Single Cancer Pathway: Data Quality and Integrity

Final Internal Audit Report

September 2021

Cwm Taf Morgannwg University Health Board

NWSSP Audit and Assurance Services

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
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Shared Services Partnership
Audit and Assurance Services

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Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Contents

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Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

Acknowledgement

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

1. Introduction and Background

Our review of Data Quality & Integrity was part of our 2020/21 programme of work but was delayed due to the pandemic. As such, this review will form part of our 2021/22 work for Cwm Taf Morgannwg University Health Board (the 'Health Board'). The review seeks to provide the Health Board with assurance that there are effective processes in place to manage the risks associated with the quality and integrity of the reported single cancer pathway data.

High quality data is important to any organisation. Within the NHS it can lead to improvements in patient care and patient safety. Quality data plays a role in improving services and decision making, as well as being able to identify trends and patterns, draw comparisons, predict future events and outcomes, and evaluate services. The Health Board must be assured that the data they are using to make decisions is accurate, complete and reliable.

The data collected is subsequently used in decision making and the reporting of key quality and performance indicators at varying levels within the Health Board and beyond, including within the Integrated Locality Groups (ILGs), at Board and committee meetings, and to Welsh Government (WG).

Over the past year, due to the Covid-19 pandemic, while there have been some revised reporting requirements, reporting in relation to cancer targets has remained. Although, changes are being implemented by WG to the way in which cancer targets will be measured.

In November 2018 the Minister for Health and Social Services announced that *"NHS Wales would introduce a Single Cancer Pathway, starting from the moment a cancer is first suspected. This new 62-day waiting time measure includes patients referred from primary care or found to have cancer in hospital care. But most importantly of all, this new Single Cancer Pathway starts when cancer is first suspected."*

In November 2020 the Minister made a further announcement surrounding the Single Cancer Pathway (SCP), which included the following key points:[1]

… "from February 2021, we will report only against the Single Cancer Pathway and will no longer report the previous measures.

… the Single Cancer Pathway will not include any adjustments – we will report the real wait.

… our starting performance measure until March 2022 will be 75%. I expect the performance measure to be revised upwards in subsequent years."

As such, the focus of our data quality and integrity review of will be on the cancer target data that is reported to Board and to WG. This work will help to inform a wider cancer services review that we plan to do in 2021/22.

Under current arrangements, the Performance and Informatics team are 'systems owners' on which data is captured. They have responsibility for extracting data reports from systems within the data warehouse, such as the Welsh Patient Administration System (WPAS). Once extracted, reports are passed to 'data owners'

[1] Written Statement: Progress on the Single Cancer Pathway (18 November 2020) | GOV.WALES

for validation. In the case of SCP data, the Cancer Business Unit perform this validation role and rectify errors ahead of the Performance and Informatics team submitting the data for inclusion in performance reports and WG returns.

In 2020 the NHS Wales Delivery Unit undertook a review within Cancer Services, specifically in Urology and Radiology. As a consequence, management developed an action plan which, at the time of our fieldwork is being implemented. The implementation of those recommendations alongside the implementation of recommendations from our review should help improve data quality in this area.

The relevant Executive lead for the review is the Interim Chief Operating Officer and the Director of Strategy and Transformation.

2. Scope and Objectives

The overall objective of this audit was to evaluate and determine the adequacy of the systems and controls in place within the Health Board in relation to the integrity and quality of the reported SCP data. The review sought to provide assurance to the Health Board's Audit and Risk Committee that risks material to the system's objectives are managed appropriately.

The review will seek to provide assurance over the following areas:

- Appropriate arrangements and procedures are in place in relation to the collection of SCP data.
- SCP data is accurately recorded for all patients in accordance with WG guidance.
- There are adequate quality assurance checks within the process to ensure the data reported is complete, valid, timely, accurate, relevant and reliable.
- Effective processes are in place to ensure timely monitoring and reporting of the SCP data, both to the WG and within the Health Board.

Our review is concentrating on the accuracy of the reported figures and not the compliance rates.

3. Associated Risks

The potential risks considered in the review were as follows:

- The service does not meet performance measures due to ineffective monitoring and governance arrangements.
- There is a lack of trust in the data due to weaknesses in the accuracy and completeness of the patient management system.
- Exposure to reputational issues for the Health Board, should reported data be found to be inaccurate or incomplete.
- Patients suffer avoidable harm through inefficiency and delays caused by data issues not being managed correctly and expediently.

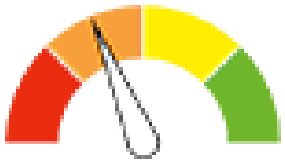
OPINION AND KEY FINDINGS

4. Overall Assurance Opinion

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

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with the single cancer pathway data quality and integrity is *limited assurance*.

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

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

As noted in the scope section, our review did not scrutinise the compliance rates against the WG 62-day SCP target, rather we reviewed if the data that informed the reported results was accurate and reliable. For our sample period of January 2021 (reported against the Single Cancer Pathway), the reported percentage of treated pathways achieving this target was 49%, against the WG initial target of 75%.

The governance structure for Cancer Services includes a recently formed Cancer Steering Group, that allows for the monitoring and reporting of SCP performance. However, we identified that some key members of the group did not regularly attend the meeting due to clinical commitments. The terms of reference for the group also remain in draft.

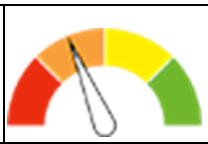
At the time of our audit fieldwork management were drafting a Standard Operating Procedures (SOP) in relation to data validation. In addition, a number of SOPs for capturing and recording SCP data were in draft and awaiting approval. We also note that, unlike other health boards, the Health Board does not have a corporate policy or strategy surrounding data quality, although a performance and clinical information strategy is in draft.

Our testing of SCP data reported to the Board and WG in March 2021 identified issues in terms of both the accuracy and completeness of the data captured for inclusion, and the validity of the data that was reported. For example, we identified an issue in the scripts that draw the data from the data warehouse for inclusion in the reports, meaning that there has been an under-reporting of the number of patients treated. Furthermore, we understand that there is an all-Wales issue where patients whose records are updated after the monthly data has been extracted for reporting, are not captured in the reported information, either in month or in the subsequent month.

Our testing to validate a sample of the cases included within the data reported in March 2021 identified instances where the source documents had not been uploaded to the clinical portal. This meant we were unable to confirm if the correct dates had been used to calculate performance against the 62-day target. While we understand that some validation work is carried out by staff in the Cancer Business Unit who undertake cancer tracker work, this was limited to those cases that breached the 62-day target and was not subject to any quality reviews. There was no validation work on cases that had met the 62-day target. Issue logs were not kept that would allow the identification of trends and help future learning. Although, we acknowledge that management are taking actions to improve the control environment, which includes the validation processes.

5. Assurance Summary

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

Assurance Summary					
1	Arrangements and procedures in for the collection of SCP data			✓	
2	SCP data is accurately recorded		✓		
3	Quality assurance checks		✓		
4	Timely monitoring and reporting.				✓

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

Design of Systems/Controls

The findings from the review have highlighted three issues that are classified as weaknesses in the system control for single cancer pathway data quality and integrity.

Operation of System/Controls

The findings from the review have highlighted two issues that are classified as weaknesses in the operation of the designed system for single cancer pathway data quality and integrity.

6. Summary of Audit Findings

In this section we set out the good practice and summarise the findings that we identified during our fieldwork. The detailed findings from our review are set out in the Management Action Plan (Appendix A).

Objective 1 - Appropriate arrangements and procedures are in place in relation to the collection of SCP data.

We note the following areas of good practice:

- Cancer Services have a documented governance structure in place that details accountability lines.
- Management has established two key forums where cancer services performance including SCP data is discussed: The Cancer Steering Group (CSG), which reports into the Cancer Programme Board (CPB). The groups share some common members that helps two-way communication.

  The CSG meetings have been held each month since its inception in January 2021. Cancer services performance is a standard agenda item.
- The CPB has a defined ToR that includes key governance information such as membership and purpose.

We identified the following findings:

- The Health Board does not have a corporate policy in relation to data quality, or operational procedures for collecting and validating SCP data. (Finding 4 - Medium)
- The terms of reference for the CSG have not been formally approved by the CPB. We also note that between January and March there were low levels of attendance by key personnel. (Finding 5 - Medium)

Objective 2 - SCP data is accurately recorded for all patients in accordance with WG guidance.

We identified the following finding:

- We identified data accuracy and validation issues in our sample of patient pathways. For example, where non-cancer pathways had been included in the data. (Finding 2 - High)

Objective 3 - There are adequate quality assurance checks within the process to ensure the data reported is complete, valid, timely, accurate, relevant, and reliable.

We note the following area of good practice:

- Monthly validation reports are sent to cancer services for validation prior to internal and external reporting.

We identified the following finding:

- We were unable to fully reconcile the data produced for reporting purposes to the systems containing the raw data as the program that had been set up for pulling the raw data did not capture patients from certain categories, meaning that the Health Board were under reporting on the number of patients treated in a month.

  We also identified a number cases that were not reported where patient records had been updated after data had been extracted for reporting purposes. Although we note that this is an all-Wales matter. (Finding 1 - High)

- Whilst some validation work was being undertaken, there were no quality assurance checks within cancer services on this validation process. Also, an issues log is not being maintained to capture any errors identified through the validation processes and allow for trends to be established. (Finding 3 - High)

Objective 4 - Effective processes are in place to ensure timely monitoring and reporting of the SCP data, both to the WG and within the Health Board.

We note the following areas of good practice:

- The SCP performance against the WG targets is reported to the Planning, Performance and Finance Committee as part of the integrated performance dashboard.
- The Board also receives regular updates on the SCP performance position as part of its assessment dashboard.
- Monthly performance information is also submitted to the WG.

7. Summary of Recommendations

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

A summary of these recommendations by priority is outlined below.

Priority	High	Medium	Low	Total
Number of recommendations	3	2	0	5

Appendix A: Management Action Plan

Finding 1- Accuracy of reported SCP data (Control design)	Risk
The WG SCP target is for 75% of cases to be treated within 62 days. The January 2021 data was reported to WG and the Health Board in March 2021 and showed only 49% of cases achieved the target. Our review is concentrating on the accuracy of the reported figures and not the compliance rates. This 49% is further broken down in the March 2021 Board report and the WG submission to show the number of breaches and treated pathways by tumour site such as lung or urology. There were 194 people recorded as treated on both the WG and Board submissions. However, when we attempted to reconcile this data to the 'number of patients treated' information on the Health Board's 'Klik sense tracker module', that holds the patient pathway data from the WPAS and other data warehouse sources, there was a difference of 15 patients. The tracker showed 209 patients treated in January 2021. The variation was because: • Six patients treated in January had not been included in the 194 cases, as two criteria within the data scripts that are used to produce the SCP report for WG and the Board were incorrect. Data from certain categories of patients was not 'pulled through' for reporting. For example, if a patient had subsequently died and the date of death field had been populated, the data in relation to these patients was excluded, even though they had been patients that were treated in that month. We understand that this error has now been corrected. • The remaining difference of nine patients was the result of a timing issue. We tested the information on the 'Klik sense tracker module' in May 2021. The tracker module is a 'live' system and so had been updated since the January data was extracted in late February, for the March WG submission and Board report. Data is not extracted until the end of the following month to allow for the records of patients awaiting test results, or treated in month, to be updated. The records for these nine patients had not been updated until after the data had been extracted in February. So, whilst they were treated in January and subsequently had a confirmed cancer diagnosis, as their records were not	The service does not meet performance measures due to ineffective monitoring and governance arrangements.

updated until after the February data cut off point, they had not been included in the reported January figures. We note that WG submissions and Board papers only report in-month figures so the nine cases identified above will not be captured in later reporting. It appears that this timing matter could occur each month, which could mean that the reported figures are not a true reflection of the total numbers of people treated in a month. We did not investigate if the nine cases met the WG 62-day target.	
Recommendation 1	Priority level
1. It should be confirmed that the criteria within the scripts used for reporting purposes has been updated, so that all appropriate patients have been captured. 2. Consideration should be given to supplementary reporting of SCP data to ensure that all treated cases have been reported and that cases not included when data is initially extracted are recorded and reported.	**High**
Management Response	**Responsible Officer & Deadline**
1. The scripts have been updated to include patients who died. Information team are reviewing the scripts of the 7 other cancer reports to check for consistency, noting many are legacy. Internal review undertaken which indicated no concerns with Swansea Bay data and Bridgend. 2. There is an all-Wales proposal for automating the approach to supplementary reporting. If agreed, DHCW have confirmed that it will take immediate effect.	Chief Information Officer – Q2 2021
Until automated approach to refresh of data / supplementary reporting has been agreed and implemented throughout the Health Board, all treated patients that are still suspected at reporting month end are being recorded & validated manually. Monthly performance reports for CTM UHB are updated to ensure that the timing issue is resolved in subsequent month's reports.	Senior Cancer Manager Completed Q1 2021

Finding 2 – Integrity of the SCP data (Operating effectiveness)	Risk

We tested the accuracy of the data reported to the Board and WG. To do this we used the January 2021 SCP data reported to the Board and tested all the cases relating to a sample of three tumour sites that were treated across the three ILGs. Our sample included cases that both achieved and breached the 62-day SCP target.

	Bridgend		Rhondda & Taf Ely		Merthyr & Cynon	
62-day target:	**Met**	**Breach**	**Met**	**Breach**	**Met**	**Breach**
Urology	5	5	-	-	-	-
Lower Gastro-intestinal	-	-	3	2	-	-
Lung	-	-	-	-	3	3

We reviewed the cases to ensure accurate recording of the initial 'point of suspicion' (when the clock starts), and the accurate recording of when treatment or care commences (when the clock is stopped). We identified data quality issues in 10/21 cases. Our review identified:

- Within the Bridgend sample, 1/5 breach cases, and 2/5 met cases, had been wrongly included in the data. Two of these cases were not cancers and should have been excluded from the data. The other was a progression of a previously diagnosed cancer and should not have been included.

  In one further breached case, the 'point of suspicion' had not been recorded correctly, but this did not change the classification of the case.

- Within the Rhondda and Taf Ely sample, for 3/5 cases we were unable to verify the timing back to the source documentation, as the referral letters had not been uploaded onto the clinical portal to confirm dates.

- Merthyr and Cynon sample – 1/6 cases could not be reconciled back to source documentation. Whilst we were able to confirm the date a scan took place; we could not trace the referral letter that led to the scan.

Patients suffer avoidable harm through inefficiency and delays caused by data issues not being managed correctly and expediently.

For a further 2/6 cases there were similar data quality issues where we could see the source documentation as the scanned referral forms were not on the clinical portal. We note that in recent months, management have undertaken their own review of data quality. We understand that the related findings report will be taken to the Cancer Management Board in June 2021.	
Recommendation 2	**Priority level**
1. Management should ensure robust processes are put in place that safeguards the integrity of the SCP data prior to it being published and reported on, including accurate input of dates and outcome data onto the clinical portal. 2. Referral letters and other key documents that support the 'start the clock' and 'stop the clock' dates should be added to the clinical portal. Note: Management added to this part of the recommendation: *Once we deploy WPRS for Cancer specialities, this data is captured and present in WCP.*	**High**
Management Response	**Responsible Officer/ Deadline**
Acknowledging the later recommendation around the need for a planned approach to improving data quality across CTM, the operating model is being amended to improve ownership of the data integrity issue. Previously, the Cancer Business Unit has held responsibility for the data aspects of Cancer service delivery. In Q3 2021/22, each ILG will take accountability for their Cancer MDTs, trackers and information analysts which will allow each CSG to own the data for their smaller group of patients.	Medical Director – Q3 2021
The CBU will oversee the roll out of robust data capture through the use of Cancer MDT e-forms in line with the Cancer Informatics plan and CANISC replacement (commencing Q3 2021/22)	SIRO – Action plan in place by Q2 2021
Wider issues around discrepancies between the paper and digital record have been identified and added to the corporate risk register. The Cancer Business Unit will develop and implement interim safeguards to mitigate risk whilst we transition from paper to digital ways of working through the HB digital strategy. This will include frequent improvement cycles	SIRO – business case for PAS upgrade submitted as part of DPIF.

and audit undertaken by clinical coding and the care teams. There are also wider issues around the PAS and WCP not conforming to information and technical standards and applications being design which do not readily enable the clinical data to be stored digitally at a data item level in a manner which it is clinically interpretable and re-usable. Business cases have been submitted collaboratively with NWIS to improve compliance with standards at the application and data storage layers to address these fundamental requirements.	
Operationally the UHB are committed to prioritising resources to strategically aligned initiatives, such as electronic referral through the WPRS and electronic test requesting for pathology and radiology and through digitising the patient record which including scanning documents, such as the referral letter, using CITO. We see the full implementation of standards and digital applications and the safe, clinically and cost effective methods required to enable our strategy and meet the need for accurate reporting data.	WPRS roll out and uptake initiative has commenced. KPIs are reported to the Digital Delivery Board.
In the short term, existent processes whereby referral information is transcribed on to the PAS will be re-affirmed, thereby ensuring key tracking data is available for a myriad of uses including, but not limited to, cancer information.	PAS manager/Head of Performance and Clinical Information SIRO - Action Plan in Place by End of Q3 2021
These interim actions will be superseded by the development of the overarching health board strategy (CTM 2030: Our Health Our Future). This will set out the design principles for clinical services and other activities and will include specific ambitions for the digital agenda. This will be supported with the appointment of a new Digital Director taking up post this autumn. This will help support the acceleration of the digital plans to support the overall HB strategy.	Director of Strategy and Transformation. Strategy to be developed by Q4 2021
There is an urgent requirement to reaffirm referral management processes and accuracy of recording of PoS when referrals are received, and uploading on to WPAS.	ILG DOO/COO – Q3 2021

Clinical service group managers are required to take ownership over the validation, cancer waiting times and their cancer waiting lists (See newly devised cancer operating framework)	ILG DOO/COO – Q3 2021
Cancer business unit to undertake quarterly audits on data accuracy of patients that are active on cancer tracker.	Senior Cancer Manager Q3 (programme of audits), Q4 2021 Audits commence.
A WPAS cancer tracker 7 training manual has been developed for all staff using this system. This has been made available online.	Senior Cancer Manager Completed
A training record has been developed and is being updated following individuals completion of training and competency of the WPAS cancer tracker.	Senior Cancer Manager Q2 2021.
Clinical Service Group & Operational Managers to ensure upgrade / downgrade SOP is followed along with diligent management of referrals within the Health Board.	ILG DOO/COO – Q2 2021.

Finding 3 - Quality assurance monitoring (Control design)	Risk
At the time of our fieldwork there was limited data validation work. Only data relating to the patients who breached the 62-day target were being checked, there was no validation work on cases where the 62-day target was met. Therefore, in relation to the January data that we tested, the target was met for 95/194 (49%) cases, and as such, it appears that no validation work would have been undertaken on these cases. As reported in finding 4, below, we acknowledge that there is a draft SOP relating to the validation of SCP data (weekly or monthly checks) that includes the requirement to undertake validation work on all cases and not just those that breached the 62-day target. In addition, there were no documented quality assurance checks carried out by senior managers on the validation work, although we understand that going forward this will happen. Furthermore, no log is maintained to record issues identified through the validation process such as missing source documentation, such as referral letters, on the clinical portal. Such a log could assist in identifying trends in errors.	Patients suffer avoidable harm through inefficiency and delays caused by data issues not being managed correctly and expediently.
Recommendation 3	**Priority level**
1. While error rates remain high, senior management quality assurance checks should be undertaking to ensure reliability of the SCP data. Consideration should be given to including these check as part of the data validation SOP that is being drafted. 2. Validation checks of both breached and achieved cases should commence in line with the draft SOP. 3. An issues log should be maintained to record discrepancies in the data identified during the validation and quality checking process to help identify any trends in errors.	**High**
Management Response	**Responsible Officer/ Deadline**
1. Monthly validation reports are sent to the cancer service supervisors via information services to support with validation.	SIRO Q2 2021

Any errors are raised with the information reporting team and any SQL script errors are reported as bugs and corrected 2. A newly developed SOP has been developed for both weekly and monthly validation of all treated patients within that given month. This is awaiting approval.	
Validation of all treated patients both in and out of target is undertaken at month end in accordance with the validation SOP. This document is currently awaiting approval.	Senior Cancer Manager Commenced May 2021
3. An issues log has been devised which logs all month end validation discrepancies in data identified, with the actions undertaken to resolve them. The discrepancies are sent to the appropriate service group managers.	Senior Cancer Manager Completed May 2021
Discrepancies identified during validation of the treated confirmed cancer patients, with the appropriate action taken to resolve the discrepancy, is sent to the appropriate service group managers to discuss with the team concerned and use as a learning opportunity.	Clinical Service Group Managers – Q2 2021.

Finding 4 - Policy and procedures (Control design)	Risk
At the time of our audit fieldwork there was no documented process in place for the verification of data. However, management have subsequently drafted a Standard Operating Procedure (SOP) for the required weekly and month end validation processes. In addition, following a 2020 NHS Wales Delivery Unit review within Cancer Services (specifically around Urology and Radiology) an action plan was agreed and management are implementing the recommendations which includes the development of SOPs relating to operational cancer management. As such, the draft policies, procedures and other guidance awaiting approval, are: • Escalation Policy; • Breach reporting SOP; and • Downgrade of suspected cancer SOP. Once approved and operational these procedures will help ensure consistent working practices and accurate capturing of data. Furthermore, the Health Board does not have a corporate policy surrounding data quality that sets the strategic direction and the commitment from the Health Board to have robust data quality processes in place. Although, we acknowledge that aspects of data quality are enshrined in existing Health Board policies such as the information governance and medical records policies. We note that the Health Board has a draft performance and clinical information strategy which, once approved and implemented, should aid enhanced operational effectiveness, through access to accurate, timely and secure data. We have sighted similar corporate policies at other health boards.	The service does not meet performance measures due to ineffective monitoring and governance arrangements.
Recommendation 4	**Priority level**
1. A corporate policy in relation to data quality should be developed that sets out the Health Board's strategic direction and its commitment to have robust data quality processes in place. 2. All draft Standard Operating Procedures in relation to the recording and validation of SCP data should be	**Medium**

appropriately approved and implemented as soon as practically possible.	
Management Response	**Responsible Officer/ Deadline**
1. The UHB's Medical records and Information Governance policies both incorporate Data Quality requirements and describe where accountabilities rest. A plan for improving data quality which is born digitally is required. The Cancer Business Unit will bring forward a proposal for the development of digitising the clinical data (a range of options are available) in Q3 2021/22. This will enable clinicians to see direct benefit from the data and to thus place more value on its integrity and value. 2. Some procedures have been introduced – upgrade / downgrade 1st June, breach reporting procedure.	*SIRO – in Q2 2021/22*
An upgrade / downgrade standard operating procedure has been developed and approved which ensures that all patients with a suspected cancer, irrespective of route are captured at point of suspicion.	Senior Cancer Manager Completed 2021
Implementation of the upgrade / downgrade SOP to be established taking into consideration local processes and variation.	ILG DOO/COO –Q2 2021.
A standard operating procedure has been devised in relation to the breach reporting process. This is currently awaiting approval but has been implemented throughout staff within the Cancer Business Unit.	Commenced May 2021
Development of a cancer operating framework which includes both local and corporate escalation processes has been developed. This is awaiting approval.	Senior Cancer Manager Commenced April 2021
Once the Cancer Operating Framework is approved, implementation throughout the Health Board is overseen by COO.	Chief Operating Officer Q2 2021.

Finding 5 - Cancer Steering Group (Operating effectiveness)	Risk
The main operational group that has responsibility for ensuring the delivery of cancer performance indicators, including the SCP, is the Cancer Steering Group. This is a newly established group which held its first meeting in January 2021. At the time of our fieldwork the terms of reference for this group were still in draft. Whilst the terms of reference require quarterly meetings, initially monthly meetings took place to allow the group to establish. Our review of the attendance of key personnel between January to March 2021 identified a low level of attendance from certain key personnel such as the cancer lead for one of the ILGs. While there is no formal escalation process for raising concerns about recurring non-attendance, we understand verbal feedback is given.	The service does not meet performance measures due to ineffective monitoring and governance arrangements.
Recommendation 5	**Priority level**
1. The terms of reference for the Cancer Steering Group should be reviewed and approved. 2. Management should either include an escalation process for dealing with frequent non-attendance by individuals or provide clarity in relation to key officers and quoracy within the terms of reference.	**Medium**
Management Response	**Responsible Officer/ Deadline**
1. The terms of reference have been reviewed, re drafted and approved via the cancer steering group, which takes into account attendance. The revised Cancer Operating Model also clarifies roles and responsibilities, underlining the requirement for all key members of the group to contribute proactively to the CSG.	Cancer Services Director/HB Cancer Clinical Lead Approved 14/7/2021
2. Unfortunately, competing priorities such as covid response, vaccination and covid recovery meant that meetings could not be supported from all departments. The UHB is investing is an additional cancer analyst post which to support the Cancer Business Unit and ILG's	Head of Information Q2 2021.

improve data quality and integrity. This post is in the process of recruitment and will be appointed to in Q3 2021/22.	

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

	**Substantial assurance**	The Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Few matters require attention and are compliance or advisory in nature with **low impact on residual risk** exposure.
	**Reasonable assurance**	The Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some matters require management attention in control design or compliance with low to **moderate impact on residual risk** exposure until resolved.
	**Limited assurance**	The Board can take **limited assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. More significant matters require management attention with **moderate impact on residual risk** exposure until resolved.
	**No assurance**	The Board can take **no assurance** that arrangements in place to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Action is required to address the whole control framework in this area with **high impact on residual risk** exposure until resolved.
	**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** but which are relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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