Medical Records Management
Final Internal Audit Report

October 2022

Cwm Taf Morgannwg University Health Board

NWSSP Audit and Assurance Services

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Contents

Review reference:	CTMU-2223-06
Report status:	Final
Fieldwork commencement:	24 May 2022
Fieldwork completion:	22 August 2022
Draft report issued:	14 September 2022
Debrief meeting:	5 September 2022
Management response received:	9 October 2022
Final report issued:	10 October 2022
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Committee:	Audit and Risk Committee

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 this review.

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Executive Summary

Purpose

To provide assurance that a process is in place for the management of medical records that ensures that records are available when and where needed and are safe and secure.

Overview of findings

We have issued reasonable assurance on this area. Overall there are good processes in place for the management of health records. The key weaknesses lie within the processes for the move away from paper records.

The matters requiring management attention include:

- Storage space is running out within the Williamstown site.
- Storage space has run out within Princess of Wales, and rack systems are broken.
- The digitisation project has stalled and been subject to delays.
- Poor quality of files returned to health records is impacting on scanning, and may present a patient safety risk.
- The development of e-forms has not progressed.

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

Report Classification

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Assurance summary[1]

	Assurance objectives	Assurance
1	Policies, procedures and guidelines	Reasonable
2	Record storage	Reasonable
3	Record transportation and availability	Reasonable
4	Move away from paper	Limited

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
2	Williamstown Storage	2	Operation	Medium
3	Princess of Wales Storage	2	Operation	Medium
4	Reporting	3	Operation	High
5	Digitisation Project	4	Operation	High
7	File Quality	4	Operation	High
8	e-Form Development	4	Operation	High

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

1. Introduction

1.1 In line with the 2022/23 Internal Audit Plan for Cwm Taf Morgannwg University Health Board (the 'Health Board' or the 'organisation') a review of medical records management has been undertaken.

1.2 The purpose of the review is to provide assurance to the Audit and Risk Committee that a process is in place for the management of medical records that ensures that records are available when and where needed and are safe and secure.

1.3 The Health Records department is responsible for the storage and provision of patient records for the majority of services proved by the Health Board. Some services are responsible for, and store, their own records, in particular Mental Health and Therapies. Health records are stored in a number of areas across with Health Board, with the two main storage facilities are within Princess of Wales, and the main storage unit in Williamstown, which hosts over a million records. Our audit work focussed on these main storage areas.

1.4 Storage of records has become an issue for the Health Board, and in order to address this, and provide a modern electronic record the Health Board has been moving towards digitising the patient record to enable this to be viewable from any site on a variety of devices.

1.5 The potential risks considered in the review are as follows:

- Inappropriate access to confidential information;
- Inaccessibility of records impacts on patient care; and
- Inefficient processes lead to increased costs.

2. Detailed Audit Findings

Audit objective 1: Appropriate policies, procedures and guidelines are in place for medical records management that cover the full records lifecycle and ensure standardisation of processes and record content.

2.1 There is a current record management policy (Reference Number: GC02a) which provides guidelines for Health Board staff dealing with corporate, non-clinical and clinical records to ensure records are maintained, managed and controlled effectively.

2.2 Within Health Records there is an up to date set of local operating procedures for the Williamstown Hub which cover all key items regarding medical record management such as: how to request records from the hub; processing case notes requests; tracking and filing case note types; and dealing with email requests.

2.3 Health Records within Princess of Wales operate a different record management process as the process is manual, dealing with physical records. Their procedures are current and include Tracking Holding Room Procedure; POW - Maesteg request procedures; POW - Late Bookings procedures and POW - Miscellaneous Team procedures.

2.4 We note that in addition to the different procedures, the responsibilities of the Health Records departments in Princess of Wales and in Royal Glamorgan differ, due to the historical basis of the respective departments. This may make it difficult to standardise processes across the Health Board and meet the differing expectations of staff. **(Matter Arising 1)**

Conclusion:

2.5 There are guidelines in place for medical records management, with an overarching policy in place which is supported by local procedure documentation at both key sites. Princess of Wales have different responsibilities and operate different processes due to the historical positioning of Bridgend. We have provided reasonable assurance over this objective.

Audit objective 2: Medical records storage facilities ensure that records are protected from unauthorised access, destruction or theft, and from accidental damage from environmental hazards.

2.6 Health records are stored at a number of places across the Health Board. The main storage areas are the Williamstown Hub which serves the old Cwm Taf area, and Princess of Wales which serves the Bridgend area.

2.7 Records are also stored with receipt and distribution areas in each hospital which handle temporary storage and transit for records moving between sites.

2.8 We also note that there are some services that handle and store their own records, in particular Mental Health and Therapies, and these areas are outside Health Records' control.

2.9 All storage areas are secure from the general public. Access to areas is controlled either via (TDSi) a swipe card, as is the case at Princess of Wales, or digital door lock and TDSi as at Williamstown. At Williamstown visitors are required to sign in and out of the building and CCTV monitoring is in place, which is monitored 24/7 by porters at the Royal Glamorgan hospital.

2.10 Storage of records within the Williamstown Hub is secure. Records are generally stored on 'off floor' racking and without over compression of files within rack spaces. However, space the Hub is running out. This is partly due to a block on the destruction of records due to the requirement to retain records for the infected blood inquiry.

2.11 Other departments use Williamstown to store archived records such as Mental Health, Therapies, Maternity, and Sexual Health. These additional records are not managed and the allocated area is full, with boxes of records stacked on top of boxes on floor areas which are now collapsing and may be causing damage to records. The current storage of these records may represent both a manual handling to staff risk and a fire risk within the site.

2.12 Furthermore, the roof at the Williamstown Hub leaks, particularly in poor weather conditions and buckets are used to capture water leaking from the roof. No records have been damaged to date, but the risk of damage remains and is not captured on the departmental risk register. **(Matter Arising 2)**

2.13 As noted above, the security of records within Princess of Wales is maintained, as the Health Records area within Princess of Wales have their own internal storage areas within the hospital. However, these areas have run out of appropriate storage for records, which are now stored on the floor, under desks between racks, and on top of the racks, although additional storage is provided in off-site locations on a Bridgend Industrial estate.

2.14 The movable rack system within the Princess of Wales department has a number of sections which cannot be used due to mechanical breakdown, which prevents staff retrieving those patient records required for clinics. We understand that there have been attempts to resolve the issue with the rack, but it remains broken. In addition, other departments have access to the health record section which increases the opportunity for records to become misplaced and not tracked accordingly. **(Matter Arising 3)**

Conclusion:

2.15 Medical records are stored in sites with a good level of physical security and in general the storage protects the records from loss or damage. There are leaks within the roof at Williamstown however, and both sites are running out of space to store records, mainly due to the moratorium on record destruction due to the infected blood enquiry. This is particularly pronounced with Princess of Wales with records stored in inappropriate areas within the departments. The old and damaged racking within Princess of Wales prevents access to records. We note that work is ongoing to source additional storage facilities, but at the time of our fieldwork this has not been completed. We have provided reasonable assurance over this objective.

Audit objective 3: Physical records are transported appropriately, tracked and records are available when and where needed by operational staff.

2.16 Storage within the Health Records department uses a consistent method that ensures records can be easily retrieved.

2.17 Retrieval of records from store is undertaken by Health Records staff. Clinic lists are provided to Williamstown staff, and records are recovered before the clinic date, then tracked and dispatched via the contractor 'Just Wales', within secure cages.

2.18 As records are stored on site at Princess of Wales, clinics make request for records direct to the team based at Princess of Wales. The team collate the required records for each clinic, track them and pass them to clinical staff.

2.19 The target timescale for retrieval and dispatch of records is 10 days in advance, however at present, due to workload, this time is currently at six days. This means there is less time to undertake additional searches should records not be immediately located.

2.20 There is a facility to make phone requests for records which are required urgently, and these requests are expedited by health records staff.

2.21 Records are transported in secure cages by the contractor (Just Wales). There are three record transport trips a day, each carrying up to six cages. The Health Board also has an arrangement with the contractor to retrieve records from the remote storage units in Bridgend via secure transportation.

2.22 Records are delivered to receipt and distribution areas (r&d) within each hospital which are staffed by health records staff. The r&d teams sort and transfer the records to individual clinics or file them in clinic 'pigeon holes' for collection by non health record staff.

2.23 The return of files to storage replicate the above process in reverse. Health records staff retrieve records from clinic areas and move to the r&d area and from there to the main storage facility.

2.24 File movements are tracked on WPAS. Records are tracked out from storage via WPAS, and then tracked back in upon return to Williamstown Hub. The file is tracked to a user and it is the user's responsibility to track any further movement of the record once the record has left Medical Records. Our testing of a sample of records did not identify any matters of concern, with the tracking process being accurate.

2.25 In the event of a record not being located there is a defined procedure for health records staff to follow in order to try and locate it. If a missing record is required for clinic, a duplicate patient file is produced to enable the patient to be seen and collect forms from that episode. These can then be added to the original file when located.

2.26 There is a log of missing records held at both Williamstown and PoW, and if a record remains missing for one month, then a Datix incident should be raised. However, we note that currently the procedure for raising Datix incidents is not always followed and there is no monitoring or reporting on missing records.

2.27 Furthermore, there is no structured reporting on the operation of Health Records which demonstrates the value of the department such as, total of records provided, percentage of missing or unavailable records etc. This would also enable the identification of areas where misplaced records occur at a higher rate. **(Matter Arising 4)**

Conclusion:

2.28 Records are securely transported between sites and there is an effective process for tracking the location of records across the Health Board. There is a procedure in place for actioning when a record is not immediately located, however we note that this is not always completely followed. In addition there is no formal monitoring and reporting on the Health Records function. Accordingly, we have provided reasonable assurance over this objective.

Audit objective 4: An appropriate process is in place to move away from physical records and to ensure that paper records are archived and destroyed appropriately.

2.29 As noted above, since 2018 there has been no destruction of records (unless the record has been digitised and verified) due to the infected blood inquiry. This is impacting on available storage in Williamstown and Princess of Wales. One solution to this is the digitisation of records. While Williamstown records are being digitised, due to the different WPAS systems in place, there is no digitisation programme for records held at PoW.

2.30 The Health Board started a digitisation project using a contractor. The organisation planned to scan 314k records within two years, which represented the bulk of anticipated live treatment records. Health Board staff were then to scan additional appointment information for those records, known as 'forward scanning'.

2.31 The digitisation project was interrupted by Covid in March 2020 which caused a significant delay, with scanning paused for nine months. It resumed in January 2021 but, due to Covid restrictions and sickness, only a small team were available to scan documents which resulted in further delays. We note that there is a 'recovery' plan in place up to get back on track by July 2023.

2.32 These delays have meant that efficiency savings have not yet been achieved as anticipated.

2.33 The digitisation project has also been effected by changes in management, such as the loss of executive sponsorship and oversight. The original project included a project board and associated monitoring which was set up by the previous executive. However, due to staff leaving, the senior risk office role for the project was vacant and work has moved into 'business as usual', with reporting to the service management board. This has meant that there has been limited routes for reporting progress and raising issues to senior management has impacted on the resolution of issues. **(Matter Arising 5)**

2.34 The process for scanning legacy files is undertaken by the contractor (Gateway). The original plan was to scan on site, but in order to catch up two off site locations are used by the contractor.

2.35 Records are selected for scanning by Health Board staff. These records are for active patients, that do not have an appointment within six weeks. A pick list is created and 60 boxes of records a day are sent for scanning. We note that there is a process for rapidly scanning records that have gone offsite but are needed urgently for clinical reasons.

2.36 Records are passed to the contractor for scanning, and the documents returned to Williamstown for quality assessing and tracking back in. As part of this process the contractor provides a spreadsheet to show the documents returned from scanning off site. We note that feedback from the quality assessments is that the scans are 98% good.

2.37 We understand that there have been issues with the scanning software (middleware) which has resulted in the scanned version of the records being lost. However the underlying reasons for this have not been established and there has been no record or reporting of the impact of this due to the absence of a project structure. **(Matter Arising 6)**

2.38 Once the legacy record is scanned, Health Board staff operate a process called forward scanning. This is the process where new appointment information is scanned into the digitised record. This allows the record to be viewed digitally in clinic.

2.39 The success, and speed of this process is impacted by poor quality of the paper records being returned. Clinics are provided with folders containing 'smart' forms as header sheets, and with a file structure in place. However, when files are returned to Health Records a large number of these files need to be reassembled to correct mistakes in filing. Staff also write on the smart forms and there have been occasions where multiple patient records have been included within a single file, or incorrect patient's information within a file (including, we understand, in one instance a 'do not resuscitate' warning). Our testing of a sample of returned files found that 70% needed to be corrected by health records staff. This is impacting on the success of the scanning process and represents a patient safety risk. We note that Health Records had not been formally monitoring and reporting these issues, although the issue has been recently raised and funding provided for staff to work with clinics to ensure they understand the filing requirements. **(Matter Arising 7)**

2.40 A further process for the removal of paper is the development of e-forms for use in clinical areas which would remove the need for paper by directly creating the electronic patient record.

2.41 We understand that there are a large number of different forms used throughout the Health Board to record information, (approximately 500). Reducing this number requires clinical input to rationalise and understand the forms that are required, but there has been a lack of engagement in this process. We also note that there is a skill shortage of IT staff who can develop e-forms, and so this aspect is not being moved forward. Work has been undertaken by the project lead to identify forms that are used the most, in order to maximise the benefits from the limited resource. **(Matter Arising 8)**

2.42 Once scanned images have passed the quality checks the record is quarantined for seven weeks and then marked for secure disposal. All disposal is carried out by a registered company which provides a certificate of destruction. A separate record is kept at Williamstown of records destroyed.

Conclusion:

2.43 There is contract in place for the digitisation of records held in Williamstown. The progress of this has been impacted by a number of factors, including Covid and the loss of executive sponsorship. There is a good process for scanning records, but this is impacted by the poor quality of paper files returned to Health Records.

2.44 A second phase for the removal of paper is the development of e-forms, but this has not progressed due to both a lack of available resource within digital and clinical engagement. Once records are scanned the quality is confirmed and there is a process for secure disposal of the physical record. We have provided limited assurance over this objective.

Appendix A: Management Action Plan

Matter Arising 1: Departmental responsibilities (Design)			**Impact**
The responsibilities set out in the local policies of the Health Records departments in Princess of Wales and in Royal Glamorgan differ due to the historical basis of the respective departments. This will make it difficult to fully standardise processes across the Health Board and lead to differing expectations from staff.			Potential risk of: • Inefficient processes lead to increased costs
Recommendations			**Priority**
1.1	The responsibilities of the Health Records departments across the Health Board should be standardised. Linked to this the procedures operating within each site should be standardised as much as possible, given the limitations imposed by digitisation.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	Accept There are challenges to standardising the operational procedures of the Health Records teams due to the variances between the digital systems used within the Princess of Wales and the rest of the Health Board. It should also be noted that some of the Health Records personnel within the Health Board are not under the direct responsibility and accountability of the Director of Digital. The Health Board has devised a programme of work to standardise the PAS in use across the Health Board. This programme is planned until the Autumn of 2024. Process will be aligned as practically possible prior to the completion of the programme.	Qtr 2 2024/2025	Director of Digital

Matter Arising 2: Williamstown Storage (Operation)			**Impact**
There are issues with the Williamstown storage facility: • Space is running out, partly due to the requirement to retain records for the infected blood inquiry. • Other departments are using Williamstown to store records, however these are not being stored appropriately and managed. The allocated area is full, with boxes of records stacked on top of boxes on floor areas which are now collapsing and may be causing damage to records. • The roof is subject to leaks, which risks damaging records.			Potential risk of: • Loss or damage to records
Recommendations			**Priority**
2.1	Work should start to identify records which could immediately be destroyed when the moratorium relating to the infected blood inquiry ends. These records should be moved to an alternate location.		**Medium**
2.2	Departments that use the facility should be requested to ensure that their records are stored safely and appropriately, and that they have an appropriate archiving and disposal process in place.		**Medium**
2.3	The risk associated with the leaking roof should be included on the departmental risk register, and appropriate actions defined.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	Partial Agreement Identification of records to be destroyed can commence and complete by end of Qtr 3 2022/2023. The Health Board is currently reviewing its estate, with a view to reducing some of its existing facilities. An alternative location would need to be procured. This	Qtr 3 2022/2023	Director of Digital

	cannot be resolved quickly due to continued financial pressures for the Health Board. An alternative location cannot be procured within the existing financial envelope of the Health Board. ***Audit Note*** *– We recognise the limitations to space and agree with the approach to identify the relevant records.*		
2.2	Agreed Review of all records stored within the Hub	Qtr 3 2022/2023	Director of Digital
2.3	Agreed Risk Register to be updated.	Qtr 3 2022/2023	Director of Digital

Matter Arising 3: Princess of Wales storage (Operation)			**Impact**
Storage space within PoW has run out. Records are now stored on the floor, under desks, between racks, and on top of the racks. In addition, the movable rack system within the department has a number of sections which cannot be used due to mechanical breakdown which prevents staff retrieving those patient records required for clinics. There have been attempts to resolve the issue with the rack, but it continues to break and become unusable. Other departments have access to the health record section which increases the opportunity for records to become misplaced and not tracked accordingly.			Potential risk of: • Loss or damage to records • Injury to staff
Recommendations			**Priority**
3.1	Appropriate storage space and facilities for records should be provided.		**Medium**
3.2	Access to the records storage area should be restricted to health records staff.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	Agreed Additional space has been identified on the Glanrhyd site.	Qtr 2 2022/2023	Director of Digital
3.2	Disagree with recommendation. Capacity within the existing Health Records team at the Princess of Wales is limited. As such services need to be able to retrieve records to ensure timely delivery of services. These staff are familiar with the site and have been accessing records as part of routine business processes. ***Audit Note*** *– Restricting records access to just health records staff is good practice. However, we acknowledge that there are limitations to staffing and operational practicalities make this difficult at the current time. We note that the agreed action in matters arising 1.1 and 4.2 may help address this matter.*	N/A	

Matter Arising 4: Reporting (Operation)			**Impact**
There is no monitoring or reporting on missing records and the procedural requirement for raising Datix incidents after 30 days is not always followed. In addition, there is no structured reporting on the operation of Health Records which demonstrates the value of the department such as total of records provided, % of records provided at point of need etc.			Potential risk of: • Loss or damage to records
Recommendations			**Priority**
4.1	Datix incidents should be raised for records missing over 30 days as per the procedure guidance.		**High**
4.2	A formal reporting process for health records should be established which includes key performance indicators such as, but not limited to: - Number of records provided - Percentage of records available at point of need - Number untracked / missing records.		**High**
Agreed Management Action		**Target Date**	**Responsible Officer**
4.1	Agreed Datix to be updated.	Qtr 3 2022/2023	Director of Digital
4.2	Agreed Performance report to be created as part of routine service provision.	Qtr 3 2022/2023	Director of Digital

Matter Arising 5: Digitisation project (Operation)			**Impact**
Management of the digitisation project has been impacted by a loss of executive sponsorship and oversight. The original project included a project board and associated monitoring, which was set up by the previous executive. Due to staff leaving the senior risk office role for the project was missing and so the work moved into business as usual, with reporting to the service management board. This has meant that there has been limited routes for reporting progress and issues to senior management and impacted on the resolution of issues.			Potential risk of: • Loss or damage to records • Increase costs
Recommendations			**Priority**
5.1	A project structure for digitisation should be re-established, and led by the executive sponsor. The structure should include monitoring and reporting of progress and issues, with resolution sought for any issues and communication to clinical services.		**High**
Agreed Management Action		**Target Date**	**Responsible Officer**
5.1	Agreed Programme board to be re-established.	Qtr 3 2022/2023	Director of Digital

Matter Arising 6: Software failures (Operation)			**Impact**
There have been issues with the scanning (middleware) software which has resulted in the scanned copy of the records being lost, leading to the need to rescan the files. However, the underlying reasons for this have not been established and there has been no record or reporting of the impact of this due to the absence of a project structure.			Potential risk of: • Loss or damage to records • Increase costs
Recommendations			**Priority**
6.1	The underlying reason for failures should be established and corrected to prevent future issues. The progress of scanning and any issues should be reported within the structure referred to in MA4		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
6.1	Agreed Underlying Issue to be identified and reported.	Qtr 3 2022/2023	Director of Digital

Matter Arising 7: File quality (Operation)			**Impact**
The success, and speed of the scanning process has been affected by poor quality paper records being returned. Clinics are provided with folders containing 'smart' forms as header sheets, and with a file structure in place. However, often when files are returned to Health Records a large number need to be reassembled to correct mistakes in filing, which results in delays to the process. We understand that staff write on the smart forms, and there have been occasions where multiple patient records have been included within a single file, or incorrect patients information within a file (including 'do not resuscitate' warning). Our testing of a sample of returned files found that 70% required health records staff to correct.			Potential risk of: • Loss or damage to records • Increase costs • Patient safety is impacted
Recommendations			**Priority**
7.1	The retuned files should be monitored and a record kept of errors in files, and the source of the files. These errors should be reported to the clinical service areas, noting that there is a professional requirement on staff to ensure appropriate record keeping and requesting that all staff ensure that file quality is maintained.		**High**
Agreed Management Action		**Target Date**	**Responsible Officer**
7.1	Agreed Standard Operating Procedure to be developed for reporting quality issues with the paper record.	Qtr 3 2022/2023	Director of Digital

Matter Arising 8: e-forms (Operation)			**Impact**
There has been limited progress in the use of e-forms to remove paper from the system. There are approximately 500 different forms in use. These require clinical input to rationalise and define those forms that are actually required and we note that there is a lack of engagement in this. We also note that there is a skill shortage of IT staff who can develop e-forms.			Potential risk of: • Loss or damage to records • Inaccessibility of records impacts on patient care • Increased costs
Recommendations			**Priority**
8.1	As part of the project structure referred to above, a workstream for developing e-forms should be established. This should include clinical input. the Health Board should seek to increase the amount of e-form development skills in place by training existing staff and recruiting to the project.		**High**
Agreed Management Action		**Target Date**	**Responsible Officer**
8.1	Agreed Workstream to be created to oversee the development of a work plan for e-Forms (including Clinical Input).	Qtr 3 2022/2023	Director of Digital

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No 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.

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