Waiting List Management

Final Internal Audit Report

June 2024

Swansea Bay University Health Board

Contents

Executive Summary ... 3

1. Introduction ... 5

2. Detailed Audit Findings ... 6

Appendix A: Management Action Plan ... 19

Appendix B: Assurance opinion and action plan risk rating ... 32

Review reference:	SBUHB-2324-13
Report status:	Final
Fieldwork commencement:	5 February 2024
Fieldwork completion:	3 April 2024
Debrief meeting:	9 April 2024
Draft report issued:	17 April 2024
Management response received:	1 May 2024
Additional work undertaken:	21/22 May and 4 June 2024
Final report issued:	28 June 2024
Auditors:	Osian Lloyd (Head of Internal Audit); Felicity Quance (Deputy Head of Internal Audit); Lisa Harte (Audit Manager)
Executive sign-off:	Deb Lewis, Chief Operating Officer
Distribution:	Craige Wilson, Deputy Chief Operating Officer; Suzanne James, Ophthalmology Specialty Manager; Abigail Morris, Interim Directorate Manager (Obstetrics & Gynaecology); Marisa Bennett, Cancer Performance & Information Manager; Marnie Lake, Head of Transformation, Performance & Improvement; Jude Austin, Service Manager (Planned Care Team); Chris Jones, Deputy Director of Transformation and Head of Healthcare Systems Engineering
Committee:	Audit 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.

Disclaimer notice - please note:

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Swansea Bay University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Our work does not provide absolute assurance that material errors, loss or fraud do not exist. Responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with Swansea Bay University Health Board. Work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, or all circumstances of fraud or irregularity. Effective and timely implementation of recommendations is important for the development and maintenance of a reliable internal control system.

Executive Summary

Report Classification

		Trend
Limited	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.	N/A

Assurance summary [1]

	Assurance objectives	Assurance
1	Maintained and Up-to-Date Waiting List	Limited
2	Patient Prioritisation	Limited
3	Monitoring Arrangements	Reasonable
4	Patient Communication	Reasonable

Purpose

To establish whether all patients on the waiting list have been assessed and assigned an appropriate priority rating in line with appropriate guidance. To include the arrangements in place to communicate and support patients.

Overview

We have issued limited assurance on this area, which focused on waiting list management within outpatient appointments for the specialties of gynaecology, ophthalmology, and cancer services; which were selected in consultation with the Chief Operating Officer (COO).

The matters requiring management attention include:

- Reviewing and finalising documented guidance to support national rules, and providing training to assist staff in clarifying roles and responsibilities to ensure the processes in relation to waiting list management are followed.
- Ensuring that data is easily accessible and demonstrating that regular checks are being undertaken to evidence that waiting lists are being maintained and up-to-date, patients are appropriately prioritised, and are offered additional support while waiting for healthcare services. However, we note that there are limitations within the national system and staff capacity issues that are impacting this area.
- Enhancements to monitoring tools and action plans to prevent data being misinterpreted and provide focus on the key areas to assist with improvement.
- Reviewing and finalising terms of reference of the governance structures that provide oversight over waiting list management and the 3Ps programme (Welsh Government's 'Promote, Prevent and Prepare for Planned Care').
- Wider triangulation of reporting to assist with organisational learning from recommendations made by the Public Services Ombudsman for Wales.

Committee reporting details the improvements made within the health board to assist with delivery of the ministerial targets for planned care. While some of the specialities reviewed highlighted limited capacity to carry out validation checks, significant central resource has been put in place to assist services that includes the healthcare engineering team and the Patient Access Management (PAM) Team.

There is less reliance on paper documentation and manual processes, but despite this, the lack of data scrutiny and integration between performance monitoring tools could pose a risk of data being misconstrued when reported. This lack of integration, coupled with the complexities and differences across operational areas has impacted our ability to carry out testing of waiting lists. Whilst access to the Planned Care dashboard and system reports were provided in May 2024 (post issue of our draft report), the evidence of validation checks is limited due to the functionality of the system.

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

Key matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	Knowledge of Waiting Time Management Processes	1	Design	High
2	Waiting List Maintenance and Patient Prioritisation	1,2,4	Design	High
3	Effectiveness of Monitoring Arrangements	1,2,3	Operation	Medium
4	Governance Arrangements	3,4	Operation	Medium
5	Organisational Learning	4	Design	Medium

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

1. Introduction

1.1 During 2020/21, planned care services had to be paused to allow the NHS to respond to the immediate demands and challenges of the COVID-19 pandemic. This, along with other factors such as a rise in referral rates and worsened population health because people have not accessed services in recent years, has inevitably resulted in longer waiting lists and increased waiting times for diagnostics and treatment.

1.2 The Welsh Government published, *'Our programme for transforming and modernising planned care and reducing waiting lists in Wales'* (April 2022). As a result, recovery targets were set which are required to be regularly monitored and reported on by the Health Board.

1.3 In September 2023, Swansea Bay University Health Board's (the health board) was escalated to enhanced monitoring for planning and finance along with all health boards in Wales and at the date of reporting remains as such. The health board is currently in targeted intervention for performance and outcomes. The Health Minister said, "*We are seeing operational pressures, long waiting lists, and an extremely challenging financial position in the NHS*".

1.4 The Board Assurance Framework outlines a key risk in relation to Planned Care (reference 3.4) noting a gap in assurance about the health board's ability to deliver that no one should be waiting for more than 52 weeks for their first outpatient appointment by June 2023 (a new target of October 2023 was agreed with Welsh Government); or by the end of March 2024, 99% of those referred for treatment will be waiting under two years; and elimination of diagnostic waits of over eight weeks by the end of March 2024.

1.5 The key risks considered in this review were:

- Waiting lists are not up-to-date.
- Patient harm due to excessive waiting times.
- Lack of action to reduce the number of patients waiting for health care services.
- Insufficient monitoring / inaccurate record keeping.
- Lack of adequate communication and support provided to patients.

1.6 Our audit has focussed on waiting list management within outpatient appointments for the specialties of gynaecology, ophthalmology, and cancer services, which were selected in consultation with the Chief Operating Officer (COO). We did not seek direct feedback from patients on their experiences nor test the data quality of the waiting lists.

1.7 Whilst undertaking this audit, we have held discussions with Audit Wales to understand progress with addressing actions arising from their work, '*'Follow-up Outpatients Appointment Review*'. Consideration was also taken of our review of '*Access to Cancer Services'* (issued June 2023 - reasonable assurance) and '*Planned Care Recovery Arrangements*' (issued February 2022 – reasonable assurance).

2. Detailed Audit Findings

2.1 The table below summarises the recommendations raised by priority rating:

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	6	1	-	7
Operating Effectiveness	-	7	-	7
Total	6	8	-	14

2.2 Our detailed audit findings are set out below. All matters arising and the related recommendations and management actions are detailed in Appendix A.

2.3 Providing system reports and access to the Planned Care dashboard impacted our ability to carry out testing of waiting lists. These were subsequently provided during May 2024 after our review had concluded, and post issue of the draft report. Further meetings were held with key officers from the specialties selected to confirm their usage of the dashboard and system reports and evidencing of checks.

Objective 1: A waiting list is in place that is maintained and up-to-date, with adequate controls to detect where patients are on several pathways.

2.4 Dedicated support has been provided to assist with making improvements with the maintenance of waiting lists, with the health board having the first Healthcare Engineering Team in the UK to design and implement processes and systems; the recent recruitment of a Patient Access Management (PAM) Team to review and develop policies and procedures, carry out data quality checks and provide training to staff; and there are designated staff that carry out validation checks within the Planned Care Team.

Policies, Procedures & Training

2.5 The Patient Access Policy is available to health board staff via the intranet and details a review date of June 2018 (see **Matter Arising 1**) but is currently being revised. There are national rules relating to Referral to Treatment (RTT) rules (see Table 1) which staff can refer to, and Standard Operating Procedures (SOPs) are being reviewed and standardised within the health board to assist with staff awareness and understanding with an appropriate framework designed to approve them.

Table 1:

Referral to Treatment	The period between a referral being made for a particular condition and treatment being commenced for that condition. Within Welsh Government's guidance, *'Our programme for transforming and modernising planned care and reducing waiting lists in Wales'* (April

	2022), the planned care pathway consists of four stages (new outpatients, diagnostics, decision to treat, and treatment). However, the health board has five stages (it is currently exploring moving to the four-stage model in line with other health boards): • Stage 1: No one should be waiting over 52 weeks for a first outpatients' appointment; • Stage 2: Patient has attended the first appointment but further investigation required; • Stage 3: Further follow Up appointment booked for further investigation; • Stage 4: Awaiting admitted diagnostic i.e., Endoscopy; • Stage 5: No patients should be waiting over 104 weeks from referral to treatment.
Single Cancer Pathway	The health board monitors two measures for the Single Cancer Pathway (SCP), which is now under Targeted Intervention: • % Performance within the 62-day target • Backlog volumes (patients waiting over 62 days)

2.6 Similarly, the Cancer Waiting Times and Escalation Policy details a review date of July 2022. This was raised as a recommendation within the '*Access to Cancer Services*' audit, therefore we have not replicated it at this report. However, documented procedures to support the Policy will also need to be developed (see **Matter Arising 1**).

2.7 Reporting to the Quality and Safety Committee (27 June 2023) highlighted that staff are not always following correct processes, as existing staff have not maintained their knowledge level; or new staff have not had the required training. As a consequence of this, two training sessions were delivered to staff during January 2024 but course delivery took longer than planned due to a lack of staff knowledge of Referral to Treatment (RTT) rules. As a result, training has now been paused and policies and procedures will be updated to provide additional clarification (see **Matter Arising 1**).

2.8 One-to-one training is planned to resume in May 2024. The Outpatients Board, at its meeting on 15 February 2024, agreed a new approach to training, including the development of a digital platform to support online training. However, training will not provide a detailed overview of the processes and rules in relation to the Single Cancer Pathway (SCP) (see Table 1), and we note that no recent training has been carried out of this area (see **Matter Arising 1**).

<u>Waiting List Maintenance</u>

2.9 Welsh Government's '*Our programme for transforming and modernising planned care and reducing waiting lists in Wales*' (April 2022) reinforces that regular reviews and validation are needed to confirm the accuracy of waiting lists. Reporting to Quality and Safety Committee (27 June 2023) confirmed that validation is an ongoing process, but patients have remained on the waiting list for

longer than necessary because waiting lists were not managed during the COVID-19 pandemic and staff are not always following the correct process.

2.10 For the specialities we reviewed (gynaecology, ophthalmology and cancer services), waiting list data is held on the Welsh Patient Administration System (WPAS), which is the system used by the Planned Care Team (and pan-Wales) when carrying out their validation checks.

2.11 Through discussion, we established that staff are carrying out checks of waiting lists, and this validation can occur at various stages, including where the patient contacts the relevant specialism. However, while staff have access to various monitoring tools and regular system reports, the information is not easily reportable (see Table 2). Outcomes of checks are usually administered to the patient record within WPAS; however, the system does not have the functionality to easily evidence changes made, e.g. patient contact and validation checks are recorded in a free-text field. A similar enhancement in relation to data accessibility has been identified with internal checks of RTT clock reset rules (see para 2.46). Combined with a delay in receiving system reports, this has impacted our ability to carry out testing of waiting lists to confirm the frequency and outcome of reviews; and that patients on several pathways have been effectively managed (see **Matter Arising 2**):

Table 2:

	Discussion with Staff	Information Provided
Planned Care	There is a dedicated validation team who contact patients on waiting lists to ascertain if they still require an appointment; identify duplicate entries on waiting lists; and highlight patients that are on duplicate pathways (to prevent appointments not being booked for the same time). Where capacity is forecasted to be an issue, this is reported to the Service Groups as part of the fortnightly scrutiny meetings. Validation checks could not be evidenced as staff update the patient record on WPAS, which is unreportable. There is also a dedicated follow up validation team, but their work has been paused so they can assist with appointment duties.	The Planned Care Team provided performance figures detailing the number of patients they contacted who were waiting for ophthalmology and gynaecology appointments and whether they were removed from the waiting list (there is no validation of new cancer patients as staff aim to book appointments as soon as they are graded in line with the ten-day target).
	***Note**: following the conclusion of our review, we were advised that the funding provided to resource the validation team ended 31 March 2024. Validation continues when booking patients in for appointments, and the Planned Care dashboard is monitored daily to identify patients who will breach RTT waiting time targets, detect duplicate entries, or*	

	patients on multiple pathways. There are plans to restore the team over the next few months to include validation of follow up appointments.	
Patient Access Management	The team carry out weekly checks that include patients 'awaiting grading', those waiting follow up appointments, those that 'Could Not Attend' (CNA) or 'Did Not Attend' (DNA), etc.	The outcomes of their review are submitted as part of monthly performance reporting to the Outpatients Board.
Healthcare Engineering	The team monitor patients 'awaiting grading', and those 'to be reviewed' (where the patient is not mapped to a pathway).	N/A
Ophthalmology	Bi-weekly system reports are utilised to detect blank or duplicate entries on the waiting list. A weekly review is carried out of patients on both the glaucoma and the cataract waiting lists (the largest sub-specialities within ophthalmology), but this was not evidenced. The waiting list targets are monitored daily using the Planned Care dashboard. Other checks of the waiting list are carried out where there is staff capacity, e.g. patients on multiple pathways.	Two validation spreadsheets were provided highlighting patients that had been checked, but it was unclear of the outcome of the review.
Gynaecology	Validation can occur at various stages where the patient makes contact or where the administration team makes direct contact with the patient. There is a daily check of both the Vitals and Planned Care dashboard to highlight waiting list breaches, cancellations, patients that have been waiting the longest or have Urgent Suspected Cancer (USC). Hysteroscopy patients have been subject to continual validation, initially through HSBUK (an external provider), but now internally for all patients over two years.	N/A
Cancer	Validation processes were reviewed as part of the '*Access to Cancer Services*' audit so we did not replicate previous testing, but note that staff review the radiology and Planned Care dashboards at least weekly; duplicate entries on waiting lists and patients on multiple pathways are checked to confirm they are valid entries; and there has been extensive manual interrogation of	N/A

	systems that do not integrate with WPAS to identify patients suspected of having cancer at an early stage, e.g. radiology investigations and histology test results (an integrated functionality to link the datasets is not possible).	

2.12 Staffing capacity within specialisms was also highlighted as a reason for not carrying out regular checks of waiting lists, for example, within gynaecology where there is a junior team in place to which additional support was provided on RTT training and to develop streamlined processes. At the date of reporting, we note the performance manager from the PAM Team, who was seconded to provide this support has been appointed as the Interim Service Manager. Currently, waiting list processes for all stages of the pathways are being reviewed within gynaecology and expectations of validation are being communicated to staff.

2.13 Addressing waiting list backlogs, to meet Welsh Government's ministerial priorities, is also having an impact within ophthalmology. Whilst mitigating measures, such as virtual clinics have been put in place, the continued demand on the service makes it hard to address the outpatient backlog.

2.14 Enhancements have been made to reporting tools to assist staff monitoring waiting lists. This includes the development of several performance dashboards e.g. Planned Care, Vitals, etc, and there is a cancer performance spreadsheet that is updated daily. The Vitals dashboard provides a visual representation of service demand, activity, and the length of time a patient has waited, and the Planned Care dashboard has a function that automatically generates reports for services to carry out checks of their waiting lists. There is also a National Data Standards which sets out the expectation of all performance submissions for all health boards in Wales.

2.15 Staff capacity issues have been highlighted and this could impact the frequency of their reviews of the dashboards. As there has been no clearly defined process for creating and approving the development of performance monitoring tools, this could affect data accuracy and consistency leading to the misinterpretation of data when it is reported (see **Matter Arising 3**). Having an integrated solution would be more beneficial and we understand that the feasibility of this is currently being explored through the PAM Steering Group who have also requested a list of dashboards users to ascertain frequency of access.

Conclusion:

2.16 It is recognised within the health board that a lack of staff knowledge regarding the RTT rules has resulted in correct processes not being followed and a lack of management of waiting lists. Work is being undertaken to further develop policies and procedures and training materials to provide clarity and support national rules. Similarly, while improvements have been made to the accessibility of waiting list data, some data is still not either reportable or provided promptly, which has impacted on our ability to ascertain the frequency and outcomes of validation checks. The data infrastructure requires review to confirm the accuracy of data to

prevent it being misconstrued. A lack of staff capacity, with their focus being prioritised on addressing waiting list backlogs, has resulted in limited oversight in some areas. Therefore, we provide **limited** assurance for this objective.

Objective 2: Effective arrangements are in place for prioritising patients based on their current health care needs (e.g. regular assessments and reprioritisation).

2.17 New and follow up ophthalmology outpatients are graded on health risk factors as part of the Eye Care Measures framework (the Royal College of Ophthalmology). This is reported to Welsh Government in addition to the current RTT waiting times:

Table 3:

Eye Care Measures	• The total number of new and follow up ophthalmology patient pathways, that have been assessed as being at risk of irreversible harm or significant adverse outcome should their target date be missed (Health Risk Factor R1), that are waiting for an outpatient appointment. • The number and percentage of new and follow up ophthalmology patient pathways, that have been assessed as being at risk of irreversible harm or significant adverse outcome should their target date be missed (Health Risk Factor R1), that are waiting within their target date or within 25% beyond their target date. • At the conclusion of our review, we were advised that an issue had been identified with the data being reported as part of the Eye Care Measures. This has been escalated to Digital Health and Care Wales (DHCW) who were investigating to ascertain if this was a national problem.
Health Risk Factor	The risk of harm associated with the patient's eye condition if the target review date is missed. Categorisations are as follows: • R1 – risk of irreversible harm or significant patient adverse outcome if target date is missed. • R2 – risk of reversible harm or adverse outcome if target date is missed. • R3 – no risk of significant harm or adverse outcome.

2.18 As highlighted under Objective 1, while assessments are carried out on patients, evidence could not be provided to determine the regularity and outcomes of the checks across the specialisms reviewed. We were unable to carry out testing to confirm that patients have been sufficiently prioritised based on their healthcare need as the information was not accessible (see **Matter Arising 2**).

2.19 Analysis taken from the Vitals dashboard (6 March 2024) identified the following categories for the number of patients within gynaecology and ophthalmology:

Table 4:

Speciality	Awaiting Grading	Routine	Urgent	Urgent Suspected Cancer (USC)	Total

Gynaecology	22	2,246	1,309	62	3,639
Ophthalmology	6,020	36	1	2	6,059

There is no separate marker for cancer patients on the Vitals dashboard therefore, cancer data is recorded within Urgent Suspected Cancer (USC).

2.20 While the Vitals dashboard details that there are 6,020 patients 'awaiting grading' (which could include patients that are urgent or USC), the Ophthalmology Service Manager explained that this figure is incorrect as the dashboard and other reporting does not extract the Eye Care Measures Ophthalmology grading on Health Risk Factor (see **Matter Arising 3**). The figure reported to Welsh Government is 279 patients. We were not advised of any issues relating to the data for gynaecology.

2.21 RTT performance data is reported to Welsh Government and so categorisations have been built in to determine what is reportable, e.g. reported, non-RTT, and unreported. An extract from the Vitals dashboard (6 March 2024) detailed the following for gynaecology and ophthalmology patients:

Table 5:

Speciality	Reported	Non-RTT	Unreported	Total
Gynaecology	3,356	64	219	3,639
Ophthalmology	5,514	23	522	6,059

2.22 As planned care services were paused during the COVID-19 pandemic and to assist with the management of longer waiting lists, an 'Unreported' categorisation was created for patients that were currently non-RTT reportable (pathways in reportable services where patients have not yet reached the reportable element of the pathway). This could be because the service is managed separately to assist with ensuring patients are seen on time and therefore the data is included in the RTT submission to Welsh Government, e.g. colposcopy is managed by Cervical Screening Wales. However, there has been no recent check across specialisms to confirm that patients remain in the correct categorisation (see **Matter Arising 3**).

2.23 WPAS has a mechanism to record reprioritisation checks. Within ophthalmology, patients chasing up appointments are advised to go back to their optician if their condition has deteriorated to be re-referred, and a form has been designed specifically to assist consultants in reprioritising cataract patients. Consultants of gynaecology and ophthalmology patients utilised the national reprioritisation tool developed using Royal College of Surgeons guidance during the COVID-19 pandemic. However, reprioritisation is not currently carried out due to staff capacity and the focus on addressing waiting list backlogs (see **Matter Arising 2**). Noting the SCP is a target of 62-days from point of suspicion to treatment, there would not be the need to reprioritise patients.

Conclusion:

2.24 The inaccessibility of data has impacted on our ability to confirm that patients have been appropriately prioritised based on their healthcare need. Therefore, the data infrastructure would benefit from a review to confirm the appropriate categorisation of patients and ensure that data is accurately and consistently recorded. A lack of staff capacity and prioritising their focus on addressing waiting list backlogs were highlighted as reasons for not carrying out regular assessments and reprioritisation based on the current healthcare need of the patient. Therefore, we provide **limited** assurance for this objective.

Objective 3: Effective action plans and monitoring arrangements are applied to reduce the waiting times for patients, with appropriate reporting to the Health Board and Welsh Government.

Monitoring Arrangements

2.25 As highlighted in paragraph 2.14 performance dashboards have been developed to assist with the monitoring of waiting lists.

2.26 While action plans are used to assist with monitoring improvements with waiting lists, there is not a consistent template used across services with a specific focus on these improvements; to confirm that the necessary actions have been undertaken; and to assist with identifying measures to sustain improvement (see **Matter Arising 3**):

Table 6:

Ophthalmology	Ophthalmology was previously under 'Gold Command' (which was established to monitor the mitigating action to address the risk of 'Follow-Up Not Booked' (FUNB), and to review the HRF R2 category of patients and Referral to Treatment Times (RTT) for cataracts to ensure there is a single approach across ophthalmology pathways to minimise duplication and consistency of reports). A recovery action plan was developed to assist with improvements. The last version of the action plan provided was August 2023. Gold Command has now been stood down because of the continued reduction in the number of follow up patients. While monthly service reports continue to provide updates on actions relating to the recovery plan, it is unclear the status of previous actions or whether these have been completed. However, the service does have an action plan to address recommendations resulting from 'Getting it Right First Time' (GIRFT), which incorporate some improvements relating to waiting lists. A regional sustainability plan is being considered for cataracts as part of the External Review of Eye Care Services in Wales (September 2021).
Gynaecology	There is no action plan within gynaecology as a significant amount of work is being undertaken in reviewing processes and theatre allocations. The GIRFT action plan has been recently reviewed.
Cancer	Services have been asked to develop action plans for each tumour site to assist with making improvements. The Cancer Performance & Information Manager confirmed that head and neck, breast and

	gynaecology have up-to-date action plans; lower and upper gastrointestinal and plastic surgery have action plans that need updating; and the action plan for lung was being finalised. As part of our review, we have only seen the action plans for breast and gynae. The '*Access to Cancer Services*' review raised an enhancement in relation to the recording of actions, so we have not replicated a recommendation during this review.

Governance Framework

2.27 The governance framework for planned care reporting consists of monthly meetings of the Patient Access Management (PAM) Steering Group; Planned Care Programme Board; Outpatients Board; Theatre Board; and Diagnostics Board. There is also an Eye Care Collaborative Group and fortnightly meetings with Service Groups (Corporate Performance Scrutiny).

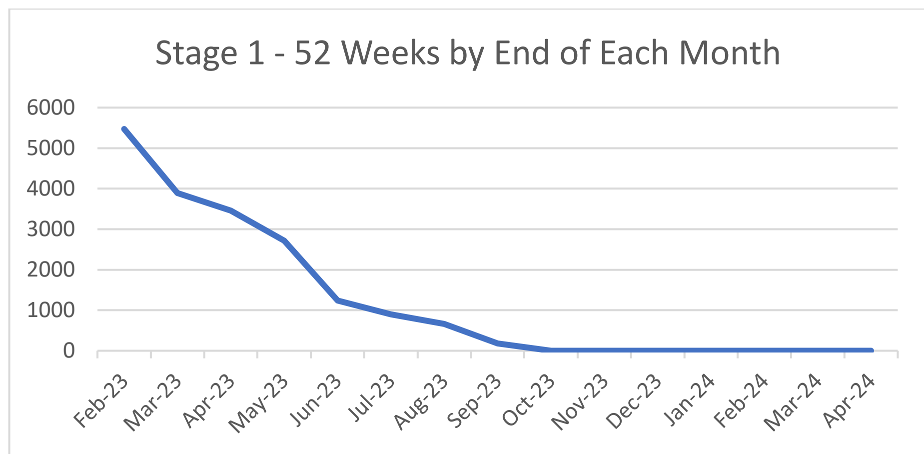
2.28 Terms of reference have not yet been finalised for both the PAM Steering Group and the Service Performance Group meetings, and finalised versions of the terms of reference for other boards and groups have not been reviewed in line with their review date (see **Matter Arising 4**).

2.29 Cancer performance is subject to a separate governance structure with terms of reference for the Cancer Performance Group and Cancer Programme & Improvement Group yet to be finalised. This was identified within the '*Access to Cancer Services*' audit, therefore we have not replicated a recommendation in this report.

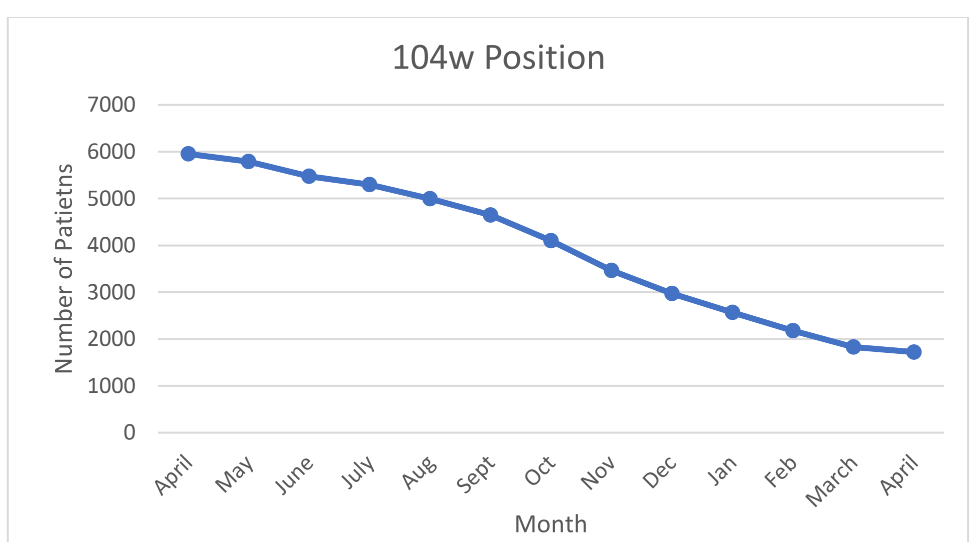
2.30 The recovery of planned care is one of the core components of the Recovery and Sustainability Plan 2022-25, and risks in relation to planned care, ophthalmology and cancer performance are actively monitored and reported to the committees where the risks are assigned, e.g. Performance & Finance Committee and Quality & Safety Committee. However, regular liaison with patients on extended waiting lists and validation is recorded as a gap in assurance for the risk 58 (failure to provide adequate clinic capacity for follow-up patients in ophthalmology results in a delay in treatment and potential risk of sight loss).

2.31 Access to planned care was highlighted as one of the factors behind the health board being placed into Targeted Intervention by Welsh Government, specifically around long waits for surgery in spinal, plastic surgery and general surgery. This increased level of escalation necessitates a formal programme management approach to planned care, led by the Chief Operating Officer (COO). The Planned Care Programme Board has accountability to the Management Board and regularly reports to both Performance & Finance Committee and Quality & Safety Committee. The COO and Deputy COO also attend monthly meetings with Welsh Government.

2.32 Planned Care performance reporting to the Performance & Finance Committee (May 2024) highlighted the improvements to reduce waiting times detailing that no patients have been waiting over 52 weeks for a first outpatients' appointment (Stage 1) since October 2023:



2.33 1,720 breaches were reported in April 2024 against the ministerial target that patients will wait less than 104 weeks for treatment within most specialties:



2.34 The health board has been working on the assumption that the target for achieving zero patients waiting over 104 weeks would be March 2025, but this has now been confirmed as December 2024 representing a greater challenge for all health boards. Orthopaedics has the greatest number of patients (631) waiting to be seen in this category in April 2024, followed by gynaecology, which is currently under internal enhanced monitoring arrangements and has 521 patients waiting, 181 of which for more than 156 weeks (a plan to improve this position has been set for the end of July 2024).

2.35 The health board has also been placed into Targeted Intervention for delivery of the Single Cancer Pathway (SCP), and regular reporting is provided to Performance & Finance Committee and Welsh Government. The latest update (23 February 2024) noted that performance with patients receiving treatment within 62 days is below the target of 75% (51% in December 2023). Most of the tumour sites did not meet the required time to treatment timescales.

Conclusion:

2.36 Developing a consistent template for the specialities with the greatest pressures, will provide focus on the delivery of enhancements required with waiting list management and may assist with the sustainability of improvement. Terms of reference for both planned care and cancer performance forums need to be revisited and finalised. There is regular performance reporting of improvements with delivering the ministerial targets for planned care waiting lists, and now the health board is under Targeted Intervention, this will result in further scrutiny. Therefore, we assign this objective **reasonable** assurance.

Objective 4: Adequate arrangements are in place to communicate with patients waiting for health care services, including the offer of additional support if required.

2.37 The health board has a Communications and Engagement Strategy (March 2023) as part of its Outpatients Transformation Programme which has been established to eliminate excessive waits for outpatient appointments. It aims to embed the Welsh Government paper, '*Our programme for transforming and modernising planned care and reducing waiting lists in Wales*' (April 2022), which sets out the five goals for planned care as seen in the diagram below:

2.38 One of the objectives of the Strategy is to, "*make sure patients and other stakeholders receive timely, relevant, and accurate information about their appointments*". The Planned Care Team is responsible for the validation checks and booking most clinical appointments for the majority of specialisms.

2.39 Contact with patients is made as follows:

- Telephone calls with patients as part of validation checks (see paragraph 2.11) or when arranging appointments confirming contact details and whether any additional support at the appointment is required. If telephone contact is unsuccessful, a bilingual letter is issued.
- Issuing letters to arrange or to book appointments.

- The 'Doctor Doctor' text system is being trialled in Trauma and Orthopaedics to determine whether patients still need an appointment, and appointments can be arranged at short notice. At the conclusion of our review, the system was due to be rolled out within some areas of gynaecology, e.g. hysteroscopy, to assist with validation of the waiting list.
- The Envoy system is used to generate texts to inform the patient of their appointment time and provides reminders.

2.40 In addition to this, gynaecology has an in-house booking team for booking some appointments, e.g. hysteroscopy. Ophthalmology has an admissions team who manage daily calls from patients and direct book the pre-assessment and cataract clinic appointments, and theatre bookings. A pre-assessment questionnaire for cataract patients is sent out approximately 26 weeks in preparation for their 52-week appointment.

2.41 We were unable to confirm that there has been regular communication with patients on the waiting lists for the specialities reviewed as the information is not easily accessible, e.g. contact recorded in a free-text field (see **Matter Arising 2**).

2.42 Welsh Government's *'Promote, prevent and prepare for planned care'* (August 2023) Policy has been developed to tackle the unprecedented delays in care and treatment. The '3Ps Policy' provides a detailed overview of what health boards, and wider services involved in delivering 3Ps support, are expected to deliver consistently across Wales under a phased implementation:

Table 7:

<table>
<tr>
<td>Welsh Government's 'Promote, prevent and prepare for planned care' (August 2023)</td>
<td>

Promote - improved health behaviours – offering information and support to patients on waiting lists on how to self-manage health and wellbeing;
Prevent - worsening health – targeted intervention for those people who have been referred to secondary care for specialist interventions;
Prepare - for treatment and recovery - providing specialist support to people leading up to their treatment, including prehabilitation.

Implementation of the 3Ps Policy will be undertaken in 2 phases:

Phase 1 (April 2023 to March 2024): Deliver on the outcomes identified for phase 1 to standardise the 3Ps offer across Wales and ensure equity of access to services for the people of Wales.

Phase 2 (April 2024 to March 2025): Embed the model as business-as-usual and extend the scope of the model to maximise integrated approaches across the health and care system to deliver seamless support to the people of Wales.
</td>
</tr>
</table>

2.43 There is a 3Ps Programme set up within the health board to assist with the delivery of the 3Ps Policy. There is dedicated project management support, and we note that a new Senior Responsible Officer (SRO) is due to be appointed (the current SRO will remain in the role until a new SRO is in place). A governance structure has been designed to include a Steering Group supported by various task and finish

groups. Terms of reference have been prepared but have not been finalised (see **Matter Arising 4**).

2.44 Programme highlights are reported to the Planned Care Programme Board. A recent submission to Welsh Government noted progress against the 35 Phase 1 deliverables for Quarter 4; 19 actions have been fully implemented; 14 actions partly implemented; 1 action in planning stage (development of an accessible directory of services for the public); and 1 action not started (there is a standardised script to support staff to identify people's needs and have conversations about what matters to them). Partly implemented actions relate to measures to offer 3Ps support at the earliest opportunity.

2.45 Recent reports to Quality & Safety Committee note that waiting times continue to be a primary theme in negative feedback from patients. Complaints can be taken to the Public Services Ombudsman for Wales, and the health board has recently received three public interest reports relating to the management of waiting lists for orthopaedic surgery. The Welsh Government requested that **all** health boards provide assurance on the audits or validation checks carried out in the last 12 months to confirm compliance with fully communicating with referrers and patients if a pathway has been closed or is re-rest from their original referral date for any reason.

2.46 In line with this request, the health board reviewed a sample of trauma and orthopaedics patients to confirm that the RTT clock reset rules had been applied appropriately. No incorrect entries were identified, but testing highlighted that patients who have had their RTT clock reset are not easily identifiable within WPAS, and the importance of adding notes to patient records for RTT event alterations. This exercise will now be carried out monthly, selecting a different speciality each time, with the results reported to the PAM Steering Group and escalated to service groups where appropriate.

2.47 The health board has also received two recent non-public interest reports from the Public Services Ombudsman for Wales relating to the delays in waiting for cancer treatment or surgery. Whilst the recommendations made within the report have been shared within the relevant service group, there needs to be wider sharing of key issues relating to waiting list performance across specialisms to highlight lessons learnt and good practice (see **Matter Arising 5**).

Conclusion:

2.48 Waiting times continue to be a primary theme in patient feedback. There needs to be better triangulation of reporting that does not just focus on performance relating to waiting times to assist with organisational learning and identifying good practice. We recognise that there is still more work for the health board to do in terms of offering more support to patients in line with Welsh Government's 3Ps Programme, but measures have been put in place to improve patient contact including the development of a communications and engagement strategy and utilising technology. We assign this objective **reasonable** assurance.

Appendix A: Management Action Plan

Matter Arising 1: Knowledge of Waiting Time Management Processes (Design)	Impact
Policies and Procedures: The Patient Access Policy is available to all staff via the intranet, which was designed to create uniformity of waiting list management processes within the Health Board. However, the Policy details it was approved by Abertawe Bro Morgannwg University Health Board's Executive Team and has a review date of June 2018. There were some revisions to the Policy during 2022, however we have been unable to obtain a copy. There are national rules relating to Referral to Treatment (RTT) rules which staff can refer to, but the Patient Access Management (PAM) Team have been updating the Policy (using the 2018 version as a baseline) and Standard Operating Procedures (SOPs) are being reviewed and standardised within the health board to assist with staff awareness and understanding with an appropriate framework designed to approve them. Revisions were near to completion, but recent training feedback has resulted in further revisions to the Policy and to the SOPs. The '*Access to Cancer Services'* audit identified that the Cancer Waiting Times and Escalation Policy details a review date of July 2022. The Policy is currently being reviewed and documented procedures to support the Policy will need to be developed. Training: Two training sessions were delivered to staff during January 2024, but course delivery was paused as outlined to Outpatients Board (15 February 2024): "*Staff within Swansea Bay University Health Board (SBUHB) have not received training on the principles of Referral to Treatment (RTT) since 2009 therefore the need for a high-quality training programme is critical. Whilst the newly established Patient Access Management Team have progressed with the development of policies and procedures and started to deliver some training sessions, significant concern has now been raised regarding the application of these rules and the impact this is having on the patient pathway. The PAM Team have reported that standards are below that expected to ensure appropriate conversations with patients about waiting times, as well as raising concern over levels of data quality and the application of RTT rules. In the few sessions that have taken place, the training has taken a lot longer than originally anticipated due to the*	Potential risk of: • Staff are unclear of waiting time management processes resulting in non-application of RTT and SCP rules. This could impact data quality, patient communication, and result in longer delays for appointments or treatments.

lack of understanding of basic rules and RTT principles."

The plan is to resume training by the end of May 2024 to support the finalised policy and SOPs, and some of the transformation funding available will be repurposed for recruitment to enable a digital platform to be developed to enhance training.

While the above training will signpost to cancer performance processes, it is not intended to provide a detailed overview as there are different pathway events and systems used. No recent training has been provided of this area.

Recommendations		**Priority**
1.1	Management should ensure that all policies and procedures that relate to the management of waiting lists (including procedures that relate to cancer performance), are developed or updated as soon as possible to provide clarity over the processes to be followed and the rules to be complied with.	**High**
1.2	Once approved, policies and procedures should be circulated to all staff and retained in a central location.	
1.3	The training programme should be finalised and rolled out to improve knowledge of key principles and guidance in relation to waiting time management and provide clarity on cancer performance processes.	
1.4	The health board should ensure that all key staff involved in the process complete the required training.	

Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	Patient Access Team to provide the Patient Access Management (PAM) Group with a list of all Policies and Procedures (relating to waiting lists) with review dates included: Patient Access Team to provide a detailed update in regards to: • which SOPs have been reviewed / approved • plan for reviewing the remaining SOPs and expected timeframe for approval	June 24	Patient Access Management Team

1.2	Patient Access Team to ensure all approved policies and procedures and communicated via the PAM Sharepoint page. Patient Access Team to agree a launch date for the page and communicate to all staff. Patient Access Team to be responsible for version and control and review of the policies and procedures.	July 24 Ongoing	Patient Access Management Group
1.3	Patient Access Management to provide an update to the PAM Group in each meeting regarding the completion of the on-line modules. Patient Access Management to provide the timelines and detail of the roll out of the training programme	Commence July 24	Patient Access Management Team
1.4	Patient Access Management to provide an update to the PAM Group in each meeting. The report to include: • Completion rate of the training modules • Attendance of each module by speciality • Areas of low attendance to be escalated	Commence July 24	Patient Access Management Team

Matter Arising 2: Waiting List Maintenance and Patient Prioritisation (Design)	Impact
Availability of Waiting List Data: Discussions with key staff established that there are checks of waiting list data, e.g. validation checks by the Planned Care Team and ophthalmology, weekly checks by the PAM Team, etc. However, it was difficult to evidence from the information provided the frequency or outcome of these reviews. Sometimes, we were unable to obtain source data only confirming the output of reviews when they were reported to the various committees and boards. We were only able to gain access to the Planned Care dashboard and system reports following the conclusion of our review to confirm that patients have been appropriately prioritised, and patients on several pathways have been effectively managed. We were unable to confirm the level of communication with patients on the waiting list as the information is not easily reportable (the WPAS system does not have the functionality to easily evidence changes made, e.g. patient contact and validation checks are recorded in a free-text field). Lack of Checks of Waiting List Data: Performance reporting to Outpatients Board (15 February 2024) noted that validation checks of waiting list data are currently being undertaken on an 'ad hoc' basis. Prioritising the focus on addressing waiting list backlogs and staffing capacity was highlighted as reasons during our audit that have impacted staff being able to carry out checks of waiting lists to ensure that they are maintained and up-to-date. There has been no recent re-prioritisation of patients based on their current healthcare need within the specialities reviewed (as the SCP is a target of 62 days, there would not be the need to reprioritise cancer patients). However, we are aware that consultants undertook this exercise during the COVID-19 pandemic within gynaecology and ophthalmology.	Potential risk of: • Infrequent checks and/or data not being readily available to evidence that waiting lists are being maintained and up-to-date resulting in data inconsistencies, and patients waiting for appointments or treatments longer than they should.

Recommendations		Priority
2.1a	A robust system should be implemented to ensure that services carry out regular and consistent reviews of waiting list data to ensure data is up-to-date and patients are prioritised based on their current healthcare need.	High
2.1b	An appropriate audit trail should be maintained to confirm the frequency and outcome of these checks.	

Agreed Management Action		Target Date	Responsible Officer
2.1a	New monitoring proforma in the process of being implemented for use within the service teams to enable review of current waiting lists and accuracy of data available in monitoring dashboards.	May 24	Service Managers
2.1b	Proformas to be reported to each of the bi-weekly meetings to provide details of what checks are being undertaken and any updates made.	May 24	Performance Scrutiny Meetings

Matter Arising 3: Effectiveness of Monitoring Arrangements (Operation)	Impact
Performance Dashboards: Several performance dashboards have been made available to staff to enable them to monitor waiting list data. As staff have cited capacity issues impacting their ability to carry out checks of the waiting list, this may also result in staff being unable to review dashboards frequently. Performance reporting to Outpatients Board (15 February 2024) also highlighted inconsistencies of these multiple tools being used with no scrutiny of data accuracy nor governance to approve the development of dashboards. The issue was also discussed at the PAM Steering Group (28 February 2024) where it was decided to review the list of dashboard users to confirm last access, and to explore the feasibility of amalgamating the dashboards. The Ophthalmology Service Manager highlighted that the Vitals dashboard and the RTT report does not extract the Eye Care Measures Ophthalmology grading on Health Risk Factor (e.g. R1, R2, R3). This explains why the Vitals dashboard is reporting 6,020 patients as 'awaiting grading' where the actual figure is 279. The Deputy Chief Operating Officer explained that Welsh Government reporting, and that carried out internally, would not use the data contained within Vitals dashboard so should not affect the accuracy of reporting. However, reporting between monitoring tools should be aligned or fully integrated where possible to prevent confusion, particularly in the absence of key staff. Action Plans: While action plans are used to assist with monitoring improvements with waiting lists, there is not a consistent template used across services to confirm that the necessary actions have been undertaken and to assist with identifying measures to sustain improvement. Note: a similar enhancement was raised in our '*Access to Cancer Services*' review. Reporting: Waiting list data for Planned Care is categorised on the Vitals dashboard as 'Reported', Non-RTT' and 'Unreported' (there is also an 'Excluded' categorisation for patients not on pathways and are therefore not RTT -reportable) to clarify what data is RTT-reportable to Welsh Government. For gynaecology, there are 219 patients that are categorised as 'Unreported' and 522 patients for ophthalmology. The Covid pandemic impacted waiting lists, which got longer and increased waiting times, but there has been no recent check of the 'Unreported' to confirm that patients have been correctly categorised,	Potential risk of: • Ineffective monitoring resulting in no action being taken to address poor performance; • Inability to make improvements to address waiting list issues; • Inaccurate reporting or significant issues not being escalated promptly.

e.g. if the RTT element of their pathway is triggered correctly.			
Recommendations			**Priority**
3.1a 3.1b	Review of the data tools available, to assist in the monitoring of waiting list performance (to include cancer performance), should be undertaken to confirm: - the tools are still required and do not cause duplicate of effort in monitoring them; - the accuracy of the data contained within them; - the data can be consistently reported. Implementation of a robust governance structure for approving performance monitoring tools.		**Medium**
3.2a 3.2b	Guidance should be provided to staff clarifying their responsibilities for monitoring the performance monitoring tools. There should be oversight to confirm that services are utilising the performance monitoring tools effectively and frequently.		
3.3	To assist with delivering and sustaining improvement within waiting list management, a consistent template for action plans should be developed to provide confirmation of ownership and timescales for implementation.		
3.4	A review of patients categorised as 'Unreported' should be undertaken to confirm that any RTT-reportable element of a patient's pathway is being triggered appropriately.		
Agreed Management Action		**Target Date**	**Responsible Officer**

3.1a 3.1b	Data quality checks and standardisation of data used for performance management are being picked up and reported via the PAM group. Review of tool requirements is being continuously undertaken as part of the bi-weekly performance meetings with the services. In addition to this, for cancer performance, requirements are discussed via an All Wales Cancer Managers forum and developments shared across Health Boards for learning. We have now developed a number of data quality checks within the Cancer Dashboard to improve accuracy of data captured for reporting purposes. Standard proformas for the data templates used in the meetings are being developed by the services assisted by the performance teams. For cancer, standardised presentation of tumour site or service waiting list data as well as standardised proformas for weekly monitoring arrangements are in place.	Monthly Meetings (Immediately) Bi-weekly (Immediately) May 25 Monthly meetings (Immediately) Weekly Meetings (Immediately)	Patient Access Management Team Service Group Directors/Performance Manager Patient Access Management Group Patient Access Management Group Cancer Service Performance Manager
3.2a 3.2b	SOP's are being developed to outline "standard work" in relation to monitoring performance and outline roles and responsibilities. User manuals and training packages in how to use performance dashboards are being developed and will be approved via the PAM group governance structure already outlined above. The Patient Access Management Team to monitor the usage of the performance dashboards and provide an update to each Service Manager and the PAM Steering Group. The Digital Team to monitor the usage of the performance dashboards and provide an update to each Service Manager and the PAM Steering Group.	June 24	Patient Access Management Team

3.3	Performance trajectories and recovery plan timelines have been aligned with the timescales outlined in the TI targets provided by WAG. Standardised templates aligned to the timescales given have been developed.	Monthly (Immediately)	Patient Access Management Team
3.4	Each month, the Patient Access Management Team to review an "unreported" waiting list and confirm that any RTT reportable element is being triggered appropriately. Any issues identified to be reported to the Service Manager and addressed asap. A record of the issues identified to be recorded and discussed at the Performance Scrutiny Meetings.	Monthly (Immediately) Bi-weekly (Immediately)	Service Managers Performance Manager

Matter Arising 4: Governance Arrangements (Operation)	Impact
Governance: There is a governance structure for oversight of planned care waiting list performance, but we have not seen the finalised versions of the terms of references for the PAM Steering Group and Corporate Performance Scrutiny meetings to confirm roles and accountabilities and that decision making is appropriate at each level of the governance structure. Our review of the final version of the terms of reference noted that: • Planned Care Programme Board - details a review date of August 2023. • Outpatients Board – the document refers to Outpatients Redesign and Recovery Group instead of the Board and details the document is draft even though the file name confirms it was finalised March 2024. • Eye Care Collaborative Group – the document details it will be reviewed annually, but records it was last reviewed October 2022 and that the Group reports to the Welsh Ophthalmic Planned Care Board (which is no longer the case). Ophthalmology was also previously under 'Gold Command' (which was established to monitor there is a single approach across ophthalmology pathways to minimise duplication and consistency of reports). Gold Command has now been stood down because of the continued reduction in the number of follow up patients and this was reported to Quality & Safety Committee (28 November 2023). Governance arrangements will also need to be reviewed as part of the development of a regional eye care service. There is also a governance structure for the '3Ps: Promote, Prevent & Prepare Programme' where terms of reference have not been finalised (draft copies were provided for the task and finish groups for 3Ps Communication & Engagement, Digital and Single Point of Contact). It is unclear whether the terms of reference for the Programme Board have been finalised. Cancer performance is subject to its own governance structure. Terms of reference for the Cancer Performance Group (CPG) and Cancer Programme & Improvement Group (CPIG) are not yet finalised. This was identified within the 'Access to Cancer Services' audit, therefore we have not replicated a recommendation in this report.	Potential risk of: • Unclear roles and responsibilities could result in poor decision making and a lack of accountability and oversight. • Resources being used inefficiently if boards and groups duplicate in their undertaking of roles and responsibilities.

The CPG'S terms of reference have been addressed and closed on the Internal Audit recommendation tracker; and that work is still needed to finalise those for the CPIG. However, there needs to be terms of reference for the scrutiny meetings with Service Groups.			
Recommendations			**Priority**
4.1	The health board should ensure that it reviews and has finalised versions of the terms of reference for boards and groups within the governance structure for monitoring 3Ps and waiting list performance.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	Finalised TOR have been presented to Planned Care Board and approved. These include: • Patient Access Management Group • 3Ps Steering Group • 3Ps Communication Task and Finish Group • 3Ps Digital Task and Finish Group • 3Ps SPOC Task and Finish Group	Complete Complete	Outpatients Redesign and Recovery Board Planned Care Board

<table>
<tr><th colspan="2">Matter Arising 5: Organisational Learning (Design)</th><th>Impact</th></tr>
<tr><td colspan="2">Following the Health Board recently receiving three Public Interest reports from the Public Services Ombudsman for Wales (11 January 2024) relating to the management of waiting lists for orthopaedic surgery, it was agreed in the PAM Steering meeting (February 2024), in line with a request from Welsh Government to all health boards, that a minimum of 50 patients who have had their RTT clock reset will be selected at random, from a different speciality each month, and independently checked to confirm the appropriateness of the application of the RTT rules.

The outcome of this review was reported to the PAM Steering Group (28 February 2024) concluding that the RTT clock reset rules had been applied appropriately for the sample selected. However, the report detailed that currently, there is no easy way to identify patients who have had their RTT clock reset in WPAS, as no flag currently exists within the system to allow identification (a SQL query had to be written to enable testing). The discussion highlighted the importance of adding notes to patient records whenever an alteration is made on an RTT event, and any issues identified as part of these checks will be escalated to service groups.

The Health Board has also received two recent non-public interest reports from the Public Services Ombudsman for Wales relating to the delays in waiting for cancer treatment or surgery (202103036 -November 2023; 202102574 - March 2023).

While the Cancer Performance & Information Manager was aware of the Ombudsman's investigations, she has not seen the resulting recommendations nor had the COO or Deputy Chief Operating Officer. The Concerns Assurance Manager (Patient Feedback Team) confirmed that action plans resulting from Ombudsman reports are shared throughout the relevant service group. However, there needs to be wider cross-service learning and reporting within the health board of issues relating to waiting list performance to highlight lessons learnt and any good practice, e.g. if there are recommendations for one specialism, these may be applicable in other areas.</td><td>Potential risk of:

• Lack of organisational learning in respect of waiting list management issues resulting in poor performance and an increase in patient complaints and Ombudsman reports.</td></tr>
<tr><th colspan="2">Recommendations</th><th>Priority</th></tr>
<tr><td>5.1</td><td>A mechanism to enable post-implementation learning should be developed to completely capture and report good practice and lessons learnt from issues relating to waiting list performance.</td><td>Medium</td></tr>
</table>

Agreed Management Action		Target Date	Responsible Officer
5.1	The Patient Access Management Team to share examples of “Good Practice” on the PAM SharePoint page The Patient Access Management Team to evaluate any concerns, complaints raised regarding waiting list management and ensure appropriate training is put in place where themes are being identified.	July 2024 onwards	Patient Access Management Team

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:

Rating	Definition
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]