Elective Waiting List Management: Single Cancer Pathway

Final Internal Audit Report

March 2024

Hywel Dda University Health Board

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

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Contents

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Committee:	Audit and Risk Assurance Committee

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

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

Executive Summary

Purpose

To undertake a review of the key controls in place to manage and mitigate the risk of failing to achieve the Welsh Government (WG) target for Single Cancer Pathway (SCP).

Overview

We can confirm the positive actions taken to identified and implement key processes and gaps in controls to mitigate the identified risk 1350 in achieving WG targets. In addition, satisfactory governance of internal and external reporting arrangements was evident.

To further support and strengthen existing controls, three medium priority matters arising were identified in regard of:

- delayed rollout of one identified action;
- review implemented key processes and gaps in control to ensure they continue to be valid and appropriate; and
- updating the Cancer Improvement Board terms of reference to reflect current arrangements.

We have concluded **Reasonable** assurance for the actions being taken on the identified risk noting further actions are required to meet WG targets.

Report Opinion

		Trend
Reasonable 	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.	n/a

Assurance summary[1]

	Objectives	Assurance
1	Controls to improve performance against Welsh Government target for SCP have been identified, with appropriate actions to address and gaps in control.	Reasonable
2	Effective action plans and monitoring arrangements to reduce the size of waiting lists, with appropriate reporting to the Health Board and Welsh Government.	Reasonable

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

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Rapid Diagnosis Clinics	1	Design	Medium
2	Key Processes and Gaps in Control	1 & 2	Operation	Medium
3	Terms of Reference	2	Design	Medium

1. Introduction

1.1 Since December 2020, NHS organisations within Wales have been required to report the diagnosis and treatment of cancer in line with the requirements of the Welsh Government's (WGs) Single Cancer Pathway (SCP). The target for treatment has remained at 62 days, however the SCP includes that reporting begins from the first point where cancer is suspected, as opposed to previous requirements which began upon receipt of a referral by secondary care.

1.2 The NHS Wales National Optimal Pathways (NOPs) have been developed as part of the SCP programme of work. They aim to establish consistent generic and site-specific pathways that describe all routes of entry, from the point of suspicion (PO) of cancer. They describe good practice diagnostic and treatment pathways, the diagnostic pathway, including staging, should be performed within 28 days from POS; and definitive treatment commenced within 21 days from date of Decision to Treat (DTT). The pathways also describes where patients should receive consistent information and support tailored to meet their needs.

1.3 The NOP's aim to provide a platform to standardise care, reduce unwarranted variation and drive improvement whilst increasing quality across each of the cancer pathways in order to:

- meet the SCP cancer waiting time of 62 days for patients presenting with a suspicion of cancer;
- improve cancer patient experience; and
- improve cancer patient outcomes throughout Wales to that comparable with the best outcomes in Europe.

1.4 During 2020/21 planned care services had to be paused to allow the NHS to respond to the immediate demands and challenges of the COVID-19 pandemic. This has inevitably resulted in growing waiting lists and increased waiting times for diagnostics and treatment.

1.5 The WG published its *programme for transforming and modernising planned care and reducing waiting lists in Wales* in April 2022, which sets out the commitment to reducing waiting lists through five key ambitions:

Ambition 1	No one waiting longer than a year for their first outpatient appointment by the end of 2022
Ambition 2	Eliminate the number of people waiting longer than two years in most specialties by March 2023
Ambition 3	Eliminate the number of people waiting longer than one year in most specialties by Spring 2025
Ambition 4	Increase the speed of diagnostic testing and reporting to eight weeks and 14 weeks for therapy interventions by Spring 2024
Ambition 5	Cancer diagnosis and treatment to be undertaken within 62 days for 80% of people by 2026

1.6 In October 2022, WG placed the Health Board into Targeted Intervention (TI) status for planning and finance, and Enhanced Monitoring (EM) for performance. WG also gave the Health Board a series of Accountability Conditions (AC) for areas where improvements are needed. These include, but are not limited to:

- at least 75% of people referred on the suspected cancer pathway start first definitive treatment within 62 days of the point of suspicion by end of March 2023; and
- reduce the backlog of patients waiting over 104 days by end of October, with clear trajectories for sustainable backlog removal by end of December.

1.7 Achievement of the 75% target is reflected on the Health Board's risk register, and identifies the controls in place to manage the risk, as well as actions to bridge any identified gaps in controls:

Risk 1350 (Risk Score 12): There is a risk of the Health Board not being able to meet the 75% target for waiting times in the ministerial measures for 2022/26 for the Single Cancer Pathway (SCP).

1.8 The potential risks considered in the review were as follows:

- undue harm to patients; and
- reputational damage.

1.9 The audit focused on the risk, controls and gaps in controls identified within risk 1350 relating to SCP.

2. Detailed Audit Findings

Objective 1: Controls to improve performance against WG target for SCP have been identified, with appropriate actions to address the gaps in control

Key Controls Currently in Place

2.1 All entries on the Datix risk register requires the identification and recording of '*existing controls and processes in place to manage the risk'.* There are currently 14 key controls currently in place for risk 1350 – see below.

NO.	KEY CONTROLS/PROCESSES
1	A GI Improvement Group has been established with the aim is to implement the NOP for the GI Pathways.
2	Fully established cancer-tracking team in place to allow patients to be proactively tracked through their pathways.
3	The development and implementation of a new cancer dashboard for Cancer Services staff and managers, allowing MDTs to actively monitor tumour site-specific patients on a SCP.
4	The piloting of Quarterly Planning and Monitoring reports developed by the NHS Executive since July 2023 to facilitate the development of targeted improvement plans per tumour site and subsequent weekly monitoring thus providing assurance of the robustness of plans.
5	The securement of funding with plans being discussed to role the RDC clinic service out across all three counties.
6	A successful FIT10 screening in the management of USC patients on a colorectal pathway was implemented in June 2020 as per the Wales Bowel Cancer Initiative. A Straight to FIT test has been implemented within the Health Board, in addition to the introduction of FIT10 screening in Primary Care.
7	Virtual appointments are being undertaken via digital solutions.
8	Weekly Cancer Watchtower meetings have been established where services managers are in attendance to monitor and address service demand, capacity and risk issues.
9	Monthly performance meetings with WG.
10	Trajectory performance plans have been developed for each tumour site by the relevant services, with regards to improving performance, backlog trajectory plans on how these improvements will be achieved.
11	Weekly monitoring of Urology diagnostic improvement trajectory via Cancer Watchtower.
12	Cancer Pathway Review Panel has been implemented to identify any risk for those patients who have not received their treatment within 146 days.
13	Process in place that improves time for patients to first outpatient appointment to improve the 28-day performance target.
14	Continued escalation of concerns regarding tertiary centre capacity and associated delays.

2.2 A review of supporting documentation, evidence and information confirmed that 13 of the 14 key controls and processes listed against risk 1350 have been implemented and operating as reported.

2.3 One key control was the roll out of Rapid Diagnostic Clinics (RDCs). Whilst an RDC has been established at Prince Phillip Hospital, Bronglais General Hospital are unable to accommodate an RDC due to the lack of room availability and Radiologist support. To mitigate this issue, Withybush General Hospital has been identified as

having both the clinical space and Radiology support to establish an RDC. However, this clinic has yet to be rolled out. **[Matter Arising 1]**

Gaps in Controls

2.4 Risk 1350 consists of four gaps in control with five actions assigned to address them. A review of documentation and information provided supported the reported progress made in addressing the identified gaps in controls, whilst one action relating to a Covid-19 screening approach has since ceased.

2.5 Where progress has been attained in addressing the gaps in controls and various processes have been implemented, consideration should be given to the revision of the controls identified and reported on the risk register entry to ensure an accurate reflection of the current position. This includes actions and processes currently in operation, such as those in paragraphs 2.11 and 2.17, and additional future actions in order to meet WG targets. **[Matter Arising 2]**

Conclusion:

2.6 Whilst the majority of key controls and identified gaps in processes have been implemented, we identified instances where further work would support and strengthen existing controls. We have concluded **Reasonable** assurance for this objective.

Objective 2: Effective action plans and monitoring arrangements to reduce the size of waiting lists, with appropriate reporting to the Health Board and Welsh Government

Internal Reporting Arrangements

2.7 The Strategic Development and Operational Delivery Committee (SDODC) received regular papers and reports during 2023-24 in regard to SCP waiting list and backlog performance figures.

2.8 The latest reports submitted to the SDODC meeting in December 2023 provided assurance of the plans in place to deliver Planning Objective 4A in relation to SCP recovery and progress achieved to reduce the volume of patients in the 62+ day backlog.

2.9 Integrated Performance Assurance Reports (IPARs) are also regularly presented to both the SDODC and the Health Board that provides progress updates on SCP current position, challenges and issues together with identified key actions and initiatives (including deadline dates).

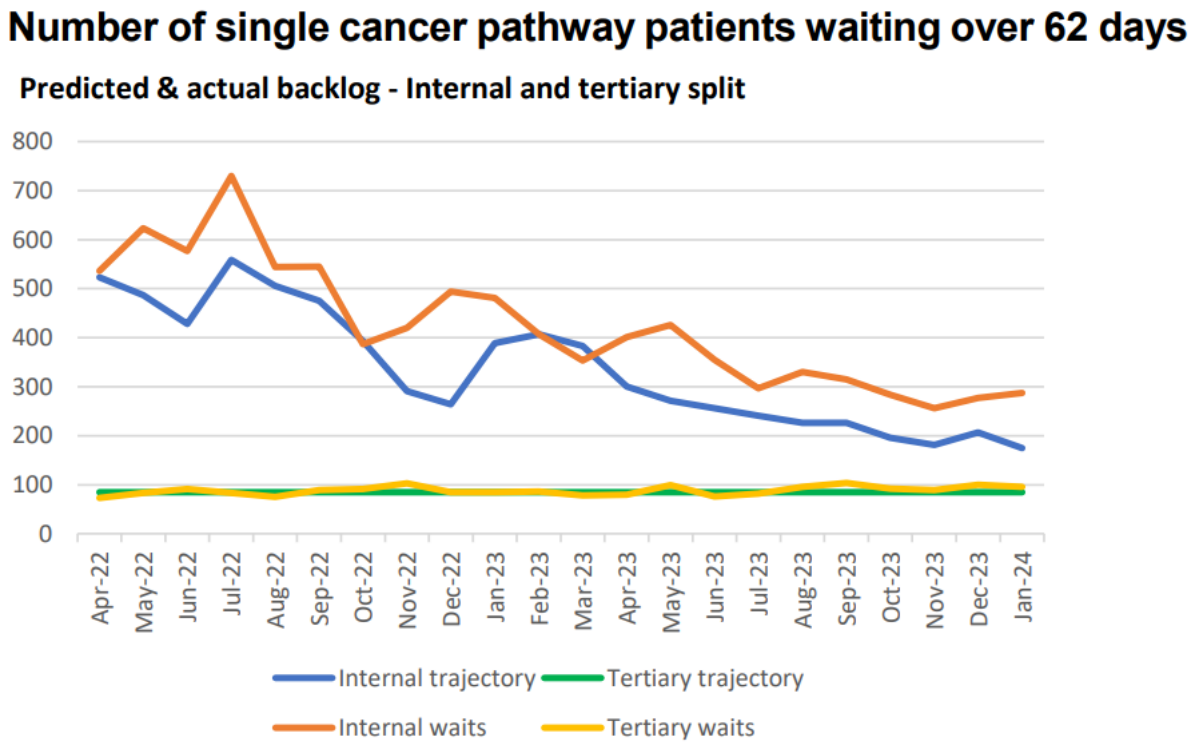
2.10 The latest IPAR submitted to SDODC in February 2024 highlighted the Health Board's position for SCP patients waiting over 62 days was 56% against WG target of 75%. Key challenges and issues, such as the reduction in capacity due to industrial action in December 2023 have impacted on this position.

Topic	Area for improvement	Latest period	Target	Latest actual	Variation	Assurance	Trajectory
Cancer	% pts on single cancer pathway within 62 days	Dec 2023	75%	56%			

Variation How are we doing over time	Assurance Performance against target	Trajectory Performance against our ambition
Improving trend	Always hitting target	Trajectory met or improved upon
Usual trend	Hit and miss target	Within 5% of trajectory
Concerning trend	Always missing target	More than 5% off trajectory

2.11 Identified actions and initiatives were also outlined including demand and capacity planning for Radiology and a new Endoscopy booking process. These actions and initiatives should also be reflected in entry 1350 on the risk register to ensure completeness in improving cancer waiting times. **[Matter Arising 2]**

2.12 A review of the Quarterly Directorate Improving Together Sessions (DITS) in July and October 2023 confirmed key information relating to the enhanced monitoring and ministerial priorities for SCP was scrutinised, including NOP updates, actual and predicted backlog data, performance and sustainability. The identification of issues/challenges and subsequent actions are captured on the Improving Together action tracker. Whilst positive progress is reflected in the number of SCP patients waiting over 62 days being reduced from over 700 in July 2022 to 383 in December 2023, the position against trajectory still requires improving – see below.



2.13 The Health Board established a Cancer Delivery Board in April 2018 with the aim of ensuring continuous improvement in the delivery of person centred cancer services. We can confirm a terms of reference (ToR) has been developed but has not been updated since 2021 including references to ex-employees as listed members and reporting arrangements to a defunct sub-committee.

2.14 A review of the Cancer Delivery Board (now known as the Cancer Improvement Board) minutes and papers confirmed the regular reporting tumour site

improvement plans, performance trajectory and backlog planning, NOP's progress reports, together with service updates.

2.15 A review of the waiting list monitoring performance and action plan arrangements was also undertaken within the following 10 cancer tumour sites.

• Breast Care	• General Surgery
• Head & Neck	• Lower Gastrointestinal (GI)
• Lung	• Dermatology
• Gynaecology	• Urology
• Haematology	• Ears, Nose and Throat (ENT)

2.16 Meetings are being undertaken within each of the sampled tumour sites with the frequency ranging from daily to quarterly and the majority supported by minutes, action plans or next steps. The more frequent meetings were in the main unminuted with next steps or actions recorded directly on patient notes. A review of minutes and paper, and also the attendance by Internal Audit at the unminuted meetings confirmed key areas of discussion focused on performance, backlog improvement, arising and potential issues, next steps and action plans.

2.17 Internal Audit also attended a Watchtower meeting in January 2024 and can confirm the scrutiny of performance, backlog improvements and future actions per individual tumour site. Where patient numbers are higher than predicted targets, further review and support is provided through weekly one-to-one sessions. **[Matter Arising 2]**

External Reporting Arrangements

2.18 The Health Board meet with WG and NHS Wales Executive on a monthly basis through the Cancer Performance Assurance Meetings and Integrated Quality, Planning and Delivery (IQPD) Enhanced Monitoring Meetings. A review of minutes and agendas confirmed discussions at both meetings centre on performance and trajectory aims, appropriate actions, backlog, future plans and concerns.

2.19 The Health Board also provides weekly cancer performance data returns to the NHS Wales Executive. This information is used to populate a performance dashboard that provides an overview of key performance indicators for cancer pathways. The dashboard is published on the dedicated Cancer Resources site.

Conclusion:

2.20 Whilst positive actions and incentives are currently in place, these have not been reflected in the risk register entry. In addition, the Cancer Improvement Board ToR has not been updated since May 2021 and does not reflect current arrangements. We have concluded **Reasonable** assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Rapid Diagnosis Clinics (Design)			**Impact**
A review of one key control identified a delay in the establishment of the Rapid Diagnostic Centre (RDC) Clinic at BGH with alternative options currently being explored for the rollout of the proposed 2nd clinic to be based at WGH.			Potential risk of: • Undue harm to patients; and • Reputational damage.
Recommendation			**Priority**
1.1	Management should reflect the actions and options to aid in the rollout of RDCs across the organisation in the risk register entry.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	Action to aid roll out of RDCs across sites have been amended in line with the current position of the HB on the risk register entry	26th March 2024	General Manager Cancer & Oncology

Matter Arising 2: Key Processes and Gaps in Control (Operation)			**Impact**
Where progress has been attained in addressing the gaps in controls and various processes have been implemented, consideration should be given to the revision of the controls identified and reported within risk 1350, such as the one-to-one meetings held by Watchtower leads with tumour sites, demand and capacity planning for Radiology, and new Endoscopy booking process.			Potential risk of: • Undue harm to patients; and • Reputational damage.
Recommendation			**Priority**
2.1	Management should review the implemented key processes and identified gaps in controls on the risk register entry to ensure they all actions and initiatives to mitigate the cancer waiting time backlog.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	The risk register entry has been amended to include the one to one meetings required for tumour sites that are in escalation. The demand and capacity modelling for radiology has been updated and the new endoscopy booking process added.	26th March 2024	General Manager Cancer & Oncology

Matter Arising 3: Terms of Reference (Design)			**Impact**
The Health Board established a Cancer Delivery Board in April 2018 with the aim of ensuring continuous improvement in the delivery of person centred cancer services. We can confirm a ToR has been developed but has not been updated since 2021 including references to ex-employees as listed members and reporting arrangements to a defunct sub-committee.			Potential risk of: • Undue harm to patients; and • Reputational damage.
Recommendation			**Priority**
3.1	The Cancer Improvement Board terms of reference should be reviewed and updated to reflect current arrangements.		**Medium**
Agreed Management Action		**Target Date**	**Responsible Officer**
3.1	The TOR for the Cancer Improvement Board are being updated.	30th April 2024	General Manager Cancer & Oncology

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

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

Prioritisation of Recommendations

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

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

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

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