forward. An option appraisal was carried out, the outcome of which was a decision to bring the Corporate Appointeeship service in-house. The Council does not currently charge clients for providing a Corporate Appointeeship service.

Summary of findings & recommendations

The following key findings and recommendations are highlighted, which have all been **agreed by Management**:

- Monthly bank reconciliations require to be reviewed by a second member of staff independent of the preparer. *Management have confirmed that a sample of monthly bank reconciliations will be spot checked by the Senior Business Support Administrator and this is now **in place**.*
- Arrangements should be made to enable designated staff within the HSCP to directly communicate with the Bank, to assist them in addressing transaction errors and in following up the non-receipt of key information. *Management have agreed to put arrangements in place **by January 2022**.*
- Appropriate processes are required for ensuring that clients are receiving all the benefits to which they are entitled and for identifying, and taking appropriate action, where clients have surplus funds, which may impact on their entitlement to benefits. *Management have agreed that processes will be put in place and clearly documented **by February 2022**.*
- The procedures for Dealing with Funds on the Death of a Client require to be finalised. *Management have confirmed that the procedures will be finalised as soon as all outstanding legal queries have been clarified **by December 2021.***
- Consideration should be given as to whether it would be appropriate to charge clients for providing a Corporate Appointeeship service. *Management have agreed to consider this when transfers are complete and the overall cost of the in-house service has been reviewed **by September 2022.***

Recommendation Summary

Recommendations Grade	High	Medium	Low	Total
Current Report	-	8	-	8
Prior Report	N/A	N/A	N/A	N/A*

* This control review is new and no prior report exists for comparison.

Materiality

As at 12 November 2021:

- 159 bank accounts have been applied for and of these 157 have been opened (12 of which have subsequently been closed due to the client's death or no longer being required). The bank accounts opened include both transfer clients and new clients.
- Applications have been sent to the DWP in 102 cases and of these 88 clients are receiving some or all of their benefit payments into their bank accounts.
- 47 clients have been fully transferred and 2 new clients are fully set-up. It is hoped to continue to make progress in closing off 2 to 3 clients per week.

Headlines

Objectives	Conclusion	Comment
1. Clear and appropriate procedures and guidance documents are in place for all aspects of the Corporate Appointeeship process.	Reasonable	A comprehensive guidance document "Corporate Appointeeship and Access to Funds: Procedures for Managing the Finances of Service Users" has been drawn up and is regularly updated, which outlines the key principles and processes relating to Corporate Appointeeship. In addition, detailed individual procedures are in place for the initial set-up, ongoing management and closure/relinquishment of Corporate Appointeeship accounts, however the procedures for Dealing with Funds on the Death of a Client are currently in draft, awaiting clarification of certain legal matters, and require to be finalised.
2. There is clear record keeping and documentation in place for the Corporate Appointeeship process, including a clear audit trail of all actions taken and appropriate arrangements in place for storing information.	Substantial	Appropriate processes are in place for the submission and authorisation of client referrals for a Corporate Appointee service on the Mosaic system, key steps and actions taken are recorded for each client in the Financial Management Activity Log and key documentation is retained. Comprehensive records are maintained by the HSCP Financial Management Service, each client has an individual folder containing details of banking, budgets, correspondence, DWP, invoices and (where relevant) transfer information from ICMS. Detailed spreadsheets are maintained – a Master spreadsheet containing key information for each client, a DWP Status spreadsheet providing details of the benefits each client receives and the status of the transfer process and a Standing Order/Direct Debit spreadsheet.
3. A clear and timely process is in place for the initial set-up of clients' Corporate Appointeeship accounts.	Reasonable	Comprehensive processes are in place for setting up client accounts, however many of the processes have taken longer than expected to complete due to the time taken to set-up bank accounts, delays experienced with the internal processes of the DWP when processing applications and issues with setting up direct debits with utility providers.
4. Appropriate processes are in place for the creation, authorisation and recording of all payments, including the setting up and authorisation of standing orders and direct debits.	Reasonable	Appropriate processes and segregation of duties are in place for the creation, authorisation and recording of payments from individual client's Corporate Appointeeship bank accounts. All payments are created on the online banking system by a Senior Business Support Assistant and are authorised on the online system by a more senior member of staff, while payments above £500 require authorisation by a manager. Regular payments are set up by Standing Order, which require to be authorised by two members of staff. The Corporate Appointeeship bank accounts are set up under the Council's banking services contract, which went out of contract on 30 September 2021, but has been formally extended for a further year, and bank charges to client accounts require review.
5. Appropriate processes are in place for client budgeting and for undertaking monthly reconciliations of each individual client's bank account.	Reasonable	For all Corporate Appointeeship clients, an individual Budget Plan is prepared on a standard template, which includes details of the date the Budget Plan was last reviewed, the reviewing officer, monthly income and monthly outgoings. Bank reconciliations are carried out on a monthly basis – for each individual client's account the budget figures for total monthly income and total monthly expenses are directly linked to the reconciliations and details of any adjustments or variations are clearly recorded.
6. Appropriate processes are in place for ensuring clients receive all the benefits to which they are entitled and for liaising with the DWP.	Limited	The responsibilities of a Corporate Appointee include claiming benefits, completing and signing any claim forms and reporting any changes in circumstances to the DWP. In respect of surplus funds, these require to be monitored to ensure funds do not exceed levels, which may impact on clients' entitlement to benefits. These areas will require future focus to ensure that all responsibilities are fully discharged.

Areas where expected controls are met/good practice

No	Areas of Positive Assurance
1.	A comprehensive guidance document is in place which clearly outlines the key principles and processes relating to Corporate Appointeeship and includes sections on Determining the Correct Financial Intervention; Responsibilities of an Appointee; Staff involved in Corporate Appointeeship; Recording Financial Management Activity on Mosaic; Applying for Corporate Appointeeship; Creating a Budget Plan; Managing a Corporate Appointee Account; Changes to Disbursements of Funds; Requests for Additional Funds by the Client; Changes to DWP Benefit Payments; Client Surplus Funds; Changes in Circumstances and the Access to Funds Scheme. In addition, to supplement the main guidance, detailed individual procedures have been drawn up covering the initial set-up, ongoing management and closure/relinquishment of Corporate Appointeeship accounts.
2.	Appropriate processes are in place for the submission and authorisation of client referrals for a Corporate Appointeeship service on the Mosaic system, key steps and actions taken are recorded for each client on the Financial Management Activity Log and copies of key documentation are retained on the system. The HSCP Financial Management Service maintain comprehensive records for all key areas of the Corporate Appointeeship process which are regularly updated, with each client having an individual folder containing details of banking, budgets, correspondence, DWP, invoices and (where relevant) transfer information from ICMS. Detailed spreadsheets are also maintained – a Master spreadsheet containing key information for each client, a DWP Status spreadsheet providing details of the benefits each client receives and the status of the DWP transfer process and a Standing Order/Direct Debit spreadsheet, which tracks progression on setting up Standing Orders and Direct Debits for each client.
3.	Appropriate processes are in place for the initial set-up of client accounts. Detailed procedures and processes are in place covering both transfer (from ICMS) and non-transfer clients, and for each client a detailed Financial Management Activity Log is maintained, which records key information including client folder set-up on activity log, client budget sent to Community Care Worker for approval, client added to Master Spreadsheet, receipt of information from ICMS, client bank account set-up online and Corporate Appointee application paperwork sent to DWP. In addition, clear processes are in place for the completion of the banking information required to provide Corporate Banking with the appropriate details requested by the Bank to open a new bank account. A detailed process is in place for informing the DWP of the HSCP taking on Corporate Appointeeship responsibility for the client and for requesting that funds are paid into the client's new Corporate Appointee bank account.
4.	Appropriate processes and controls are in place for all payments made from individual client's Corporate Appointeeship bank accounts, including clear segregation of duties between the creation and authorisation of payments – payments are created on the online banking system by a Senior Business Support Assistant and are authorised by a second member of staff who is independent of the preparer. Regular payments are set-up by Standing Order, which require to be authorised by two members of staff, while one-off payments are recorded in the client's log of Unplanned Income and Spending within the budget spreadsheet. Appropriate supporting documentation is retained for all payments made.
5.	Appropriate client budgeting and reconciliation processes are in place. All clients have an individual Budget Plan in place and as part of the process for transferring Corporate Appointeeship clients, the documentation provided by ICMS includes a copy of the client's budget summary, which is reviewed and approved by the Community Care Worker, while for new clients HSCP staff work with the client in drawing up the budget. On a monthly basis a bank reconciliation is carried out of each client's bank account. The Budget Plan figures for Total Monthly Income and Total Monthly Expenses are directly linked to the bank reconciliations, unplanned income and unplanned spending (i.e. not included in the budget) is clearly recorded and details provided in the log of Unplanned Income and Spending, and details of any adjustments or variations are clearly recorded.

Recommendation Grading/Overall opinion definitions

Recommendation	Definition
High	Recommendations relating to factors fundamental to the success of the control objectives of the system. The weaknesses may give rise to significant financial loss/misstatement or failure of business processes.
Medium	Recommendations which will improve the efficiency and effectiveness of the existing controls.
Low	Recommendations concerning minor issues that are not critical, but which may prevent attainment of best practice and/or operational efficiency.

Levels of Assurance	Definition
Substantial Assurance	There is a sound system of internal control designed and operating in a way that gives a reasonable likelihood that the objectives will be met.
Reasonable Assurance	Whilst there is a sound system of internal control, there are minor weaknesses, which may put some of the objectives at risk or there is evidence of non-compliance with some of the controls, which may put some of the objectives at risk.
Limited Assurance	Weaknesses in the system of internal control are such as to put the objectives at risk or the level of non-compliance puts the objectives at risk.
No Assurance	Control is generally weak leaving the system open to error or abuse, or there is significant non-compliance with basic controls, which leaves the system open to error or abuse.

Internal Audit

Risk Management at a Divisional/HSCP level

May 2021

Internal Audit Assurance assessment:

Control Objective 1	Control Objective 2	Control Objective 3
Moderate Assurance	Moderate Assurance	Moderate Assurance

Timetable

Date closing meeting held: 13th May 2021

Date draft report issued: 20th May 2021

Date management comments received: Various (all before 8th June 2021)

Date Final report issued: 8th June 2021

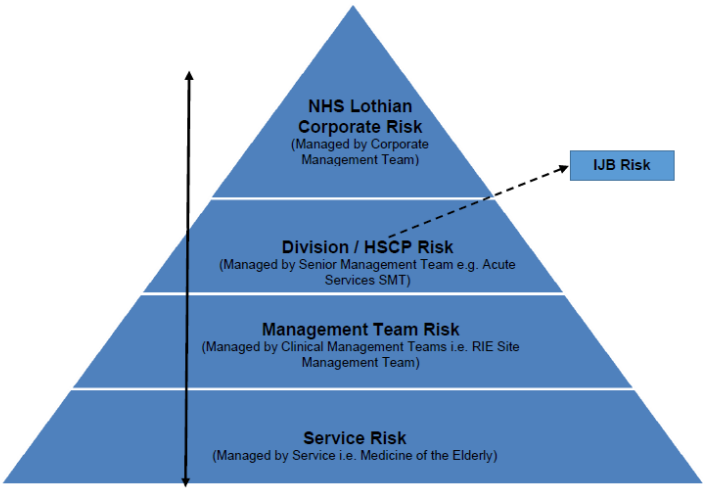
Date presented to Audit and Risk Committee: 21st June 2021

Contents

1. Introduction

1.1 Under Public Sector Internal Audit Standards (PSIAS) we are required to consider certain aspects of NHS Lothian's risk management arrangements on an annual basis. NHS Lothian have an established Risk Management Policy with a supporting Risk Management Operational Procedure to aid the implementation of the policy and ensure consistency of approach in operational risk management.

1.2 The process outlines the Risk Register Hierarchy (see diagram below), including what risks should be managed at what level. including their escalation up or down. This recognises that some risks can be managed at an operational level or lower level if they do not have an impact across the whole system.



1.3 The Quality Team has already identified areas to strengthen the risk management process at the corporate risk register level, including how risks should be accepted on to the risk register, plans to mitigate the risk, looking at risk gradings and how senior management oversight should be provided. Therefore, our review has not focused on NHS Lothian Corporate risks, but instead considered how risks are managed lower down the hierarchy, specifically at a Division/HSCP level.

Scope:

1.4 Our review has sought to support the work of the Quality Team. We have focused on the controls in place (design and operation) to ensure risks are managed at an operational level at the Division level on the hierarchy. We have considered how this is managed within each Division/HSCP. We considered the controls in place (design and operation) to ensure risks are captured, ensuring risks are not duplicated and how this links to the corporate risk register, including appropriate escalation and de-escalation of risks, focusing on how risks are escalated to a corporate risk level.

Acknowledgements

1.5 We would like to thank all staff consulted during this review, for their assistance and cooperation.

2. Executive Summary

Summary of Findings

2.1 The table below summarises our assessment of the risks and the adequacy and effectiveness of the controls in place to meet each of the risk areas agreed for this audit. Definitions of the ratings applied to each action are set out in **Appendix 4**.

No.	Control Objectives	Assurance Level	Number of Findings			
			Critical	High	Medium	Low
1	Risks at a Divisional/HSCP level are being captured and considered by the right teams on a regular basis	Moderate Assurance	-	-	2	-
2	Risks are being addressed and are given appropriate attention to reduce their impact or likelihood, with appropriate senior management oversight	Moderate Assurance	-	-	2	-
3	Significant risks recorded at the Divisional/HSCP level are escalated to the corporate risk register if appropriate and in a timely manner	Moderate Assurance	-	-	1	-
Total			-	-	5	-

Conclusion

2.2 Through discussions with the Divisions/HSCPs, each were clear on their responsibilities in relation to risk, why risk management is important and how risks should be identified and documented. This could be articulated through the management of risks during the COVID-19 pandemic, requiring services to respond quickly, and risks be managed in an agile manner. Additionally, the Divisions/HSCPs were comfortable with how they could escalate risks if they could not be managed at the Divisional level and how to do this appropriately. However, it was also recognised that DATIX (the risk management system) was not always updated to reflect the risk management processes being undertaken on a day-to-day basis and areas for improvement were required.

2.3 A good culture around risk management within the Divisions/HSCPs was noted through our discussions, with all being aware of their responsibilities in relation to risk and examples provided to demonstrate how risks have been managed during the COVID-19

pandemic. Additionally, there was a good understanding of what risks should be managed at what level and where escalation may be required. However, there is in some places a lack of formalisation of processes and documentation behind the understanding demonstrated. This has been recognised throughout the Divisions, with East Lothian HSCP implementing a quarterly Risk Management Group, Edinburgh HSCP setting up a Risk Management Forum and Committee and REAS looking to formalise processes to make risk management business as usual as we emerge from the COVID-19 pandemic.

2.4 Areas for improvement identified through our review included:

- Formalising the risk management procedures in place within each Division/HSCP to clearly articulate how risks are managed, through which groups and how often, to ensure responsibilities in relation to risk management are clearly documented.
- Performing an overall review of the risks captured in DATIX and ensuring they are updated accordingly, as the risks were outdated in a lot of cases.
- Ensuring all senior management teams at the Divisions/HSCP are considering risks as a standing agenda item and ensuring general managers and service line managers are considering risks as part of their formal meetings too.
- Considering within the Divisions/HSCP how formalised reporting of progress against actions for high and very high rated risks could be incorporated into their risk management procedures to provide assurance over the actions being taken.
- Reconsidering how Divisional/HSCP high or very high risks could be reported into NHS Lothian, given the refreshed role of the CMT. There is also an opportunity to create a more formalised escalation route for risks to NHS Lothian via this route. Any changes made to the reporting and flow of risks should be updated in NHS Lothian's Risk Management procedures.

Methodology and Approach

2.5 We conducted interviews with staff from all Divisions/HSCPs to gain an understanding of the risk management processes in place at each. In addition, we reviewed their risk registers and supporting documents to assess how risks were being captured and considered on DATIX. Where possible, we obtained evidence of senior management team meeting minutes or minutes/agendas from other groups to corroborate the processes described by management.

2.6 It should be noted that we reviewed the controls in place over the capturing and recording of risks, linked to senior management oversight and escalation, however, we have not reviewed the legitimacy or accuracy of the risks identified as part of this review.

2.7 A complete listing of staff involved, and documents reviewed can be seen at **Appendix 3**.

3. Management Action Plan

Control objective 1: Risks at a Divisional/HSCP level are being captured and considered by the right teams on a regular basis	
Finding 1.1 – Not all divisions have defined risk management procedures in place	**Medium**
There is notable variation in how risks are managed across the Divisions/HSCPs. This is expected given the differing governance structures and functions each has. The risk management processes currently used or recently implemented by each has been summarised within Appendix 1. However, not all risk management processes within the Divisions/HSCPs are formalised, either via a procedural document or flow chart. Paragraph 4.23 of the NHS Lothian Risk Management procedure states that all senior management teams should have an explicit process in place for managing risks within their own area. Whilst the processes in place for risk management could be described by all, there is a risk that without a formalised document describing these processes that all relevant parties, including service level managers, lack clarity in responsibilities in relation to risks. Additionally, there were instances where meetings relating to risks were not minuted, such as the quarterly risk management meeting at East Lothian HSCP, and there would be benefit in doing so in order to provide robust evidence of the system in control in place relating to risk and for clear documentation of how decisions have been made.	
<u>Recommendation</u> All Divisions/HSCPs should ensure they have documented procedures, aligning to the NHS Lothian risk management framework, which clearly articulate their risk management processes. Additionally, risk management meetings should be formally minuted, documenting discussion of risks and how key decisions relating to risks have been made.	
<u>Management Response, Action, Responsibility and Target Date</u> Management responses, actions and target dates have been received from each of the Divisions/HSCPs for this recommendation. These have been included at Appendix 2 for each. When writing this report, we were aware not all actions applied to each of the Divisions/HSCPs and we asked management to consider each finding in relation to their own procedures and reflect on improvements which could be made. We are satisfied where management have stated that they already comply with the recommendation that we agree and that no action is required.	

Control objective 1: Risks at a Divisional/HSCP level are being captured and considered by the right teams on a regular basis	
Finding 1.2 – Datix is not up to date for all Divisions/HSCPs with areas for improvement noted	**Medium**

Through interviews with Divisions/HSCPs it was acknowledged that DATIX (the risk management system) is not always kept up to date. This is partly reflective of the COVID-19 pandemic where risks have been managed on a much more agile basis, and the discipline of updating DATIX has not been a high priority. This has occurred to varying degrees at each Division/HSCP.

This was corroborated through review of each Divisions/HSCPs risk register where the following areas for improvement were noted:

- Review of risks are not always being performed in a timely manner, with many reviews past their due dates. Multiple occasions of this happening could be seen in each Division/HSCP risk register (with the exception of Midlothian HSCP). For example, some risks are listed on DATIX as requiring review in 2017, yet this has not been updated since. In addition, reviews were overdue where controls were deemed to be inadequate, and therefore we would expect these to be being considered in a more urgent manner.
- Poor articulation of risks and their associated action plans. This was noted throughout all risk registers where the action plan included refence to a specific group but did not always outline what that group was expected to achieve in relation to management of the risk. In addition, the adequacy of controls is not always documented beside the action plan. This occurred in REAS, Acute, East Lothian, West Lothian and Edinburgh HSCP's risk register.
- Potentially outdated risk ratings or no risk rating associated with identified risks. For example, within REAS, Acute and Edinburgh HSCP's risk register there were a number of High rated risks, where the adequacy of controls was noted as satisfactory which could indicate that the risk had been managed to a lower level and a reduction in rating required. In addition, there were 3 risks within the Acute risk register with no grading, and 4 within Edinburgh HSCP with no grading.
- Duplication of risks within risk registers. For example, within Edinburgh HSCP there were multiple risks relating to lone working/violence and aggression with very similar action plans associated. In addition, this is a risk on the corporate risk register, and should be reviewed in conjunction with this to ensure each risk register only includes actions relating to each. Additionally, REAS includes risks on self-harm and ligature, which are directly linked and could be amalgamated into one risk.
- Duplication of risks to the corporate risk registers. For example, on the REAS risk register risk 2386 relates to Traffic Management. This is not articulated as to how REAS would specifically manage the risk, and therefore, this would be more appropriate to be solely on the corporate risk register. In addition, Acute has two risks relating to Access to Treatment which are also held on the corporate risk register.

However, the differentiation of how the risk is being managed at each level is not currently clear, with actions overlapping.

Whilst examples have been pulled out from specific risk registers above, the same themes for improvement appeared across most risk registers. Additionally, it should be noted that outdated DATIX entries was a known area for improvement identified through all interviews undertaken, and work is underway within each Division/HSCP to update these.

Recommendation

Each Division/HSCP should perform a review over their senior management team risk register to ensure risks are appropriately documented on the risk management system. This should consider, but is not limited to the following:

- can risks be managed at an operational level (i.e. do they actually need to be on the divisional risk register)
- does the risk description articulate the residual risk not being managed by the service level
- who owns the risk and associated controls and do the controls set out clear lines of accountability
- is there a plan in place to manage higher level risks which will be appraised by senior management
- does the risk rating reflect the residual risk taking into account the plans in place
- is there any overlap/duplication of risk.

Going forwards, Divisions/HSCP should look to update DATIX on a more regular basis, the process for which could be documented in the procedures developed from Finding 1.1.

Management Response, Action, Responsibility and Target Date

Management responses, actions and target dates have been received from each of the Divisions/HSCPs for this recommendation. These have been included at Appendix 2 for each.

When writing this report, we were aware not all actions applied to each of the Divisions/HSCPs and we asked management to consider each finding in relation to their own procedures and reflect on improvements which could be made. We are satisfied where management have stated that they already comply with the recommendation that we agree and that no action is required.

Control Objective 2: Risks are being addressed and are given appropriate attention to reduce their impact or likelihood, with appropriate senior management oversight	
Finding 2.1 – Not all Divisional/HSCP Senior Management Teams or service delivery teams have risk as a standing agenda item at their monthly meetings.	**Medium**

It is expected that senior management teams of each Division/HSCP will have oversight of the risk management processes within their service, and that risks should be considered as part of the senior management team meetings. Additionally, risks should be considered by management teams and service level teams below their level – and evidence of this happening could not always be provided. It was noted through interviews at the time of the audit that the following practices were occurring:

- Acute risks are managed at the Clinical Management Group level, with these risks being escalated directly to NHS Lothian Executive Team via the Healthcare Governance Committee, if necessary. These risks are not going through the Acute Senior Management prior to escalation as should be the process. In addition, as the Clinical Management Group focus on clinical risks, there is currently no formal forum to consider wider risks facing the service.
- REAS risks are considered at each senior management team meeting, but not as a standing agenda point or in relation to the risk register. Additionally, it was noted that risk is not currently a standing agenda point on general managers meetings.
- East Lothian and Edinburgh HSCP have recently implemented a governance structure for the management of risks. However, these structures do not feed directly into their senior management teams to provide oversight to them. Whilst it is recognised that members of the senior management team (including the Chief Officer) will be on the risk committees, it would still be prudent to report risks or activity of the risk management groups to the senior management teams. Additionally, the frequency these groups plan to meet may not allow for timely consideration of risks. For example, very high risks should be being considered on a monthly basis – and it may be better to consider these at the senior management team meetings than wait for the quarterly risk reporting groups.
- East Lothian, West Lothian and Edinburgh HSCP noted that risks would be escalated to a senior management level via general managers if necessary. However, it was not evidenced that general managers consider risks as a standing agenda item or on a regular basis.

It should be recognised that improvements have been made since the time of the audit, with REAS, for example, including risk as a standing item on their Performance Management Agenda.

Recommendation

All Divisions/HSCPs should ensure risk is a standing agenda item on the senior management team agenda. This should be done even where risks are being managed through another committee (such as East Lothian and Edinburgh HSCP) to ensure the whole senior

management team have oversight of the risks and the process for managing risks. The review of risks should be minuted as part of the monthly meetings to document the oversight provided by the senior management teams. Additionally, each Division/HSCP should ensure that management teams and service levels below them are considering risks on a regular basis. This could be done by ensuring team meetings consider risk as a standing agenda point, or through other committees, such as at Midlothian HSCP where all general managers attend the Business Governance Group and discuss their individual risk registers. This would provide assurance to the senior management team that risks are being considered at this level.
<u>Management Response, Action, Responsibility and Target Date</u> Management responses, actions and target dates have been received from each of the Divisions/HSCPs for this recommendation. These have been included at Appendix 2 for each. When writing this report, we were aware not all actions applied to each of the Divisions/HSCPs and we asked management to consider each finding in relation to their own procedures and reflect on improvements which could be made. We are satisfied where management have stated that they already comply with the recommendation that we agree and that no action is required.

Control Objective 2: Risks are being addressed and are given appropriate attention to reduce their impact or likelihood, with appropriate senior management oversight	
Finding 2.2 – Formalised review of risks at a senior management team level should be introduced for higher level risks	**Medium**
NHS Lothian's Risk Management process recommends that a review of the risk register should be carried out at least every 3 months at the appropriate level, although individual risks, depending on their risk rating, may be reviewed more frequently. It is also recommended that risks should be reported to an appropriate forum/committee within the Divisions/HSCPs to consider progress against actions. For very high risks, this could be done once monthly and for high risks every three months by the senior management team. With medium and low level risks considered on a less frequent basis and can be via management teams, rather than the senior management teams. Through discussions with the Divisions/HSCPs, risks, including very high and high level risks are being managed by risk handlers on an ongoing basis and discussed with risk owners on a one-to-one basis but there is not necessarily formalised compliance reporting of progress against actions to a forum such as the senior management team. There is a risk that without formalised reporting of risks against action plans, that actions are not addressed in a timely manner or actions do not reflect the risk as it changes. Again, it is recognised that the risk rating of some risks may be higher than required, as per Finding 1.2 and reporting against all high level risks may not be required once a review of DATIX has been performed.	
<u>Recommendation</u> There is an opportunity for the Divisions/HSCPs to consider how to incorporate compliance checks of high and very high level risks to their risk management processes, reporting progress against action plans to the relevant senior management teams or risk forums at an appropriate frequency. These should go as papers to the relevant committees with discussions minuted accordingly. The agreed process should be incorporated into the formalised procedures, as per Finding 1.1. This process should be considered following a review of DATIX and the risk ratings, as per Finding 1.2 to ensure risk ratings are appropriate and do not result in over-reporting.	
<u>Management Response, Action, Responsibility and Target Date</u> Management responses, actions and target dates have been received from each of the Divisions/HSCPs for this recommendation. These have been included at Appendix 2 for each. When writing this report, we were aware not all actions applied to each of the Divisions/HSCPs and we asked management to consider each finding in relation to their own procedures and reflect on improvements which could be made. We are satisfied where management have stated that they already comply with the recommendation that we agree and that no action is required.	

Control Objective 3: Significant risks recorded at the Divisional/HSCP level are escalated to the corporate risk register if appropriate and in a timely manner	
Finding 3.1 – There is an opportunity to consider the process for reporting and escalating risks, incorporating the refreshed role of the CMT in relation to risk.	**Medium**

The NHS Lothian Risk Management procedure includes an escalation flowchart. Within this it states that where risks are unable to be managed at a Divisional/HSCP level then the Risk Owner should present the risk to an appropriate Executive Director prior to discussion at CMT to ensure all efforts to mitigate the risks are appraised.

Through interviews with the Divisions/HSCPs it was noted that known escalation routes did include discussing the risk with their relevant executive director, as well as taking the risks through the Healthcare Governance Committee. However, it was unclear what the process was once a risk had been flagged to an Executive Director or the Healthcare Governance Committee. Additionally, the Healthcare Governance Committee's role in relation to risk is around assurance over the actions taken to mitigate risks and not necessarily to escalate risks to the corporate risk register level, therefore, not an appropriate medium to escalate risks.

Additionally, as stated at paragraph 6.1 of the NHS Lothian Risk Management procedure, every 6 months Divisional High/ Very High risks are reported to the Audit and Risk Committee. On review of Audit and Risk Committee meeting minutes from April 2019 to April 2021, this has not been taking place. On reflection, however, it should be considered whether the Audit and Risk Committee is the best forum for these risks to be reported to given their focus on the corporate risk register and supporting the Board in their assurances over risk.

It is recognised, that the corporate management team (CMT) are taking a more formal role in relation to risk management, where the corporate risk register is going to be discussed every 2 months. It would be appropriate to consider how this forum can be used to formalise the process for the escalation of risks as well as the reporting of risks from the Divisional/HSCP level. It would still be appropriate to report very high or high divisional risks to provide oversight of risks which could impact NHS Lothian or which may require to be escalated on to the corporate risk register.

<u>Recommendation</u>

There is an opportunity for NHS Lothian to consider how risks from a Divisional/HSCP level should be reported going forwards, with the NHS Lothian risk management framework being updated accordingly. Now a more formalised process, the review of the corporate risk register by the CMT could include the review of Divisional high and very high risks (shifting this responsibility away from the Audit and Risk Committee). In addition, this could include consideration of any risks at a Divisional/HSCP level which have been escalated which may need to be included on the corporate risk register.

NHS Lothian's risk management procedures should be updated to incorporate the refreshed role of the CMT and reporting which will be reviewed as part of their remit. These changes should be communicated to the Divisions/HSCPs.

<table>
<tr><td colspan="2">Management Response

• The CMT will consider twice a year high and very high risks at an Acute and HSCP level to assess risks that may require escalation onto the CRR.
• The CMT Risk paper will ask that the CMT consider any operational risks that require escalation for potential inclusion on the CRR.
• The review of NHSL Risk Policy and Procedure (2018) will incorporate audit findings and response including the role of the CMT.

Management Action

• The first consideration of high and very high risk from across the system will take place in September 2021.
• The CMT paper will have within it a standard section asking the CMT to consider strategic and operational risks for potential escalation on to the CRR from June 2021.
• The NHSL Risk Policy and Procedure is due for review which will be completed by October 2021 and will incorporate internal audit findings and actions.</td></tr>
<tr><td>Responsibility:

Associate Director for Quality Improvement & Safety</td><td>Target Date:

As outlined above for the 3 actions to be taken (June 2021, September 2021, October 2021)</td></tr>
</table>

4 Internal Audit Follow-up Process

4.1 Approximately two weeks following issue of the final Internal Audit report, a member of the Audit Team will issue an ‘evidence requirements’ document for those reports where management actions have been agreed.

4.2 This document forms part of the follow up process and records what information should be provided to close off the management action.

4.3 The follow-up process is aligned with the meetings of the Board’s Audit & Risk Committee. Audit Sponsors will be contacted on a quarterly basis with a request to provide the necessary evidence for those management actions that are likely to fall due before the next meeting of the Audit and Risk Committee.

4. Appendix 1 – Risk Management Processes

Below outlines the high level processes described to us by each of the Divisions/HSCPs during the interviews undertaken. Where possible, we have corroborated these processes.

West Lothian HSCP
West Lothian HSCP Senior Management Team (SMT) meet formally once a month. Risk is on the agenda of each SMT meeting, and a formal review of the risk register is performed at SMT every quarter. Monitoring of risks will be done on a one-to-one basis between the Risk Handler and Risk Owner, and this is not currently minuted or evidenced.
East Lothian HSCP
East Lothian HSCP over the last 6 months, have implemented quarterly risk management meetings specifically for risks where a review of the risk register is performed. However, these meetings are not currently minuted. Monitoring of risks is through these meetings, however, again this review is not currently minuted or evidenced.
Midlothian HSCP
Midlothian HSCP Senior Management Team meet every 2 weeks and risk is a standing agenda item. The Senior Management Team is supported by 4 committees (Business Governance Group, Finance and Performance, Staff Governance and Clinical Care and Governance) each of which have risk as a standing agenda item. Service level risks are considered monthly via the Business Governance Group. Monitoring of risks is through these forums. This process is supported by Midlothian's HSCP Risk Reporting Structure.
Edinburgh HSCP
Edinburgh HSCP have recently introduced a Partnership Risk Committee and Partnership Risk Forum to manage risks. The Forum will meet every 2 months and feed into the Committee which will meet every quarter. Given this is a new process, minutes of these meetings could not be provided at the time of the audit. Monitoring of risks is planned to be via the forum and committee going forwards. This process is supported by Edinburgh HSCP Risk Management Guidance.
REAS
Recognising the change in the senior management team in REAS just prior to and during the COVID-19 pandemic, risk management procedures have not yet become business as usual. The senior management team meets formally once a month where pertinent and emerging risks are discussed and monitored. However, risks or the review of the risk register is currently not a standing agenda item on the senior management team meetings. Since initial discussions with internal audit, this has been improved with the risk register forming a standing item on the monthly performance meetings agenda.
Acute Services
Risks relating to service areas are discussed through the Acute Services Clinical Management Group and is a standing agenda item. Risks identified at this group are reported to the Healthcare Governance Committee. However, there is not a formal process in place to review risks at a Senior Management Team level. Monitoring of risks is currently through the Clinical Management Group.

5. Appendix 2 - Management Responses, Actions, Responsibility and Target Dates

	Management Response	Management Action	Responsibility &Target Date
REAS Responses			
Finding 1.1	REAS has introduced a monthly performance meeting - the first meeting was on 5th May and risk register was on agenda and will be discussed routinely going forward.	Ensure Risk register is on agenda for REAS monthly performance meetings going forwards.	Responsibility: REAS Services Director Target Date: Now complete (following initial discussions with internal audit)
Finding 1.2	Risk Registers will be reviewed through performance meeting discussions and ensure that the mitigations are appropriate to the risk and the residual risk rating is commensurate. Business Manager, when appointed, will have responsibility for updating the risk register quarterly on portfolio.	Maintain performance meeting. Appoint Business Manager.	Responsibility: REAS Services Director Target Date: 31.08.2021 to allow appointment process
Finding 2.1	New Performance meeting introduced - the first meeting was 5th May 2021. This will be monthly going forward and risk register will be a standing item	Ensure performance meetings happen	Responsibility: REAS Services Director Target Date: Now complete (following initial discussions with internal audit)
Finding 2.2	New Business Manager will have responsibility of working with senior managers to ensure action plans to mitigate risks are progressed and reported to performance meeting.	Continue performance meeting. Appoint Business Manager.	Responsibility: REAS Services Director Target Date: 20.05.2021
Midlothian HSCP Responses			
Finding 1.1	Midlothian Health and Social Care Partnership meets this recommendation. We have well documented procedures in place which align to the NHS Lothian Risk Management framework. Risk is reviewed routinely at governance meetings with minutes and action logs to ensure accurate recording of risk and allows for ongoing monitoring.	Midlothian Health and Social Care Partnership will continue our work to ensure risk is accurately recorded and well monitored. Ensuring that the importance of risk management is well communicated to all staff and those identified as risk owners/handlers are clear on their responsibilities and accountabilities.	N/A
Finding 1.2	Midlothian Health and Social Care Partnership already has strong processes in place to ensure we are complaint with this requirement. Each Service has a local risk register which is reviewed at Business Governance meetings, if escalation is required, risks are taken to HSCP		N/A

	SMT for discussion, where appropriate and agreed, they are added to HSCP SMT risk register which is maintained by the Risk Management lead (Roxanne King – Business Manager). All risks are assigned an appropriate owner and handler and have clear and effective mitigation in place to control. Minor level of overlap/duplication due to the nature of our structure but impact is kept to a minimum by having a clear structure in place. No action required	
Finding 2.1	As detailed within the recommendation, Midlothian Health and Social care ensures that risk is a standing agenda item on all governance meetings as well as a standing agenda item on the Senior Management Team two weekly meeting. No action required	N/A
Finding 2.2	Midlothian Health and Social Care Partnership carries out compliance checks of high or very high risks as part of an additional quarterly review of risk management at the Senior Management Team meeting. This is to ensure that controls in place are mitigating the risk and the risk is either stabilised or decreasing in likelihood/impact. Updates are added onto the HSCP SMT risk register on Datix with next review date added. High severity risks are monitored every 2 weeks during Senior Management team (as indicated on Datix). No action required	N/A
Acute Services Responses		
Finding 1.1	Risk management processes embedded in site and services Directorates. Signed off through Site and Service Hospital Management Groups (HMG/Directorate SMT). Acute Risk Register formally discussed and signed off at Acute Senior Management Team (SMT) 3 monthly or by risk review date:- • New risks will be identified via a proforma monthly and recorded with rationale of why added to Acute Risk Register also recorded. • Existing risks will be reviewed and risk mitigations discussed and recorded.	Responsibility: Chief Officer for Acute Services Target Date: At Acute SMT Jun 24th 2021, and monthly thereafter.
Finding 1.2	Full review of Acute Risk Register at SMT on 24 June 2021 3 monthly review of risks at SMT thereafter, or in line with risk review date. Datix updated after each SMT. • Risks for escalation or review monthly agenda item. Datix updated after each SMT. • Site and Service Directorates and Acute Division Risk Registers on DATIX.	Responsibility: Chief Officer for Acute Services Target Date: By/ at Acute SMT – 24th Jun 2021
Finding 2.1	Site and service teams have risk register as a standing agenda item on their monthly management team meetings. Risk Workshops to be supported at local site and directorate level by Acute Business Manager.	Responsibility: Triumvirate (Chief Officer for Acute Services, Medical & Nursing

	Clinical risks standing agenda item on acute Clinical Management Group (CMG). Monthly review of Clinical risks takes place at CMG. Chaired by Acute Nurse Director and Acute Medical Director. Minuted discussion. New risks and risks for review standing agenda item on Acute SMT from June 2021 incl. onwards and following discussion DATIX will be updated. Review of risks on Acute SMT Agenda 3 monthly or by risk review date. Monthly review through CMG and Acute SMT.		Directors & Acute service business manager) Target Date: SMT - Jun 24th 2021 and monthly thereafter
Finding 2.2	As above. Process already embedded for CMG Acute SMT 3 monthly or by risk review date for all including High or Very High risks - with progress against action plans recorded.		Responsibility: Triumvirate (Medical & Nursing Directors & Acute service business manager) Target Date: June 2021 – Acute SMT
West Lothian HSCP			
Finding 1.1	Whilst there are arrangements in place for identifying risks across the organisation, it is accepted that there could be clearer processes in place and documented procedures which explain the partnership's approach to risk management. Whilst risk management is discussed in a range of forums, it is again accepted that there is no written process which outlines expectations or defines responsibilities around this across the organisation. Risk management is discussed on a regular basis at the partnership's senior management team and in the NHS management senior management team meeting but we need to review how risks are escalated and put a formal arrangement in place for recording discussions and assessing risk.	A full review will be undertaken by the senior management team of the governance routes for risk management including where risks are discussed and documented having regard to the Lothian Risk Management Procedure as recommended. The review will be complete and revised processes and procedures put in place by 30th June 2021 to give time for a comprehensive review to be undertaken and revised arrangements put in place. Arrangements have already been put in place for discussion about risk to be minuted and will become a standing item on the agenda for meetings.	Responsibility: West Lothian HSCP Head of Health Target Date: 30 June 2021
Finding 1.2	A review of the risk register is already underway and with the risk register being a standing item on the agenda for management team meetings, it should give the required assurance over risks being current and subject to review.	Review of risk register to be completed by 30 June 2021.	Responsibility: West Lothian HSCP Head of Health Target Date: 30 June 2021
Finding 2.1	Discussion does take place regarding risks and risks escalated by General Managers where appropriate, but it is accepted that this is not always documented in	Risk management is now included as a standing item on the agenda for management team meetings. General managers will be expected	Responsibility: West Lothian HSCP Head of Health Target Date:

	the way it should be. Further action has been taken recently on training for Senior Managers across the Partnership to ensure that we are consistent in our assessment of risk.	to report on risk in their area as a matter of course in those meetings.	30 June 2021
Finding 2.2	A degree of consistency is required in the partnership on compliance checks details of which will be included in revised documentation.	Details of the frequency of compliance checks will be incorporated into the review of risk management and incorporated into written processes for the partnership.	Responsibility: West Lothian HSCP Head of Health Target Date: 30 June 2021
Edinburgh HSCP			
Finding 1.1	The Edinburgh Health and Social Care Partnership recognise that they are on a journey in relation to their risk management approach and have developed an integrated approach to risk management that aligned to the approaches taken my partners.	• Roll out its risk management approach across the Partnership which includes guidance on how to identify risks, monitor, escalate and review risks. • Ensure Risk Committees and Forums will be minuted.	Responsibility: Edinburgh HSCP Chief Officer and Operations Manager Target Date: June 2022
Finding 1.2	The Partnership Executive Management Team recognise that they have further work to embed their new integrated approach to risk management which includes an approach for ensuring risks are managed at the right level within the organisation and a mechanism to escalate risks whether appropriate and that the.	• Review and agree the Executive Team risk register. • Work with the Wider Leadership Team through the Risk Forum and their management teams to develop divisional and team risk registers • Embed the escalation process from team to risk forum to ensure risk is managed at the correct level • Review risks across the Partnership for any overlap / duplication or areas where a risk is consistently being raised and make recommendations to the Risk Committee. • Agree the most appropriate risk management recording tool.	Responsibility: Edinburgh HSCP Operations Manager Target Date: June 2021
Finding 2.1	The Partnership recognises that risk needs to continue to be a focus within all teams with the Partnership and as part of the rollout of the risk management guidance, teams will be involved in developing their risk registers and looking at mechanisms in place to	• Development of a process note on where risks will be discussed for each team and what frequency this will be undertaken. Risk registers should also go via the Operational and Strategic Management Teams to	Responsibility: Edinburgh HSCP Operations Manager Target Date: June 2022

	ensure risks are regular discussed through focussed discussions at management teams or team risk committees set up.	provide a divisional overview of common risks. • Scrutiny of team risk registers as a role of the Risk Forum • Risk activity report to be submitted to the risk forum and an update report from the Forum on to the Committee • Clear communication how to escalate risks to the Risk Forum	
Finding 2.2	The Partnership recognise the importance of robust risk management procedures and the rollout and embedding of the risk management guidance should ensure that there is appropriate scrutiny of very high and high risks, and these should be adequately monitored through DATIX.	• All high or very high risks (and associated actions plans) will be scrutinised at the Risk Forum on a bi-monthly basis. Where the risk rating cannot be reduced, they will be escalated to the Partnership Risk Committee.	Responsibility: Edinburgh HSCP Operations Manager Target Date: June 2022
East Lothian HSCP			
Finding 1.1	Risks are discussed and registers updated quarterly the risk register is a live document however, no minute of this meeting is kept.	Quarterly risk meeting to be minuted.	Responsibility: East Lothian HSCP Chief Officer Target Date: 30th September 2021
Finding 1.2	East Lothian consider that DATIX is updated on at least a quarterly basis however will review the commentary around responsibility for actions.	Review commentary on responsible officers and actions.	Responsibility: East Lothian HSCP Chief Officer Target Date: 30th September 2021
Finding 2.1	Risks are discussed in an individual basis and escalated to the risk management meetings but will be added to the senior manager meetings as a standing agenda item	Add Risk Management to agenda for management team meeting.	Responsibility: East Lothian HSCP Chief Officer Target Date: 30th September 2021
Finding 2.2	East Lothian Risk Register is reported to the IJB Audit and Risk Committee on a regular basis. It also is reviewed through East Lothian Council and NHS Lothian processes as required.	Continue to report to relevant governance committees.	Responsibility: East Lothian HSCP Chief Officer Target Date: 30th September 2021

6. Appendix 3 – Staff Involved and documents reviewed

Staff Involved:

- Associate Director for Quality Improvement & Safety
- Quality & Safety Assurance Lead
- Acute Hospital Services Chief Officer
- Acute Nurse Director
- Acute Service Business Manager
- REAS Services Director
- Edinburgh HSCP Director
- Edinburgh HSCP Chief Finance Officer
- Edinburgh HSCP Operations Manager
- Edinburgh HSCP Head of Operations
- East Lothian HSCP Chief Officer
- East Lothian HSCP Head of Operations
- East Lothian HSCP Emergency Planning, Risk and Resilience Officer
- West Lothian HSCP Chief Officer
- West Lothian HSCP Head of Health
- Midlothian HSCP Chief Officer
- Midlothian HSCP Business Manager
- Midlothian HSCP Integration Manager

Documents Reviewed:

- NHS Lothian Risk Management Policy
- NHS Lothian Risk Management Operational Procedure and associated documents
- Corporate Single System Services Risk – 15th March 2021
- Audit and Risk Committee minutes April 2019 - April 2021
- Audit and Risk Committee Corporate Risk Register Paper – 26th April 2021
- NHS Lothian Risk Management Architecture – July 2020
- Chief Officers Meeting (IJBs) – Risk Mapping Paper – 28th October 2019
- Edinburgh HSCP Executive Team Risk Register – 27th April 2021
- Edinburgh HSCP Risk Management Guidance v.04
- Edinburgh HSCP Partnership Risk Committee v.03
- Edinburgh HSCP Partnership Risk Forum v0.3
- Edinburgh HSCP Risk Committee Papers – 6th April 2021
- REAS Risk Register – 28th April 2021
- REAS SMT Minutes – 17th March 2021, 17th February 2021
- REAS Performance Management Agenda – 5th May 2021
- Midlothian HSCP Risk Register – 30th April 2021
- Midlothian HSCP Risk Reporting Structure
- Midlothian HSCP SMT Agenda – 28th April 2021,
- Midlothian HSCP Business Management Committee Agenda – 27th April 2021
- Midlothian HSCP example service level risk register – April 2021
- East Lothian HSCO Risk Register – 12th May 2021

7. Appendix 4 - Definition of Ratings

Findings and management actions ratings

Finding Ratings	Definition
Critical	A fundamental failure or absence in the design or operating effectiveness of controls, which requires immediate attention
High	A key control failure has been identified which could be either due to a failure in the design or operating effectiveness. There are no compensating controls in place, and management should aim to implement controls within a calendar month of the review.
Medium	A control failure has been identified which could be either due to a failure in the design or operating effectiveness. Other controls in place partially mitigate the risk to the organisation, however management should look to implement controls to fully cover the risk identified.
Low	Minor non-compliance has been identified with the operating effectiveness of a control, however the design of the control is effective

Report ratings and overall assurance provided

Report Ratings	Definition	When Internal Audit will award this level
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 one Critical finding or a number of High 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)
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)
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)