Cancer Services
Final Internal Audit Report

May 2024

Cardiff & Vale University Health Board

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

Contents

Review reference:	CVU 2324-23
Report status:	Final Report
Fieldwork commencement:	December 2023
Fieldwork completion:	29th February 2024
Debrief meeting:	1st March 2024
Draft report issued:	12th March 2024
Management response received:	30th April 2024
Final report issued:	1st May 2024
Auditors:	Ian Virgil – Head of Internal Audit Lucy Jugessur – Deputy Head of Internal Audit Andrea Calise – Audit Manager
Executive sign-off:	Paul Bostock – Chief Operating Officer
Distribution:	Matthew Temby – Director for Planned and Specialised Care Michael Eastwell – General Manager for Cancer services
Committee:	Audit & Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

Acknowledgement
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Executive Summary

Purpose

Review the effectiveness of the structures and processes in place to provide sustainable cancer services that deliver the single cancer pathway standards.

Overview

We have issued reasonable assurance on this area. The matters requiring management attention include:

- Further clarity on the remit, roles and responsibilities of clinical boards and the Cancer Services Team.
- Improve the visibility of suspected cancer patients entering pathways.
- Undertake a technology gap analysis of the current IT Infrastructure and its ability to support the cancer delivery remit.
- Secretarial support is advised for documenting the Executive Cancer Board business.
- Define the risk management process for the Cancer Services team.

Other recommendations / advisory points are within the detail of the report.

Report Opinion

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved

Assurance summary[1]

Objectives		Assurance
1	Roles and responsibilities	Reasonable
2	Governance Arrangements	Reasonable
3	Improvement trajectories and action plans	Substantial
4	Performance metrics	Substantial
5	Monitoring and reporting	Reasonable

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Clarity on roles and responsibilities	1	Operation	Medium
2	Visibility of patients on Suspected Cancer Pathways	1	Operation	High
3	Executive Cancer Board business is not minuted	2	Design	Medium
4	Define risk management arrangements for the Cancer Service Team	2	Design	Medium

1. Introduction

1.1 Our audit review of Cancer Services was completed in line with the 2023/24 internal audit plan for Cardiff and Vale University Health Board (the 'Health Board').

1.2 Welsh Government developed the Single Cancer Pathway as a way of improving cancer outcomes in Wales. In November 2018, a Single Cancer Pathway was introduced which started from the moment a cancer is first suspected and therefore is a more accurate way of measuring the times to treatment for patients that are in the health system. We note that Cardiff and Vale began reporting against the SCP in December 2020. The 62-day waiting time measure includes patients referred from primary care or found to have cancer in hospital care.

1.3 Welsh Government has introduced the Single Cancer Pathway as one of the Ministerial Priorities of "reduction in backlog of patients waiting over 62 days to enable delivery of 75% of patients starting their first definitive cancer treatment 62 days from point of suspicion."

1.4 To inform the review, we held several meetings with staff from the Cancer Services Team and staff from a sample of three Clinical boards:

- Clinical, Diagnostics & Therapeutic
- General Medicine
- General Surgery

1.5 The Chief Operating Officer was the lead Executive for this review.

Audit Risks

1.6 The potential risk as detailed within the Board Assurance Framework is as follows:

- There is a risk that the organisation will not be able to provide effective, high quality and sustainable cancer services.

2. Detailed Audit Findings

Objective 1: The Health Board has a structure to support the delivery of Cancer Services, which includes clearly defined roles and responsibilities within the Cancer Team and the Clinical Boards.

2.1 The Chief Operating Officer is the Executive Lead for cancer delivery which is part of the Planned Care Programme.

2.2 The Health Board has developed a roadmap for delivering improvements across its cancer services and has agreed several deliverables within its 5-year Cancer Strategy (2023-28). The Strategy adopts the Welsh Government's Quality Statement for Cancer and builds on the Cancer improvement Plan for NHS Wales (2023-26) issued by the Welsh Cancer Network.

2.3 The Cancer Services (CS) team is a centralised function within the Health Board. Its remit is to oversee and scrutinise the system-wide management of cancer

patients as they enter and progress through the pathway (from the point of suspicion through to their initial treatment). The team provides guidance and support to the 13 tumour sites on pathway management ensuring compliance with Welsh Government guidance (Welsh Health Circular 2023/025 – Guidelines for managing patients on the suspected cancer pathway).

2.4 The CS Team consists of a management team made up of operational staff (two Improvement Project Managers, Cancer Service Manager and General Manager for Cancer) and clinical staff (Lead Cancer Nurse, Lead Cancer GP, Lead Cancer Assistant Medical Director). The management team oversee two workstreams which are undertaken by teams of Cancer Trackers and Multi-Disciplinary Team (MDT) Cancer Co-ordinators.

2.5 Cancer Trackers are responsible for identifying and tracking patients with a suspicion/confirmation of cancer who have not received their initial treatment. They will flag and escalate slow-moving pathways promoting action by tumour sites. At a more granular level, Cancer Trackers collect and analyse data stored amongst various databases (both internal and national), validating the integrity, and presenting the data to tumour sites to identify/discuss bottle necks and agree actions to ensure that cancer patients are moved along the pathway in a coordinated, consistent, and equitable manner.

2.6 The Cancer Tracker team is aligned with the operational structure of the Clinical Boards ensuring that at least one Cancer Tracker is in place for each tumour site. We can confirm that Standard Operating Procedures are in place for the tracking of patients within each tumour site.

2.7 The Multidisciplinary Teams Coordinator's role is to provide consistent patient-centred focus throughout the pathway of care, by providing one point of contact along the administration pathway for the Multidisciplinary Teams. This will ensure coordination of the patient journey. Similarly to Cancer Trackers, MDT Coordinators are also responsible for tracking the patients along their care pathway identifying potential breaches of cancer waiting times and targets.

2.8 To inform this objective we also considered the roles and responsibilities within our sampled Clinical Boards and the cross-working relationships between the CS Team and individual tumour sites. Feedback was positive with most tumour sites having a clear understanding of the role and remit of the CS Team. There were a number of tumour sites which were not clear on the distinction of roles and responsibilities and felt that processes were often being duplicated and that further clarity of the roles and responsibilities was required. We noted that the set up within tumour sites differed with some having specific resources in place for Cancer Pathway Coordinators who were responsible for data integrity/validation of pathways. Discussions with the CS Team noted that cross-working relationships were more successful with Cancer Pathway Coordinators. **(Matter Arising one – Medium Priority)**

2.9 There were over 2,000 patients with suspicion/confirmation of cancer being actively tracked by the Cancer Services Team as at February 2024 within the Health Board. Given the sizeable scale and number of patients being tracked and the fluid nature of status changes with each pathway, the tracking of every patient is an intensive and laborious task. Due to their independence, the CS Team cannot control the various stages of data entry/input for the pathway stages. Given this, system-wide data integrity plays a pivotal role in enabling the early identification of suspected/confirmed cancer patients by the CS Team. Discussions and observations with staff raised concerns on the full visibility of Suspected Cancer Pathway (SCP) patients. (**Matter Arising Two – High Priority**)

Conclusion:

2.10 The Health Board has agreed on its operating model to deliver cancer services and has set this out within the Cancer Service Strategy (2023-28). The CS Team has a clear remit for monitoring and supporting the Clinical Boards with the delivery of the Single Cancer Pathway Standard. Our discussions with staff found that whilst there is a positive cross-working relationship between the Cancer Service Team and Clinical Boards, further clarity is needed on the roles and responsibilities for the CS Team and Clinical Boards to avoid overlap/duplication. The current IT Infrastructure poses data integrity risks that could impact the ability to maintain effective oversight of all patients referred to the Health Board with a suspicion of cancer. We have provided **Reasonable Assurance** for this objective.

Objective 2: Appropriate governance arrangements have been established which provide effective oversight of cancer services, ensuring that they are subject to effective scrutiny and review.

2.11 One of the Health Board's strategic objectives is to have sustainable cancer services that deliver the single cancer pathway standard to treat patients with a confirmed diagnosis of cancer within 62 days.

2.12 The Board Assurance Framework (BAF) has a specific risk aligned to cancer service delivery: *(Risk 4) - There is a risk that the organisation will not be able to provide effective, high quality and sustainable cancer services.* We reviewed the latest version of the BAF presented to the Board in January 2024 and can confirm that all mitigating controls listed are in place and working effectively.

2.13 As stated in paragraph 2.1, cancer service delivery is a key component of the wider Planned Care Programme. On a monthly basis, the General Manager for Cancer provides updates to the Planned Care Programme Performance and Assurance Board (PCPPAB). As part of the presentations, cancer metrics are discussed, and actions are agreed to improve performance trajectory.

2.14 The PCPPAB is chaired by the Chief Operating Officer and attended by the Director for Planned and Specialised Care who are the Executive Sponsor and Senior Responsible Officer for the Planned Care Programme respectively. We note that the Director for Planned and Specialised Care routinely provides updates to the

Health Board's Senior Leadership Team on the progress of the programme (which includes cancer service delivery).

2.15 There is also an Executive Cancer Board (ECB) which meets every two months and has the strategic remit for cancer services and provides oversight and direction in matters relating to the cancer agenda. The ECB is attended by a number of internal/external stakeholders which include senior management from the Clinical Boards, clinical and operational cancer leads from the Health Board, Public Health Wales (Screening Services), Patient Experience (Wales Cancer), Velindre NHS Trust and Wales Cancer Network.

2.16 We were not able to confirm if the ECB was operating in line with its terms of reference as the meetings are not minuted. **(Matter Arising 3 – Medium Priority)**

2.17 Discussions with the General Manager for Cancer Services also noted that the CS Team's approach to risk management was unclear. **(Matter Arising 4 – Medium Priority)**

Conclusion:

2.18 The Health Board has robust governance arrangements in place which provide effective oversight of cancer services ensuring they are subject to effective scrutiny and review. Cancer service delivery is a key strategic objective for the Health Board and is recognised as a key risk within its Board Assurance Framework. The remit of cancer service is reviewed and scrutinised at various committees/boards of the Health Board. We note that ECB meetings are not being minuted and advise that this be resolved. The risk management arrangements in place for the CS Team are unclear and require formalisation. We have provided **Reasonable Assurance** for this objective.

Objective 3: Clinical Boards have appropriate performance and improvement trajectories for cancer services including detailed actions plans where required.

2.19 The Health Board has set up a Cancer Delivery Group which meets weekly and is attended by senior operational management from the Clinical Boards and the CS Team. The meeting is also attended by all the Clinical Board Directors of Operations, Director for Planned and Specialised Care and chaired by the Chief Operating Officer. We also note that there is a Cancer Clinical Lead forum which meets every two months.

2.20 The meeting is operational in nature and utilised to review and discuss cancer performance and setting improvement trajectories for each tumour site. We noted that formal action plans are agreed and shared with the respective tumour sites following each meeting and progress monitored at the following meetings.

2.21 We reviewed presentations delivered in January and February 2024 and can confirm that the performance and improvement trajectories agreed are appropriate

and to a level of detail that allows identification of pathway bottlenecks and capacity issues/restraints.

2.22 We also note that Clinical Boards and specialities have agreed action plans as part of the wider waiting list management commitments of the Planned Care Programme, some of which are pivotal to the improvement of cancer delivery:

- Outpatients – Validation of cancer waiting lists.
- Endoscopy Cancer Diagnostics – Eradicate the cancer patient backlogs by the end of quarter 4 2023/24 and implementation of mediums to improve Did Not Attend (DNA) and appointment cancellation rates.
- Radiology & Cellular pathology – Create additional diagnostic capacity through productivity improvements.

The above action plans are monitored as part of the monthly Planned Care Performance and Assurance Board.

2.23 At a more granular level, the CS Team also meet with tumour sites on a weekly basis to discuss those patients that are on a suspected/confirmed cancer pathway awaiting treatment and actions are agreed locally to progress/escalate actions as relevant. This is covered in more detail under objective 5.

Conclusion:

2.24 The Health Board has agreed adequate performance and improvement trajectories for all Clinical Boards responsible for cancer service delivery. We sighted evidence confirming that action plans are agreed both at tumour site, speciality and Clinical Board level and progress on implementation is regularly reviewed. We have provided **Substantial Assurance** for this objective.

Objective 4: The Health Board has developed appropriate metrics to capture the performance of cancer services and the reporting of measures, such as the number of patients entering the single cancer pathway (SCP).

2.25 We reviewed samples of presentation slides for the weekly Cancer Delivery Group which met in January 2024. We can confirm that the cancer metrics agreed at each tumour site are appropriate and in line with the Ministerial ambitions set by Welsh Government/NHS Wales Executive:

Historic and trajectory performance data (split by tumour site)

- 14 day first contact (21 for skin) - number of patients that have breached;
- 28 days to inform patients on diagnosis - number of patients informed; and
- Patients receiving treatment within 62 days (SCP) and number of breaches.

Health Board wide cancer metrics

- 12-month future forecast of backlog of suspected/confirmed cancer patients above 62 and 104 days yet to receive treatment; and

- Summary of causes for delay to meet Suspected Cancer Pathway (late referrals, clinical decisions, late diagnostic reporting, capacity issues, patient choice).

2.26 All Health Boards in Wales are required to submit monthly cancer performance data to Welsh Government through a portal hosted by Digital Health and Care Wales (DHCW). The data is collated, summarised and published by DHCW via an All-Wales Dashboard and is readily accessible by the public. We also note that the Health Board submit "weekly" snapshots of the active open pathways on the SCP to the Delivery Team of the Wales Cancer Network.

2.27 We reviewed the Monthly Cancer Performance Report issued to Welsh Government for November and December 2023 and note that updates are provided on the following cancer metrics:

- Performance overview and actions in place to improve or maintain performance;
- Charts and narrative on the referrals onto the SCP;
- Performance against the National Optimal Pathways for Outpatients, Diagnostics (Endoscopy, Radiology and Cellular Pathology);
- SCP compliance treatment volumes;
- Above 62 and 104 day backlog of suspected/confirmed cancer patients; and
- Pathway review data and reasons for breaches within the month.

Conclusion:

2.28 The Health Board has developed appropriate cancer metrics which adhere to the Ministerial ambitions for the SCP. Cancer performance data is routinely monitored and reported both internally throughout the governance structure of the Health Board and also externally to Welsh Government and Wales Cancer Network. We have provided **Substantial Assurance** for this objective.

Objective 5: The deliverables for the single cancer pathway are regularly monitored, with assurance provided to the Board and appropriate Committees and where performance issues are encountered, appropriate rectifying action is undertaken.

2.29 As stated in various sections of this report, cancer delivery is a key priority for the Health Board and is a key delivery objective of the IMTP for 2023/24. We note that the Health Board has agreed to measure its performance against the following milestones:

Quarter 1 2023/24

- Achieve an above 75% compliance with the 62-day SCP standard – We note that this is currently not being met by the Health Board or any of the other Health Board in Wales. We recognise however that Cardiff & Vale has made

significant improvements in relation to the SCP standard and achieved an all-time high compliance rate of 70.2% in December 2023 since the SCP standard was introduced.

- Develop draft UHB cancer strategy to deliver national cancer pathways - We can confirm that this has been implemented with the endorsement and approval of the Cancer Strategy (2023-28) by the Senior Leadership Team in July 2023

Q3 2023/24

- Achieve an above 80% compliance with the 62-day SCP standard – as above this is not currently being met.

2.30 The Chief Operating Officer presents the Integrated Performance Report to the Finance & Performance Committee on a monthly basis. The data within the report covers the following in relation to the SCP:

- Total number of patients on Suspected Cancer Pathway;
- Total number of patients on Suspected Cancer Pathway over 62 days; and
- Total number of patients on Suspected Cancer Pathway over 104 days.

We note that the Integrated Performance Report is also presented to the Board at each meeting.

2.31 As per paragraph 2.27, the Health Board reports monthly into Welsh Government setting out its performance for the month and recovery action plans being agreed where issues are encountered. We note the following key highlights from the cancer performance for the Health Board as reported in December 2023:

- Performance vs the SCP Standard stood at 70.2%. This is a 12% improvement from the 58% reported in November 2023.
- Endoscopy - Recovery plans are in place for the complex therapeutic endoscopies which made up a high proportion of longest waiting patients. This has already reduced the patient numbers by 12 and is anticipated to clear the backlog by the 25th of March 2024.
- Radiology - Waiting times for CT are stable with up to 97% of scans achieving request to report in under 14 days (when excluding patient choice and DNA). MRI remains more challenging at 58% however it was confirmed that there are further plans in place to refine this.
- Pathology - There have been big improvements to pathology turnaround time which resulted in all samples being reported in time for the December 2023 data submission for the first time. There is still intent to further reduce waiting times to help enable the cancer pathway compliance. There is continual increase in the number of patients requiring genetics which is adding further complexity to the cancer pathways, often resulting in an additional wait of up to 14 days.

Conclusion:

2.32 We can confirm that the Health Board's deliverables for the Suspected Cancer Pathway are regularly monitored with assurance provided to the Finance and Performance Committee and to the Board. Where performance issues are encountered, appropriate action plans are put in place and monitored for progress. However, the Health Board is currently not achieving the milestones within it's IMTP. We have provided **Reasonable Assurance** for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Clearly defined roles and responsibilities (Operation)			**Impact**
Weekly tracker meetings take place between Cancer Trackers and management of the relevant tumour sites. The CS Team was clear on the purpose of these meetings however feedback from tumour site staff suggested a lack of shared clarity relating to the meeting purpose, the roles of those attending and expected outcomes. Some tumour sites felt that there was duplication with tumour site staff performing duties of Cancer Trackers such as accessing patient records to provide updates on information already visible and readily available to cancer trackers.			Potential risk of: • There is a risk that the organisation will not be able to provide effective, high quality and sustainable cancer services.
Recommendations			**Priority**
1.1	Management should consider the purpose and operating arrangements of the weekly cancer tracker meetings and clarify these and the roles of those in attendance in documented terms of reference/operating arrangements.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	Standard Operating Procedure and Terms of Reference documents to be created in collaboration with appropriate clinical board managers outlining the scope and purpose of the cancer tracking meetings. This document should also include a roles and responsibilities component for the relevant Cancer Services and Clinical Board staff.	30/05/2024	Michael Eastwell

Matter Arising 2: Visibility of SCP patients (Operation)	**Impact**
Discussions with management highlighted concerns on the appropriateness and suitability of the IT Infrastructure in place to support cancer service delivery. **Data collection** Cancer Trackers have access to a number of internal/external databases and are responsible for checking these daily for patients coming through the Health Board on suspicion/confirmation of cancer. This can mean checking up to 10 systems/databases at any given time. Cancer Trackers are only able to identify patients that have been flagged as "Urgent Suspected Cancer" at referral stage. As such, the CS Team relies heavily on system-wide data integrity. Discussions with Cancer Trackers noted that flags are not always applied consistently and for these, the CS Team is often unaware of their existence until further into the pathway. **Data population** Data collected by Cancer Trackers is populated within the Cancer Tracking Module (CTM), an internal system built by the IT department of the Health Board. We note that CTM does not integrate with the wider systems/databases of the Health Board and as such, Cancer Trackers/MDT Co-ordinators are responsible for manually populating the information. Given that the CS Team could track up to 2,000 patients daily, maintaining the CTM database is often time consuming, labour-intensive task subject to risk of human error.	Potential risk of: • There is a risk that the organisation will not be able to provide effective, high quality and sustainable cancer services.

Recommendations		**Priority**
2.1	A system-wide project should be undertaken with the aim of improving integrity/quality for Suspected Cancer Pathway data.	**Medium**
2.2	Management should undertake a technology gap analysis of the current IT Infrastructure and its ability to support the cancer delivery remit.	**High**

Agreed Management Action	**Target Date**	**Responsible Officer**

2.1	Cancer Services, led by the General Manager for Cancer Services will deliver on a continual improvement plan for refining and improving the quality of the SCP cancer data set. Aspects of this are outlined within the digital plan within the cancer strategy.	Continual improvement until 2028	Michael Eastwell
2.2	The Cardiff and Vale UHB Cancer Strategy 2023-2028 identifies "Adopting Digital First" as a key component. In December 2023 the 1, 3 and 5 year priorities were presented and agreed outlining the direction towards refining and improving the IT infrastructure, reducing duplication and automation of data collection. As part of this work, a gap analysis was undertaken specifically around digital requirements. The Executive Cancer Board will act as the overriding governance structure monitoring the delivery against these key objectives.	Continual improvement until 2028	Angela Parratt

Matter Arising 3: Executive Cancer Board is not minuted (Design)			**Impact**
At the time of the audit, we were unable to independently verify whether the Executive Cancer Board was operating in line with its Terms of Reference as meetings were not being minuted. We were advised that they were not being minuted due to lack of secretarial support. The General Manager for Cancer Services acknowledged the finding but reassured us that the meetings were taking place as planned.			Potential risk of: • There is a risk that the organisation will not be able to provide effective, high quality and sustainable cancer services.
Recommendations			**Priority**
3.1	Arrangements should be put in place to ensure that the business of the Executive Cancer Board is appropriately documented. As a minimum we would expect there to be: • Minutes for each Executive Cancer Board meeting; • Members attendance; • Standing agenda of items to be discussed; and • Log of key actions/decisions from each meeting.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	The General Manager for Cancer Services will produce a needs requirement paper outlining the administrative support required for the service to deliver on the recommendation to be presented to the Director for Planned and Specialised Care. In the interim, options for administrative support to the Executive Cancer Board will be sought within the current establishment.	01/06/2024	Michael Eastwell Matt Temby

Matter Arising 4: Approach to risk management (Design)			**Impact**
Discussion with the General Manager for Cancer Services noted that the risk management approach by the CS Team was not clear and that the team did not directly possess a risk register. We appreciate that operational risks relating to cancer would be captured by Clinical Boards however we consider that the CS Team should have access to a risk register for recording risks and escalating these where applicable.			Potential risk of: • There is a risk that the organisation will not be able to provide effective, high quality and sustainable cancer services.
Recommendations			**Priority**
4.1	Risk management and risk reporting approach for the Cancer Services Team be agreed and as a minimum consider the arrangements for: • Identifying the risk; • Analysing the risk; • Prioritising the risk; • Treating the risk; and • Monitoring / escalating the risk as appropriate.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	The Lead Cancer Nurse will create a unified risk register for cancer which will be governed via the Executive Cancer Board. This will be compiled in accordance with the Clinical Boards identifying, risk reviewing and unifying all relevant risks from within their individual risk registers, as well as risks identified internally from within Cancer Services. Those risks identified as most vulnerable will be reviewed at Cancer Executive Board with an expectation that remedial actions be identified and implemented at the point of presentation.	31/03/2025	Annette Beasley

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**Unsatisfactory assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

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

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership