

Data Quality

Final Internal Audit Report

2024/25

Swansea Bay University Health Board



Reasonable Assurance

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Review Reference

SBU-2425-20

Fieldwork

14 November 2024 – 31 January 2025

Executive Sign Off

10 March 2025

Audit Committee

March 2025

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Executive Summary

Purpose

Review of the structures and processes for ensuring data quality and accurate reporting within the health board, with a focus on the validation of waiting lists on the Welsh Patient Administration System (WPAS).

Overview

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

1. Whilst WPAS benefits from proactive data quality oversight, other clinical systems lack equivalent monitoring, relying on users to identify and report issues, which may lead to inconsistent data management and delays in resolving data quality issues.
2. Linked to the above matter, the Information Governance Learning and Operational Group (IGLOG) has data quality as a key agenda item, and should receive assurance from across the clinical system landscape rather than the current limitation of WPAS data quality only.
3. The scheduled 2025 meetings of the IGLOG and Information Governance & Cyber Security Assurance Group (IGCAG) have been delayed due to capacity restraints within the IG team.
4. The Terms of Reference of the IGLOG and the Patient Access Management Steering Group (PAMSG) remain in draft format.
5. The governance framework for PAMSG and its sub-group, the Patient Access Policy and Procedures Working Group, is unclear, with different structures noted between the groups' TORs and the actual reporting relationships.

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

Scope & Assurance Summary

Objectives

		Related Findings	Assurance
1	Guidance is in place that sets out the requirements and responsibilities for data quality across the health board	-	Substantial
2	There are adequate quality assurance checks to ensure the data reported is complete, valid, timely, accurate, consistent and precise	1	Reasonable
3	There is appropriate monitoring and reporting of data quality within the health board	2, 3, 4, 5, 6	Limited

Management Actions

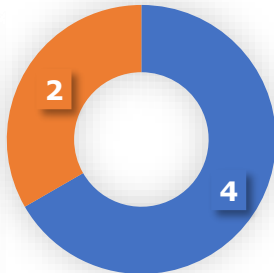


High Priority



Medium Priority

Themes



- Governance
- Information, Data Quality & Data Accuracy

Risk Types

- Financial Loss
- Legal & Regulatory Non-Compliance
- Quality or Safety Issues
- Public Perception & Reputational Risk

Findings & Agreed Action Plan

Objective 1: Guidance is in place that sets out the requirements and responsibilities for data quality across the health board.

Substantial

The health board has a Digital Strategy in place, which has recently been reviewed and updated. Whilst it was not approved by the Board at its September 2024 meeting due to further required refinement, it is scheduled to be re-submitted to the Board for approval in March 2025. In addition, a 5-year Quality Strategy is in place, published in 2023, and supports the achievement of the health board's strategic goals of being a digital-first, data-driven organisation.

An established Data Quality Policy is in place, which has recently been reviewed and updated, and is currently going through the approval process. The policy covers all types of activity where data is collected. Roles and responsibilities are clear with an emphasis on data quality being the responsibility of all staff. If persistent data quality issues are identified despite training and support, staff may be subject to disciplinary action.

Whilst no specific Data Quality training is in place, where issues and trends are identified, the Data Quality team will offer support in the form of additional training if required. We noted an established Clinical Systems intranet page is in place, which hosts a variety of e-learning user guides and online training for all health board applications.

The Patient Access Management Support Team (PAMS) is currently rolling out a training program aimed at enhancing staff understanding of Referral to Treatment (RTT) rules, their impact on patient pathways, and the role of the Welsh Patient Administration System (WPAS) in managing those pathways. A PAMS SharePoint site is under development, but will include Policies and Procedures, Planned Care Academy and Digital Dashboards. We positively note that the Patient Access Policy was revised and approved by the Patient Access Management Steering Group in October 2024. We also highlight favourably that these improvements will contribute towards addressing previous recommendations made within the internal audit report on Waiting List Management (SBU-2324-13).

We identified no matters arising for this objective.

Objective 2: There are adequate quality assurance checks to ensure the data reported is complete, valid, timely, accurate, consistent and precise.

Reasonable

The Data Quality team is established and primarily concentrates on enhancing the quality of data within WPAS. This approach ensures that essential quality assurance standards are maintained where they have the greatest impact. The team employs a range of strategies to drive improvements, including providing training and support, investigating and correcting erroneous data, and implementing system changes where possible. Product Specialists are in place for all health board clinical systems, and we note from our review of three systems (TOMS Theatre system, Signal and the Welsh Nursing Care Record (WNCR)) that whilst the latter system benefits from proactive monitoring for data quality issues, the others are more reactive in approach with reliance on the service highlighting any issues to the Product Specialist to investigate. **See Key Finding 1.**

The Data Quality team receive the Validation at Source Service (VASS) reports generated by Digital Health and Care Wales (DHCW). On a weekly basis, they process WPAS data through the VASS checks, uploading files and receiving error reports in return. The team reviews these errors and conducts further investigations with the relevant service teams. The VASS reports provide organisations with early warnings of potential data quality issues on a monthly basis, allowing for corrections to be made before the data is finalised for submission to the national database. We reviewed the VASS report that was presented at the October 2024 IGLOG meeting and positively note that the team is currently maintaining over 97% compliance, which compares well against other NHS Wales health boards.

In addition, the Data Quality team run a range of reports to monitor and address specific data quality issues within WPAS. These reports are run daily to identify any discrepancies or errors in the data, which are then corrected by the team where possible. In cases where additional information is needed, the team liaises with the relevant service areas for support. We are pleased to note that the team is actively working on transforming these reports into digital dashboards using Microsoft PowerBI, enhancing both accessibility and efficiency.

In relation to the Referral to Treatment (RTT) process within planned care, the Health Care Systems Engineering Team utilise dashboards to check and monitor all stages. In January 2024, the Public Services Ombudsman published a report into the investigation of a complaint against the health board regarding orthopaedic waiting times, in which recommendations were made to improve service management inclusive of a full audit of the waiting lists. We were informed that the health board conducted an audit of over 1,800 pathways and submitted the results, which concluded that 96.5% of the pathways were managed appropriately, to the Ombudsman in December 2024. No significant impacts on patient care or inaccuracies in reported waiting times were found. In response to the Ombudsman, the health board identified a series of improvement recommendations that it would implement in respect of training and education and ongoing monitoring. Our review highlighted that the health board has made good progress in these areas including the launch of the Planned Care Academy and development of training modules, and continued monthly audits of waiting lists to ensure sustained compliance and to identify any issues. The audit findings are used as a feedback loop for staff to address and rectify issues promptly, in addition to enhancing the planned care training programme if any thematic issues are noted.

Key Findings	Risk & Impact	Agreed Management Action
<p>1 Data Quality Monitoring</p> <p>Whilst the Welsh Patient Administration System (WPAS) benefits from proactive and comprehensive data quality checks and monitoring, other clinical systems within the health board do not have equivalent oversight, with limited data quality reporting and dashboarding. Whilst Product Specialists are in place for clinical systems, data quality issues in these systems are primarily identified and reported by users which can lead to inconsistent data quality management, and delayed identification and resolution of data quality issues.</p>	<ul style="list-style-type: none"> • poor decision making; • failure to achieve performance measures and organisational objectives; • patient harm; and • exposure to financial loss and reputational damage. 	<p>Agreed Action:</p> <p>The Product Specialists carry out various data quality tasks as part of their day to day duties and data quality forms part of their job description. The data quality measures for the systems managed by Digital Services will be formalised, documented and monitored to allow reporting and therefore improved oversight.</p> <p>A process will be implemented to agree data quality measures for new systems/ modules or upgrades to existing systems and these will form part of the transition to business as usual following implementation.</p> <p>SBU has a mixed economy of systems managed centrally within Digital Services and others that are managed within specialty/ service areas, such as Radiology, Pathology, Cardiology, where digital subject matter experts manage, maintain and monitor the service-specific systems in those areas. The subject matter experts provide quarterly updates to the Digital Services Management Group (DSMG). Taking a pragmatic approach to reporting from the specialty/ service areas, Data Quality will be added to the standard reports that these services provide to DSMG.</p> <p>Expected Evidence of Implementation:</p> <p>Data Quality reporting to IGLOG for systems managed within the Clinical Systems and Data Quality team in Digital Services.</p> <p>Data Quality reporting to Digital Services Management Group (DSMG) for service specific clinical systems.</p>
<p>Theme: Information, Data Quality & Data Accuracy</p>	<p>Medium Priority</p> <p>Control Operation</p>	<p>Officer: Head of Digital Applications / Head of Digital Operations Service Modernisation and Transformation</p> <p>Date: 30/06/2025</p>

We acknowledge that the governance structure for data quality has undergone a period of significant change. The Information Governance Learning and Operational Group (IGLOG) has recently been established and reports to the Information Governance & Cyber Security Assurance Group (IGCAG). The first IGLOG meeting was held in October 2024, during which data quality was included as a key agenda item. IGLOG will receive quarterly VASS check reports, which currently include 301 checks covering validity and consistency indicators. These indicators assess a variety of datasets such as Admitted Patient Care (APC), Outpatient Activity (OPA), Outpatient Referrals (OPR), Emergency Department (ED) and Critical Care (CC), with specific focus on the timeliness of submissions and the validity/consistency of the data within WPAS. We note that no assurance was provided over other clinical systems within the health board. **See Key Finding 2.**

We note that the Terms of Reference (TOR) for IGLOG was presented to the Group for approval at its first meeting, however, minutes from the meeting are unavailable and we have been unable to determine whether approval was granted. **See Key Finding 3.** We further note that the governance structure within the TOR has since changed, in that the IGCAG has recently altered its reporting route from the Workforce, Organisation Development & Digital Committee to the newly established Digital, Data, Innovation and Research Committee (DDIRC), which held its first meeting in November 2024. As IGCAG has not met since its last meeting in September 2024 and IGLOG has not met since its first meeting in October 2024, we have also been unable to verify the effectiveness of the new reporting route, due to the absence of meeting minutes. As outlined in the TORs, IGLOG is expected to meet quarterly and IGCAG on a bi-monthly basis. However, due to capacity constraints within the IG team, these meetings have not occurred as scheduled. **See Key Finding 4.**

Separately, in respect of Referral to Treatment (RTT) reporting we noted that the Patient Access Management Service (PAMS) has been set up specifically to support staff to deliver improved patient access. The PAM Steering Group (PAMSG) was established in November 2023 to scrutinise and monitor the performance of the health board’s Referral to Treatment Times (RTT), to ensure the trajectories and plans set out in the annual plan are achieved. Whilst we observed a good level of reporting to PAMSG, we have been unable to determine the onward reporting journey to the Board. We noted that the PAMSG Terms of Reference (TOR) remains in draft format, and we were not provided with a finalised version, despite this finding being raised and indicated as completed in a previous internal audit report on Waiting List Management (SBU-2324-13). This may also impact the accuracy of the Audit Committee recommendations’ tracker if incorrectly recorded. **See Key Finding 5.** The draft TOR references the provision of support to the Planned Care Board. However, during our review of the governance structure for the newly established sub-group of PAMSG (Patient Access Policy and Procedures Working Group), we observed a different structure. Specifically, the Quality and Safety Committee (QSC) holds delegated authority over PAMSG, rather than the Planned Care Board. Our review of QSC papers did not identify any updates from the PAMSG. **See Key Finding 6.** However, we did observe comprehensive reporting on RTT via regular Planned Care Updates, Integrated Performance Updates and Targeted Intervention Reports to the Performance and Finance Committee.

Key Findings	Risk & Impact	Agreed Management Action
<p>2 Data Quality Reporting</p> <p>Linked to key finding 1, not all clinical systems within the health board are proactively monitored for data quality issues. Whilst we note that IGLOG will receive quarterly validity and consistency reports, this pertains to WPAS data only. As IGLOG includes data</p>	<ul style="list-style-type: none"> • poor decision making; • failure to achieve performance measures and organisational objectives; • patient harm; and • exposure to financial loss and reputational damage. 	<p>Agreed Action:</p> <p>As per KF1, provide data quality updates and improvement plans:</p> <ul style="list-style-type: none"> • to IGLOG for systems managed within the Clinical Systems and Data Quality team in Digital Services, and

	<p>quality as a key agenda item, it is essential that it receives data quality updates and improvement plans across all clinical systems, not limited to just one. This approach ensures comprehensive oversight and facilitates consistent monitoring and improvement of data quality across the entire clinical system landscape.</p>		<ul style="list-style-type: none"> to Digital Services Management Group (DSMG) for service specific clinical systems
		High Priority	<p>Expected Evidence of Implementation:</p> <p>IGCAG minutes reflecting Data Quality reporting to IGCAG for systems managed within the Clinical Systems and Data Quality team in Digital Services.</p> <p>DSMG minutes reflecting Data Quality reporting to Digital Services Management Group (DSMG) for service specific clinical systems.</p>
	Theme: Information, Data Quality & Data Accuracy	Control Operation	<p>Officer: Head of Digital Applications / Head of Digital Operations Service Modernisation and Transformation</p> <p>Date: 30/06/2025</p>
3	<p>Information Governance Learning & Operational Group TOR</p> <p>The TOR for the Information Governance Learning & Operational Group (IGLOG) currently remains incomplete and in draft format. We further note that it does not reflect the current governance structure and reporting route.</p>	<ul style="list-style-type: none"> poor decision making; failure to achieve performance measures and organisational objectives; patient harm; and exposure to financial loss and reputational damage. 	<p>Agreed Action: The draft ToR will be updated to clarify the governance structures and reporting routes before being presented to the next IGCAG meeting in April 2025.</p>
		Medium Priority	<p>Expected Evidence of Implementation:</p> <p>Approved minutes of April 2025 IGCAG.</p>
	Theme: Governance	Control Operation	<p>Officer: Assistant Director of Digital Services - Business Management and Information Governance</p> <p>Date: 10/04/2025</p>
4	<p>IGLOG and IGCAG Meetings</p> <p>As outlined in the TORs, IGLOG is expected to meet quarterly and IGCAG on a bi-monthly basis. However, due to capacity constraints within the IG team, these meetings have not occurred as scheduled.</p>	<ul style="list-style-type: none"> poor decision making; failure to achieve performance measures and organisational objectives; patient harm; and exposure to financial loss and reputational damage. 	<p>Agreed Action: Dates for the bi-monthly IGCAG for 2025 have been confirmed and the IGLOG dates are currently being finalised.</p>
		Medium Priority	<p>Expected Evidence of Implementation:</p> <p>Meeting schedule for 2025 for IGCAG and IGLOG.</p>
	Theme: Governance	Control Operation	<p>Officer: Assistant Director of Digital Services - Business Management and Information Governance</p> <p>Date: 10/04/2025</p>

5	<p>Patient Access Management Steering Group TOR</p> <p>The TOR for the PAM Steering Group remains incomplete and in draft format, despite being identified as an action and indicated as completed in a prior audit (SBU-2324-13).</p>	<ul style="list-style-type: none"> • poor decision making; • failure to achieve performance measures and organisational objectives; • patient harm; and • exposure to financial loss and reputational damage. 	<p>Agreed Action: The ToR for the PAM Steering Group have been updated to reflect the newly created working groups that now feed into this group and is on the agenda for review and approval at the May 2025 PAMSG meeting.</p>
Theme: Governance		Medium Priority	<p>Expected Evidence of Implementation:</p> <p>Final version of the ToR, which will be uploaded the Patient Access SharePoint site.</p>
		Control Operation	<p>Officer: Head of Transformation, Performance and Improvement</p> <p>Date: 31/05/2025</p>
6	<p>Patient Access Management Governance</p> <p>The governance framework for the PAM Steering Group and its sub-group, the Patient Access Policy and Procedures Working Group, is unclear, with different structures noted between the groups' TORs and the actual reporting relationships.</p>	<ul style="list-style-type: none"> • poor decision making; • failure to achieve performance measures and organisational objectives; • patient harm; and • exposure to financial loss and reputational damage. 	<p>Agreed Action: The PAM Steering Group ToR have been updated to reflect the newly created working groups that now feed into this group and is on the agenda for review and approval at the May 2025 PAMSG meeting.</p>
Theme: Governance		Medium Priority	<p>Expected Evidence of Implementation:</p> <p>Final version of the ToR, which will be uploaded the Patient Access SharePoint site.</p>
		Control Operation	<p>Officer: Head of Transformation, Performance and Improvement</p> <p>Date: 31/05/2025</p>

Appendix A

Assurance Opinion

	Substantial	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
	Limited	More significant matters require management attention. Moderate impact on residual risk exposure until resolved.
	Unsatisfactory	Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.
	Advisory	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 Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)

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Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

