Bundle Quality, Safety & Experience Committee 23 March 2022

2	OPENING BUSINESS
2.1	11:00 - QS22/71 Apologies For Absence
2.2	11:02 - QS22/72 Declarations of Interest
3	STRATEGIC ITEMS FOR DECISION
3.1	11:05 - QS22/73 Vascular Update
	QS 22.73 - Vascular Paper NL 18 3.docx
3.2	11:50 - QS22/74 Waiting list management report - For information
	QS 22.74 - Waiting list management internal audit cover report.docx
	QS 22.74a - Final Internal Audit report - Waiting list mangement.pdf

Cyfarfod a dyddiad: Meeting and date:	**23 March 2022 Extra Ordinary Quality and Safety Experience Committee**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Short Term Changes to Vascular Model
Cyfarwyddwr Cyfrifol: Responsible Director:	Nick Lyons, Executive Medical Director
Awdur yr Adroddiad Report Author:	Neil Rogers, Acute Care Director
Craffu blaenorol: Prior Scrutiny:	None
Atodiadau Appendices:	Appendix 1: Monitoring arrangements for the short term changes within the Vascular Network

Argymhelliad / Recommendation:

The Committee is asked to note the actions taken in response to recent safety concerns

Ticiwch fel bo'n briodol / Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		**Ar gyfer Trafodaeth For Discussion**	**x**	**Ar gyfer sicrwydd For Assurance**		**Er gwybodaeth For Information**	

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable	**Y/N**

Sefyllfa / Situation:

Short terms changes to service model in North Wales Vascular Network

A recent Never Event and a Serious Incident related to the vascular service has led to consideration of any necessary enhancements to our service model in the short term (28 days) to mitigate potential risks to the quality and effectiveness of the service.

These changes are in addition to the wider improvement and transformation that continues to be taken forward in the Vascular Improvement Plan. This plan includes work to develop a Community of Practice within the Welsh vascular networks and closer links for BCUHB with NW England

Consultant Workforce.

The fragility of the Consultant workforce to cover services on the three sites to provide the "hub and spoke" model remains a key challenge. Short-term resilience in rotas and the bolstering of support in

safety critical elements of the service is the purpose of the short term changes in service delivery in the North Wales Vascular Network.

Cefndir / Background:

The existing Vascular Improvement Plan lays out the Health Board's actions in response to the invited service review by the Royal College of Surgeons, national audits and other quality and patient experience issues within the service.

Safety concerns highlighted in week commencing March 7th 2022 have now led to changes in service delivery in order to mitigate risks highlighted in those incidents.

The incidents are still under investigation and learning from the incidents is under regular review. In addition to the changes outlined in this paper the role of an external radiology reporting service is being considered as well as consideration of the need for any professional regulatory actions.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications

The hub and spoke model for delivery of vascular services, supported by external review, remains the model for delivery of vascular services in North Wales.

Opsiynau a ystyriwyd / Options considered

A number of options to mitigate risks have been considered by the operational and clinical teams. The Executive Team agreed the following proposal on 17th March 2022 following the introduction of immediate make safes on 11th March 2022.

This model will remain in place for 28 days from 17th March and will be reviewed, with the support of Liverpool University Hospital NHS Foundation Trust, to consider whether this period should be extended. That review will be reported, and a decision made, at least 7 days before the end of the 28 day period. Additional actions are meanwhile being considered and developed.

In hours: Monday-Friday:

Theatre- Dual Consultant operating for the following complex procedures:

1. All ruptured and symptomatic aortic aneurysms
2. All bypass procedures
3. All trauma cases resulting in major arterial and/or venous bleed
4. Aortic and limb graft occlusions requiring thrombo-embolectomy
5. Ruptured pseudo-aneurysms.

On call (Vascular Consultant of the week, VCOW)

- **A VCOW** rota (one BCU consultant on call every day in normal working hours) remains in place.
- A second consultant is now timetabled to be present on the hub site for regular commitments (including outpatients and elective operating).
- When additional consultant input is required at the hub site to support in hours dual operating, this may need to be sourced from spoke site consultant provision

This arrangement will require the standing down of a small number of day case lists, out-patient clinics and will need temporary changes in the job plans of consultants.

This is estimated to impact upon no more than 20 routine day case procedures over the course of the coming 28 days and no more than 50 outpatient attendances.

The further cover arrangements across the 24/7 period are summarised as follows:

Overnight Monday-Friday:

On call-

- One BCU employed consultant on call. Any complex cases (listed below) will be discussed with LUHFT and transferred out to Liverpool as appropriate; it is anticipated that this will be no more than 4 patients per week.

- The Liverpool service, as a regional tertiary centre, is available to provide enhanced remote clinical advice 24/7.

- Emergency overnight operating will only occur in the event of risk to life and limb. Any patient where the consultant believes that a procedure is required in the overnight period will be discussed with the Liverpool team to ensure that is the appropriate way forward. Appropriate documentation will be expected in the patient medical records and compliance with this will be audited on a daily basis by the Site Medical Director at YGC.

- A reporting process is in place to ensure all transfers to Liverpool are reported and assurance that follow up arrangements are not compromised

Weekend Friday 5pm - Monday 8am:

2 Consultants will be on-call at all times

The availability of two consultants will enable better coverage of the three sites, and enable dual consultant operating for any complex procedures undertaken over the weekend. The impact on workforce availability and wellbeing will be closely monitored.

MDT Arrangements

- MDT arrangements have been strengthened to ensure that where emergency surgery is considered, there will be an MDT discussion between a minimum of 2 Consultant Vascular Surgeons, the Consultant Anaesthetist and Consultant Intensivist / on call Physician as appropriate.

- From April 2022, the Memorandum of Understanding (MoU) with LUHFT commences, and BCUHB clinicians will be able to formally join the Liverpool MDT to discuss complex cases. The MoU has now been signed off by the LUHFT Executive Medical Director.

- The Clinical Director for Vascular (LUHFT) or his nominated deputy will be present for the BCUHB MDT, and will work with the team to review clinical and theatre practices and service processes as part of the MoU.

Patient Safety Improvement (WHO Checklist and Human Factors)

Additional measures are in place to improve patient safety. This includes the embedding of a member of the patient safety team (with theatre practice development experience) into the YGC site to support the review and improvement of the standard surgical safety processes (including a focus on the WHO Checklist). The Transformation and Improvement Team are recruiting a Clinical Quality Improvement Fellow post (six months) to focus on the sustainability of this surgical safety work, including the focus on the WHO Checklist.

A safety culture survey has also been undertaken across all Surgical Directorates, and this is now being analysed to support this work.

A human factors faculty is in development, and following a procurement exercise, AQuA (the Advancing Quality Alliance, an English NHS improvement collaborative) has been appointed to support this work. The vascular service will be among the prioritised areas for this support, alongside wider surgical specialties. A weekly strategic group is meeting to progress this work at pace. The detailed implementation plan has yet to be finalised but the work is expected to commence in April.

A dedicated Vascular Quality Team has also been created for the coming months, by redeploying existing quality staff to focus solely on this speciality. They are supporting the work of the Vascular Quality Panel and providing objective facilitation of incident, serious incident and complaint investigations. This team is being managed by the Acting Associate Director of Patient Safety.

Operational Arrangements

The repatriation policy has now been signed off by all 3 acute sites, and will facilitate the rapid transfer back of patients from hub to spoke site when clinically appropriate, to ensure better availability of beds on Ward 3 (YGC vascular ward) to be responsive to emergency patients as they present across North wales. This is a crucial step given that delays in transfer to the hub and delays in Emergency Departments have been a theme in previous incidents.

An agreement remains in place for complex cases and this will now be further developed in line with the procedures below.

The following procedures will now be consistently discussed both in and out of hours with tertiary providers. It is anticipated that the majority are likely to be referred to the existing tertiary centres, resulting that in addition to the current 1-2 patients per week being referred a further 4 patients per week will receive care in North West England

1. All aortic graft infections (Liverpool Royal)
2. All redo endovascular open aortic surgery (Liverpool Royal)
3. All Supra renal and thoracic aneurysms (Liverpool Royal)
4. Explanation of aortic grafts for infection , endoleak etc (Liverpool Royal)
5. Endovascular and open management of mesenteric ischaemia (Liverpool Royal)
6. Thoracic outlet and first Rib resection procedures (Liverpool Royal)
7. All open inflammatory aneurysms (Liverpool Royal)

8. All renal ischaemia cases (open and endovascular) (Liverpool Royal)
9. Complicated aortic dissections (Liverpool heart and chest)
10. Paediatric arterial injury (Alder hey hospital)
11. Interventional Radiology (IR) is only available in-hours; a review of all procedures out of hours that require IR should be considered for transfer to LUHFT
12. All Major Vascular trauma already goes to the University Hospital North Midlands (Royal Stoke) trauma centre.

Goblygiadau Ariannol / Financial Implications

The changes outlined will require additional payment to support enhanced out of hours cover and the provision of further outpatient capacity. The likely costs are currently being finalised.

Dadansoddiad Risk / Risk Analysis

Based on analysis of recent incidents, this package of measures has been put in place to provide further mitigation of potential harm to patients.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

A Memorandum of Understanding between The Royal Liverpool has been agreed and will come in to place in April 2022 and is currently being reviewed by the Health Board before final signing.

Asesiad Effaith / Impact Assessment

A Quality Impact Assessment and Equality Impact Assessment has been completed

Appendix 1

Monitoring arrangements

Action resulting in changes for patients	Impact	Monitored	Lead
Complex patients transferred out to Liverpool	Approximately 4 patients per week	Weekly audit based on proforma	YGC Medical Director
Routine day cases who will have treatment delayed as a result of provision of dual surgeon operating.	Approximately 20 patients per month	Weekly monitoring through the operational team	Vascular Network Director
Routine outpatient attendances who have treatment delayed as a result of provision of dual surgeon operating and required job changes	Approximately 50 patients per month	Weekly monitoring through the operational team	Vascular Network Director
Desktop exercise to validate patients currently on the follow up waiting list who are overdue to enable risk stratification	100 per week to be completed across the 3 sites	Weekly monitoring through the operational teams	Vascular Network Director
Additional patients seen in OPD as a result of risk stratification achieved through waiting list initiatives	Numbers to be determined when impact of current workforce changes implemented	Weekly monitoring through the operational teams	Vascular Network Director
Patients repatriated back to local spoke site more quickly	Care delivered closer to home	Weekly monitoring through operational teams	Vascular Network Director

Cyfarfod a dyddiad: Meeting and date:	**Quality, Safety and Effectiveness Committee 23rd March 2022**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Waiting list internal audit report
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris, Deputy Chief Executive / Executive Director of Nursing and Midwifery
Awdur yr Adroddiad Report Author:	Dave Harries – Head of Internal Audit Nicola Jones – Deputy Head of Internal Audit
Craffu blaenorol: Prior Scrutiny:	The progress report has been considered and approved by the Deputy Chief Executive
Atodiadau Appendices:	Appendix 1: Limited assurance report: Waiting list management

Argymhelliad / Recommendation:

The Committee is asked to:

- Receive the report on waiting list management

Ticiwch fel bo'n briodol / Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval	✓	**Ar gyfer Trafodaeth For Discussion**		**Ar gyfer sicrwydd For Assurance**	✓	**Er gwybodaeth For Information**	
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						**N**	

Sefyllfa / Situation:

The Internal Audit Plan is produced in accordance with the requirements as set out within the Public Sector Internal Audit Standards: Standard 2010 – Planning.

The progress report is produced in accordance with the requirements as set out within the Public Sector internal Audit Standards: Standard 2060 – Reporting to Senior Management and the Board.

Cefndir / Background:

This report is submitted to the QSE Committee following its approval by the Deputy Chief Executive on the 18th of March 2022, following the March Audit Committee.

This report is submitted to the QSE in order to provide timely assurance, due to the limited assurance audit opinion and the potential impact on the annual governance statement disclosure.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications

This report is part of the Internal Audit plan for 2021/22 was approved by the Audit Committee in March 2021.

Opsiynau a ystyriwyd / Options considered

N/A
Goblygiadau Ariannol / Financial Implications The progress report may record issues/risks, identified as part of a specific review, which has financial implications for the Health Board.
Dadansoddiad Risk / Risk Analysis The report details internal audit assurance against specific reviews which emanate from the corporate risk register and/or assurance framework, as outlined in the internal audit plan.
Cyfreithiol a Chydymffurfiaeth / Legal and Compliance The audit plan for 2022/23 is required in accordance with the Welsh Government NHS Wales Audit Committee Handbook – Section 4.4 Reviewing the internal audit plan. The progress report is required in accordance with the Welsh Government NHS Wales Audit Committee Handbook – *Section 4.5 Reviewing internal audit assignment reports.*
Asesiad Effaith / Impact Assessment The Internal Audit report provides third line assurance to the Board, through its Committees, on the effectiveness of the Health Board's risk management arrangements, governance and internal controls. This report does not have an impact on equality nor human rights beyond what is drawn out specifically in respect of individual audits and is not discriminatory under equality or anti-discrimination legislation.

Waiting List Management: Review of the Welsh Government initiated Patient Validation Exercise, Risk Stratification and patient removal from lists
Final Internal Audit Report

March 2022

Betsi Cadwaladr 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 Betsi Cadwaladr University Health Board

Contents

Review reference:	BCU-2122-14
Report status:	Final Internal Audit Report
Fieldwork commencement:	7 October 2021
Fieldwork completion:	6 January 2022
Debrief meeting / Discussion draft:	6 January 2022
Draft report issued:	2 February 2022
Management response received:	11 March 2022
Approval and final report issued:	18 March 2022
Auditor(s):	Principal Auditor, Deputy Head of Internal Audit
Executive sign off:	Deputy Chief Executive / Interim Director of Regional Delivery
Distribution:	Head of Ambulatory Care, Directorate General Manager - Surgery, Anaesthetics & Critical Care, Directorate General Manager - (General Surgery West) Directorate General Manager (General Surgery Central)
Committee:	Audit Committee

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

Disclaimer notice - please note

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

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

Executive Summary

Purpose

The objective of the audit was to assess the Welsh Government initiated tranche 'patient' validation exercise and more broadly, the prioritisation of waiting lists for planned care and removal of patients from the waiting lists.

Overview

We have issued limited assurance on this area.

The significant matters which require management attention include:

- The outpatient's governance spreadsheet needed tighter controls to ensure the integrity of the data relating to access and who is populating the spreadsheet with information.
- Evidence from the risk stratification waiting list (2.16) shows that patients within Orthopaedics and Urology as being overdue within the "Risk Strat/Reprioritised Status" section.
- 56 reasons for the removal of patients from waiting list. Information extracted from respective PAS systems for East, Central and West slightly differ in the wording of the reasons, making it difficult when merging reports as well as potential confusion for inputting.

Report Classification

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

Assurance summary[1]

	Assurance objectives	Assurance
1	Oversight and review of the status and progress of waiting lists within the Health Board	Reasonable
2	The Welsh Government (WG) initiated, locally delivered tranche 'patient' validation exercise	Limited
3	Assessment of clinical risks relating to delays, with these recorded and actioned where appropriate.	Limited
4	Patients removed from waiting lists.	Limited

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

	Key Matters Arising	Assurance objective	Control Design or Operation	Recommendation Priority
1	Future arrangements for large scale tranche validation exercises		Operation	High
2	Assessment of clinical risks relating to delays		Operation	High
3	Patients removed from waiting lists		Operation	Medium

1. Introduction

1.1 The review of Planned Care – Waiting List Management has been completed in line with the 2021/22 Internal Audit Plan. The review has sought to provide the Health Board with assurance that waiting lists are accurate and being managed appropriately, with risks to patients assessed and monitored.

Following the impact of the COVID-19 pandemic, the health board is intending to recover delayed planned care activity in a timely, risk-based manner. As of July 2021, there were more than 40,000 patients affected. Clinical and Operational teams are taking actions to address the backlog, with specialties managing waiting lists through validation of patient data and assessment of clinical risks.

1.2 The following risks are identified at the outset of the review:

- waiting lists are not effectively managed, resulting in inaccurate lists and delays to patients (this risk was considered only in the context of the tranche validation exercise);
- patients have been removed from lists without appropriate communication; and
- there is a lack of assurance that clinical risks have been assessed.

1.3 The internal audit has assessed the adequacy and effectiveness of the internal controls in operation. Weaknesses have been brought to the attention of management and advice issued on how particular problems may be resolved and control improved to minimise future occurrence.

1.4 This audit has reviewed the implementation of the one-off Welsh Government initiated tranche patient validation (not the standard patient validation carried out within each site as part of their core functions) – it is not expected that this will be repeated in this way again. This report will support the lessons learnt currently being carried out on that one-off initiative which will inform how the Health Board moves towards automation/digitisation/business as usual.

1.5 The objective of the audit was to assess the arrangements in place for review and prioritisation of waiting lists for planned care. The review has considered the following areas:

- oversight and review of the status and progress of waiting lists within the Health Board;
- the WG initiated, locally delivered tranche 'patient' validation exercise;
- assessment of clinical risks relating to delays, with these recorded and actioned where appropriate; and
- patients removed from waiting lists, to ensure they have received the appropriate communication.

The audit has sampled Urology, Orthopaedics and Dermatology.

2. Detailed Audit Findings

Objective 1: Oversight and review of the status and progress of waiting lists

2.1 There is a Planned Care Transformation Group (PCTG) in place which meets fortnightly and has oversight of the waiting lists within the Health Board. The Terms of Reference (ToR) includes the following objective:

Treatment of patients

Monitoring of cohort 1 and 2 and the allocation of funding to differing services to reduce backlogs and scrutinise business cases from a planned care perspective.

2.2 We were provided with the minutes of four of the meetings and confirm that all were quorate, with appropriate attendance. Cohort 1 and 2 are an agenda item on three of the sets of minutes however discussion taking place on both cohorts is visible within all the minutes provided. The Group reports to the Executive team meeting and we were provided with evidence to demonstrate this reporting for the meetings in June and August 2021.

2.3 Previously, a Planned Care Performance Review Group met monthly, however these have since been superseded, moving to weekly with overarching access meetings alternating between Surgical and Women's and Area, Medical, Diagnostics and Therapies. This meeting reports into the Planned Care Transformation Group, the meetings are not minuted but an action log is in place.

2.4 Local access meetings take place weekly, chaired by the Directorate General Managers (Surgery) and the Interim Assistant Director of Community Services (Dermatology). Waiting lists are reviewed at a patient level to determine actions that need to be taken to ensure patients are treated as soon as possible. The information from these meetings is report into the overarching access meeting.

Conclusion

2.5 There are oversight and reporting arrangements in place within the Health Board that oversee the total waiting lists, and local meetings that review the lists at a patient level. The Executive Team are provided with an update from the Planned Care Transformation Group.

Objective 2: Welsh Government initiated, locally delivered tranche 'patient' validation exercise

2.6 'Stage of Pathway' is used to identify the point at which a patient is waiting in respect of their overall diagnosis and treatment. The definition of each stage is shown in the table below.

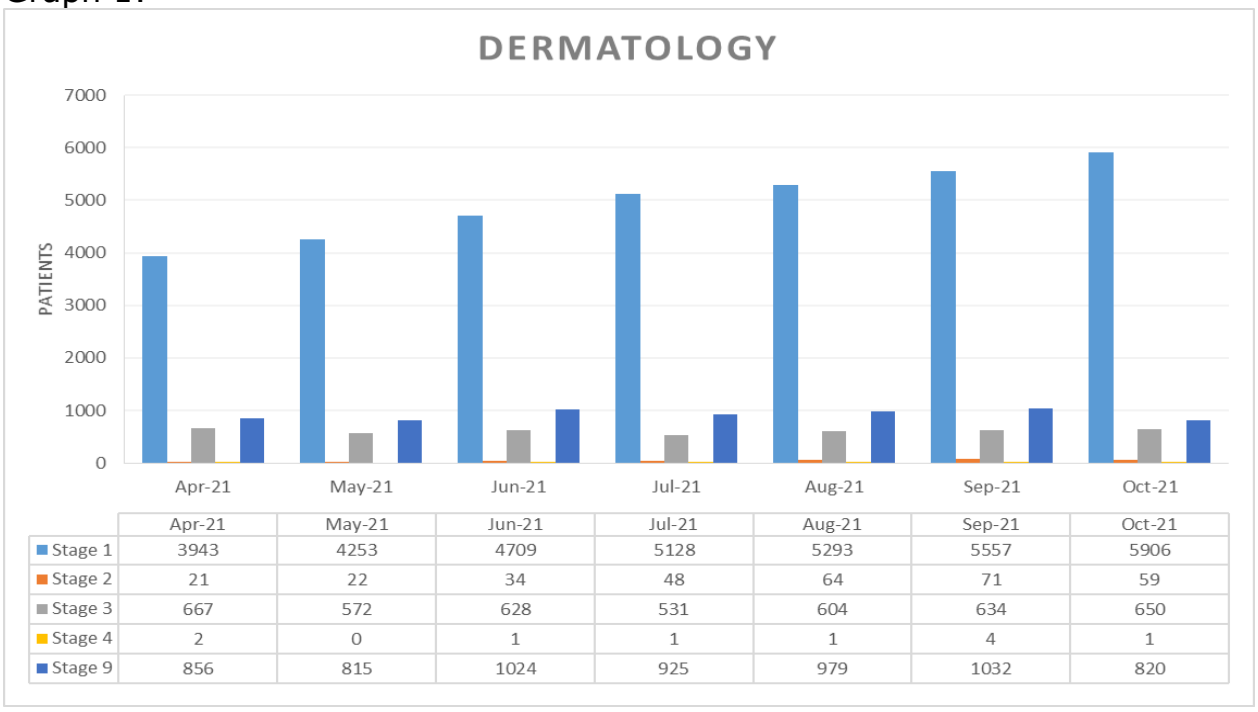
Table 1: NHS Wales Data Dictionary Stages of pathway

Stages of the Pathway	Stage of the Pathway
1	*Waiting for a new outpatient appointment. A new Outpatient Appointment may come from any referral source. A patient will be at Stage 1 only once.*
2	*Waiting for a diagnostic or Allied Health Professional (AHP) test, intervention or result. For relevant diagnostic and AHP services.*
3	*Waiting for a follow-up outpatient appointment or waiting for a decision following:* *1) An outpatient appointment.* *2) A diagnostic or AHP intervention result.* *3) Or where the patient is waiting, and the stage is uncertain/unknown.*
4	*Waiting for an admitted diagnostic or therapeutic intervention (i.e., treatment) only.*
9	*Not applicable – e.g., closed pathway*

2.7 We obtained data from Informatics for April 2021 – October 2021 displaying referral to treatment (RTT) summary details sent to the Digital Health and Care Wales (DHCW) monthly. The tables below depict what movement through the stages has taken place during the time period stated within the sampled areas of Dermatology, Urology and Orthopaedics.

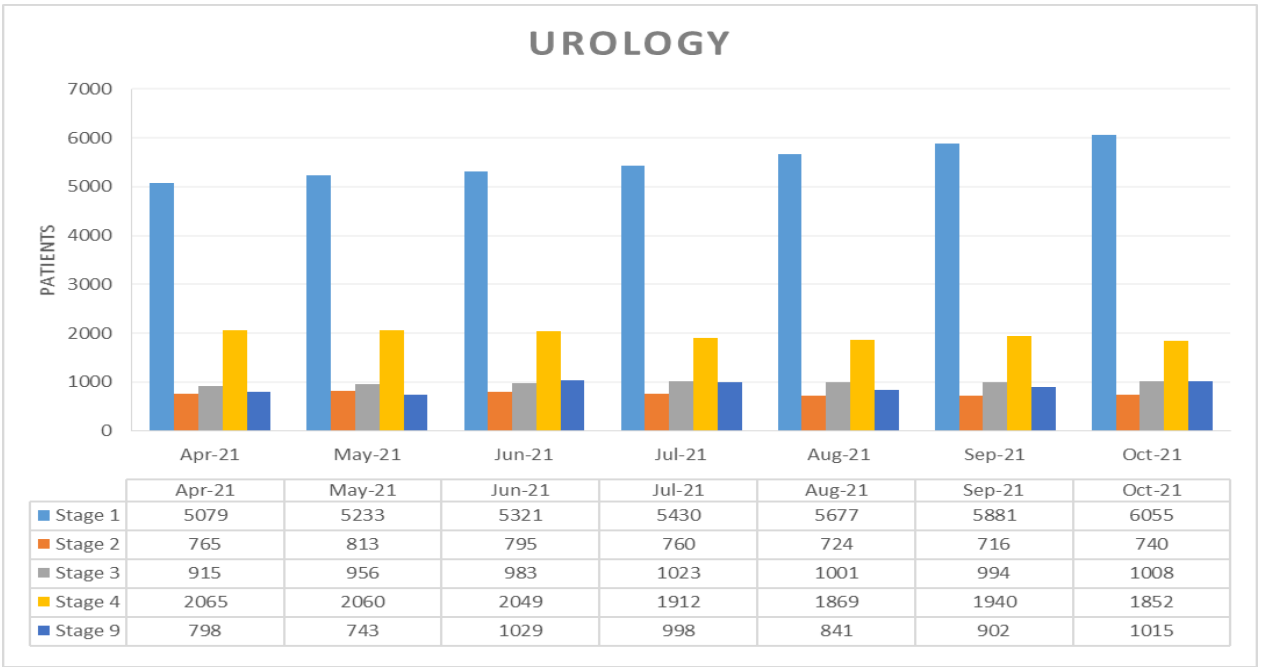
2.8 The data within the graphs shows little movement within the stages over the period stated.

Graph 1:



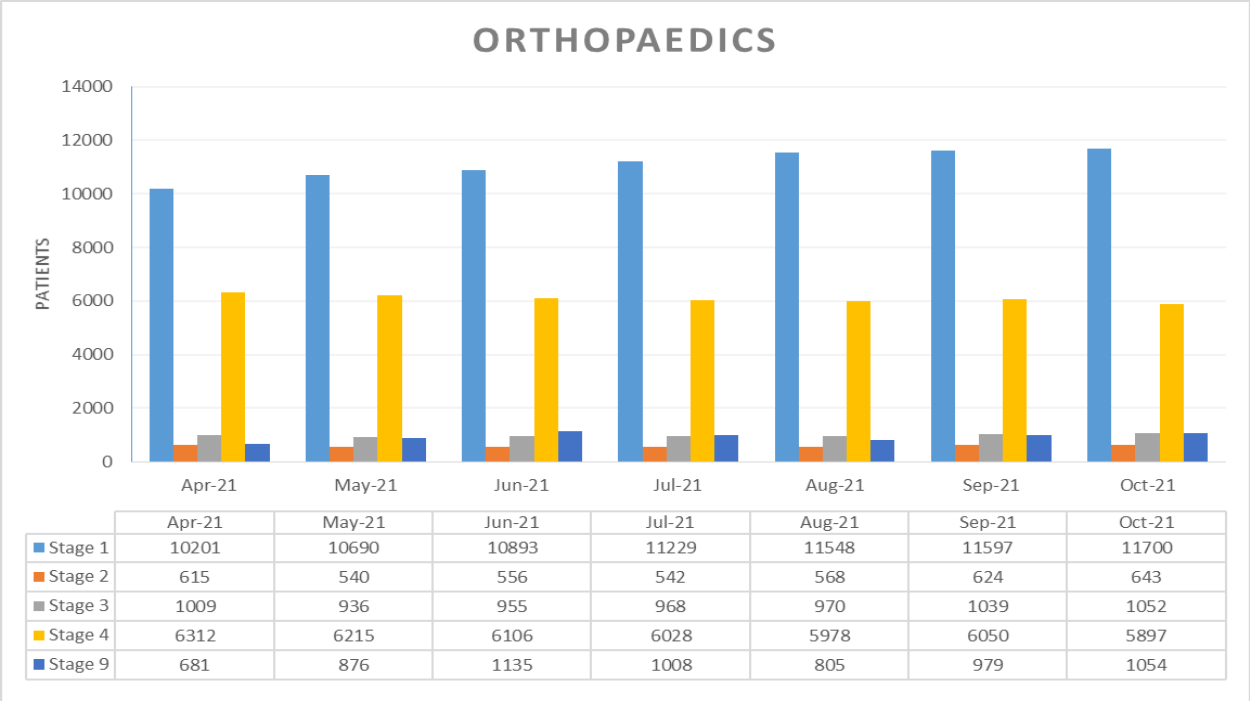
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Stage 1	3943	4253	4709	5128	5293	5557	5906
Stage 2	21	22	34	48	64	71	59
Stage 3	667	572	628	531	604	634	650
Stage 4	2	0	1	1	1	4	1
Stage 9	856	815	1024	925	979	1032	820

Graph 2:



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Stage 1	5079	5233	5321	5430	5677	5881	6055
Stage 2	765	813	795	760	724	716	740
Stage 3	915	956	983	1023	1001	994	1008
Stage 4	2065	2060	2049	1912	1869	1940	1852
Stage 9	798	743	1029	998	841	902	1015

Graph 3:



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Stage 1	10201	10690	10893	11229	11548	11597	11700
Stage 2	615	540	556	542	568	624	643
Stage 3	1009	936	955	968	970	1039	1052
Stage 4	6312	6215	6106	6028	5978	6050	5897
Stage 9	681	876	1135	1008	805	979	1054

2.9 Following the unprecedented circumstances due to the pandemic and inevitable impact on waiting lists within all Health Boards across Wales, the Welsh Government initiated local Health Boards to undertake a large-scale tranche patient validation exercise at Stage 1 and Stage 4.

The Health Board sent out letters to all outpatients on the Stage 1 and Stage 4 a waiting lists (Waiting 48 weeks and over as of 30th June 2021). This was to determine if the patient's circumstances or needs had changed. Patients were asked to complete and return the questionnaire online.

We were advised during the review that in early meetings that took place to formulate the plan to undertake the WG initiated trance validation exercise, the managers on the sites have shared that they expressed concerns with the approach for the reasons of both clinical and administrative capacity and ability to maintain the activity using the methods provided

2.10 A presentation to the Planned Care Transformation Group on the 12th November 2021 provided an update on the stage 1 validation position.

Table 2: Initial Letters sent during period 05/07/21 – 13/08/21

Position as 11th November 2021

Total Records Validated	***20,112***	
Total Responded Remain	*12,544*	*62%*
Total Responded Remove	*2,143*	*11%*
Total Responded Non-responders	*5,280*	*26%*
Total Other (check required, deceased)	*145*	*1%*
Still Requiring Clinical Review/Review Outcome	*7,031*	*5%*
Of which, 'deteriorating statement'	*6,305*	*31%*

Total Records Validated	***20,112***	
Could be removed from waiting lists now	*1,926*	*10%*

2.11 The questionnaire included a 'deteriorating statement', asking if the patient believes they have deteriorated. 6,305 completed the deteriorating statement [for all sites]. The total number of patient responses who said yes for the specialties in our review as of the 11th November 2021 are:

- Urology – 630
- Dermatology - 323
- Trauma & Orthopedics – 1,755

We note that the lack of clinical capacity to review these patients to see if they should be expedited, against the competing priority of the re-purposing of any spare capacity to support the vaccination booster drive, has been logged as a tier 1 corporate risk at a score of 16 (ref.4260) on the 11th January 2022 and is awaiting Executive approval prior to the escalation process.

2.12 Figures detailed above were captured on governance spreadsheets for East, Central and West.

Details on the spreadsheet included, NHS number, patients name, patient contact details, Area, Case Reference Number (CRN), Unique Patient Identification (UPI), Consultant and specialty.

A temporary call centre consisting of shielding nurses and administrators was set up to receive the responses and populate the Governance spreadsheets. We are unclear how many individuals have access to populating the governance spreadsheets, so there is a risk that the data may be corrupted or deleted in error.

2.13 We combined all three governance spreadsheets and corroborated the data back to the total of 20,112 records validated. Using data interrogation software on the three spreadsheets we identified the following:

- Duplications – 1 duplication of the same patient within the same specialty (Trauma & Orthopaedics).
- 3 patients had the same unique patient identification (UPI) and NHS number (including 1 from Trauma and Orthopaedics).
- 51 records did not have a 10-digit NHS ID Number (Some were duplicates of Case Reference Number). This included 11 from our sample areas:
  - 3 urology
  - 6 Orthopaedics
  - 2 Dermatology
- One had a UPI No as a '6' (Urology)

- One with a duplicate NHS number, same name but different dates of births. (Not within our sample)
- Duplicate UPI number but two different names. (Trauma & Orthopaedics and Urology)

2.14 For those patients classed at stage 4, we were advised that all patients on the waiting list (patients who require routine surgery work) have required a refreshed waiting list, where each patient confirms they wish to actively remain on the waiting list.

2.15 With the Health Bard undertaking the stage 1 validation exercise manually, a business case has been developed for an automated validation tool within the Wales Patient Access System (WPAS).

The Head of Ambulatory Care along with technical colleagues are exploring plans to digitise and automate the patient validation process, to move away from tranche validation into BAU.

Following a meeting with WG leads 13th January 2022, there is an opportunity to seek national funding and deliver locally as a proof of concept to potentially be scaled up nationally.

2.16 Whilst this report does not explore the process undertaken in each site to undertake their specific functions for patient validation of waiting lists. We noted that validation activity in both Urology and Orthopaedics is managed by the respective site leads in Surgery, whilst Dermatology is managed by the Interim Assistant Director of Community Services.

2.17 We were provided with a document that sets out the rules for managing referral to treatment waiting times. The document provides a complete reference source of the waiting times management rules relating to the 26-week referral. This is followed by all three areas for the monitoring of waiting lists.

All three specialities take a comparable approach to the validation process. Weekly access meetings are held where they discuss:

- Follow up backlog,
- Long waiters list, and
- Risk stratification waiting lists.

These meetings feed into the overarching access meeting mentioned above.

Conclusion:

2.18 The governance spreadsheet required tighter controls to ensure the integrity of the data relating to access and who is populating the spreadsheet with information. Robust back-up arrangements should be established to ensure this key source of waiting list data is available in the event of corruption/data loss, resulting in patient harm – other options should be reviewed to move away from a spreadsheet to a more stable application.

Evidence within the graphs shows little movement within the stages over the period stated.

Objective 3: Assessment of clinical risks relating to delays

2.19 The Royal College of Surgeons issued a reprioritisation code list and associated documentation where the onset of the pandemic meant many elective surgeries were cancelled. Following recommencement of elective surgery, a large proportion of these patients waiting were either approaching or had exceeded their 26-week target.

Patient risk stratification focuses on patient management of harm and alternative treatment regardless of which area the patient was receiving the treatment.

The table below details the groups and how patients requiring surgery have been classified.

Table 3:

Priority Level	Description
1a	Emergency - operation needed within 24 hours
1b	Urgent - operation needed with 72 hours
2	Surgery that can be deferred for up to 4 weeks
3	Surgery that can be delayed for up to 3 months
4	Surgery that can be delayed for more than 3 months

2.20 Clinicians risk stratify patients when they are listed for surgery and is record within the patient administration system for reporting. At present, the Welsh Patient Administration System (WPAS) is used within East and Central, with the West using Profile Information Management System (PIMS).

2.21 As of 31 January 2022, there were 25,086 admission pathways recorded across the Health Board. Twenty one percent (5,367) of these had not been risk stratified.

2.22 All three areas for Urology and Orthopaedics provided evidence that the patients on the waiting lists had been risk stratified. We received a spreadsheet for East and Central patients titled risk stratification waiting list reconciliation dated 25th October 2021. This document is presented to the local access meetings on a weekly basis. Whilst we can confirm that all patients had been risk stratified, we also noted that out of the 950 patients identified within the "Risk Strat/Reprioritised Status" 938 were classified as being overdue.

We have included the total number of admissions for Urology and Orthopaedics as at the 31st January 2022

- Urology 670, (6603 total admissions)
- Orthopaedics 105, (1501 total admissions)
- Other specialities on spreadsheet 163

2.23 The document highlighted all the elective priority levels that had been left blank for both specialties in East and Central. As well as differing risk

stratification priority scores within the sections of referral comments, elective priority score and risk stratification score.

2.24 We were informed by Dermatology that no risk stratification has taken place as they do not have any stage 4 patients.

Conclusion:

2.25 Evidence from the risk stratification waiting list reconciliation spreadsheet shows that patients within Orthopaedics and Urology have been risk stratified. **However, patients were highlighted as being overdue within the "Risk Strat/Reprioritised Status" section**, which could result in patient harm if they are not seen within the original timescale noted when first risk stratified.

There are conflicting risk stratification priority scores within the sections of referral comments, elective priority score and **risk stratification** score potentially leading to confusion, it is noted that the areas are aware of this and have highlighted it as an issue.

Consideration needs to be given to the potential for harm to the patient on both points above.

Objective 4: Patients removed from waiting lists

2.26 We were provided with evidence from the Informatics Department detailing all the patients removed from the waiting lists of the three specialties between April 2021 and October 2021.

2.27 The data was taken from WPAS and PIMS systems and included in-patients and out-patients. A further breakdown of the data including the reasons for removing patients from the list can be found in Appendix B

2.28 The table below, by specialty, details patients removed from the waiting lists in the period:

Table 4:

	Speciality		
Patient type	Urology	Trauma & Orthopaedics	Dermatology
In-Patient	1,405	2,104	1
Out-patient	1,565	2,349	47
Total	2,970	4,453	48

The review of data identified:

- There were 56 reasons in total for removing the patients.
- Reasoning for removal of patients between West compared to East and Central differ (we note that WPAS does not support the West removal codes).
- 378 patients had been entered in error.
- 788 patients had no reason recorded for being removed from the lists.

Conclusion:

2.29 Data is being recorded in all areas across the three sites, however we have identified issues of concern regarding the patients included in error and those with no reasons recorded – management should undertake a follow-up review to confirm the accuracy of this data.

Standardisation of the reasons to remove patients should be developed to ensure consistency across the Health Board.

Appendix A: Management Action Plan

Matter Arising 1 - WG initiated, locally delivered tranche 'patient' validation exercise - (Operation)	Impact
There is a *governance* spreadsheet in place which contains the details of all patients who are awaiting an Outpatient appointment and have been validated. At the time of the review over 20,000 patients were recorded on this spreadsheet. We were unable to ascertain who has access to and who is populating the governance spreadsheet. We also found the following • Duplications – 1 duplication of the same patient within the same specialty (Trauma & Orthopaedics). • 3 patients had the same unique patient identification (UPI) and NHS number (including 1 from Trauma and Orthopaedics), • 51 records did not have a 10-digit NHS ID Number (Some were duplicates of CRN No's), this included 11 from our sampled areas: • 3 urology • 6 Orthopaedics • 2 Dermatology • One had a UPI No as a '6', • One duplicate NHS number had the same name but different date of births, and • One had the same UPI number but two different names.	The integrity of the data on the governance spreadsheet cannot be determined, which could result in patients not being contacted or details being incorrect.
Recommendation	**Priority**

The governance spreadsheet required tighter controls to ensure the integrity of the data relating to access and who is populating the spreadsheet with information. Robust back-up arrangements should be established to ensure this key source of waiting list data is available in the event of corruption/data loss, resulting in patient harm – Options should be reviewed to move away from a spreadsheet to a more stable application	High	
Agreed Management Action	**Target date**	**Responsible Officer**
This report audits information on **ONLY** the one-off WG initiated tranche patient validation (not the standard patient validation carried out within each site as part of their core functions) – it is not expected that this will be repeated in this way again; this report will support the lessons learnt that was carried out on that one-off initiative that has informed the improvements in patient validation. On the 10th December 2021, the patient activity was safely closed down, the spreadsheets locked to 'read only' on the SharePoint site and downloaded by the Head of Ambulatory Care. To manage the remaining activity based on the patient responses, the spreadsheets were split into manageable cohorts of data and handed over to named individuals in the PABC to disseminate the remaining work. Much of the work has completed now with the remaining outstanding areas of work pertain to (i) adding validation markers and (ii) clinical validation of the patients that requested to remain & provided a 'deterioration statement'; both of which have been picked up in the latest validation cleanse activity (Step 1 and Step 2 below) **Action 1** – Cleanse the Waiting Lists	**Action 1 –** 31/07/2022	Head of Ambulatory Care

Steps	
Step 1	Tidy up validation markers in PAS post S1 Tranche Validation Exercise

	Step 2 – Complete the post S1 Tranche Validation Exercise work to clinically validation patients that requested to remain & provided a 'deterioration statement' Step 3 – Undertake cleanse of 'duplicates' on the waiting lists Step 4 – External Validation: Task 1 –run our PTL data through their validation software to report on findings Task 2 – phone contact - validation of all patients >36wks and un-validated S1 and S4 Task 3 – pathways validation to be defined based on the output from Task 1.		
Action 2 - Project to Automate & Digitise the Patient Validation Exercise - This project will use digital transformation in conjunction with process redesign to deliver significant and tangible improvements, removing much of the administration function – moving patient validation into business as usual rather than cohort or tranche activity. Phase 1 will be a proof of concept with one or more specialities. Funding is being sought via the WG who have engaged on the initiative with a view to scaling up pan-BCU		**Action 2** – 30/09/2022 (funding dependant)	Head of Ambulatory Care
Action 3 - Review and redesign the Service Validation Models pan-BCU		**Action 2** – 31/03/2023 (funding dependant)	Head of Ambulatory Care

Matter Arising 2 - Assessment of clinical risks relating to delays (Operation)	Impact	
Evidence from the risk stratification waiting list reconciliation spreadsheet shows that patients within Orthopaedics and Urology have been risk stratified. However, the patients were highlighted as being overdue within the "Risk Strat/Reprioritised Status" section. • Urology 670 (6603 total admissions) • Orthopaedics 105 (1501 total admissions) • Other Specialities on spreadsheet 163 There are conflicting risk stratification priority scores within the sections of referral comments, elective priority score and risk stratification score potentially leading to confusion, it is noted that the areas are aware of this and have highlighted it as an issue.	Patients are not risk stratified when due, which could lead to deterioration and potential harm to patients.	
Recommendation	**Priority**	
Patients who are identified as being overdue should be risk stratified as a priority. Records should be updated to confirm risk stratification has been completed and these should be reviewed on a regular basis to ensure there is minimal risk of patient harm	High	
Agreed Management Action	**Target date**	**Responsible Officer**
This pertains to the risk stratification of patients on the stage 4 waiting lists. Patients are referred into our waiting lists from GPs as either urgent or routine. The patient is then triaged and confirmed as urgent or routine prior to 1st appointment. At 1st appointment the patient is considered for surgery and risk stratified in line with the Royal College of Surgeons guidance as P1-P4, when the patient joins the Stage 4 waiting list.		Site Directorate General Managers

As at 10th March 2022 the data across all sites shows by speciality the number of patients where the P value is 'unknown' i.e. not entered into the PAS is as follows: ▪ T&O – 298 ▪ Urology – 150 ▪ General Surgery – 21 ▪ Breast – 24 ▪ Colorectal – 58 ▪ UGI – 18 ▪ Vascular – 108 ▪ ENT – 56 ▪ Max Fax - 28 As the focus of this internal audit report highlighted T&O and Urology; with these two specialities making up 64% of all patients without a P value in the PAS, these will be prioritised, followed by the remaining specialities to achieve the following actions:		
Action 4 – Validation of missing risk stratification data at an *individual patient level* (i.e. patients with unknown P value where the 1st appointment has already been held and where the PAS has not yet been updated) with planned review including informatics team pulling a live report in readiness for 30th April 2022.	**Action 4**- 30/04/2022	
Action 5 - In line with generic admin processes, each site will work to ensure that for those patients that have received their 1st appointment and are awaiting surgery, a P value will be entered into the PAS within 6 weeks of that 1st appointment.	**Action 5** – 31/05/2022	
Action 6 – Progress will be monitored locally on each site through a standing item at the weekly site *Access Meetings* to ensure the progress in action 4 is maintained	**Action 6 -** 31/03/2022	

Action 7 – Pan-BCU progress will be reviewed and monitored monthly at the Planned Care Operational Meetings to ensure the progress in action 4 is maintained	**Action 7 -** 31/03/2022	

Matter Arising 3 - Patients removed from waiting lists (Operation)	Impact	
Information on patients removed from waiting lists was extracted from the respective Patient Administration Systems for East, Central and West. The wording of the reasons is slightly different between the systems, making it difficult when merging reports as well as potentially confusing for those who are inputting the reasons. We identified: • 378 patients had been entered in error • 788 patients had no reasoning provided for being removed from the lists (these were categorised as "Null" and "Unspecified")	Potential for miss-reporting	
Recommendation	**Priority**	
Standardisation of the reasons for removal should be developed to ensure consistency across the Health Board and enable analysis of reasons why patients are removed from waiting lists. This would also potentially reduce any inputting errors.	Medium	
Agreed Management Action	**Target date**	**Responsible Officer**

WPAS Central is the nationally hosted instance into which 'West PIMS' and 'East WPAS instance' data will be moved over to (project full end May 2023). Whilst we cannot risk any delays to the West implementation which is due in May 2022, there is opportunity to standardise the codes on East WPAS earlier than their planned migration in 2023. The following actions reflect this:		
Action 8 – West Standardisation: WPAS West implementation is due to go live 16th May 2022 and this will standardise the removal reasons with the Central WPAS instance	**Action 8** May 2022	WPAS Standardisation lead
Action 9 – Ahead of the East migration to the Central WPAS instance, the codes will be standardised in the East WPAS instance tables to align with the Central WPAS removal codes.	**Action 9** July 2022	WPAS Standardisation lead
At this point the removal codes for all patients pan-BCU will be standardised.		

Appendix B: Out-Patients and In-Patients Reasons for removal from Health Board Waiting List

AREA	Out-Patients

Row Labels	Urology	Trauma & Orthopaedics	Dermatology
Appointment Inconvenient		1	
C.N.A & discharge	18	15	
Cancelled by GP	12	1	
Cancelled by GP or Cons	1		
Cancelled by Health Authority	1	10	
Cancelled by Hospital	40	142	2
Cancelled by patient	60	70	
Clerical error	30	23	
Conditioned Resolved	4	2	
Did not attend & Patient Discharged	18	192	1
Died (before appointment)	7	3	
Discharged by Consultant	12	1	
Discharged following consultant decision		1	
Entered in error	46	115	3
Inappropriate Referral	195	368	9
Moved to Treatment waiting list	397		
NHS Patient seen as Private	43	66	
No response to partial booking letters	4	10	
NULL	7	12	
Outpatient Attendance	96	8	
Patient cancelled repeatedly	1	1	
Patient did not attend	9	2	
Patient did not phone	59	135	30
Patient died	72	76	1
Patient failed to opt-in		1	
Patient moved away from area	4	7	
Patient no longer requires treatment	15	12	
Patient no longer traceable	1	1	
Patient no longer wants treatment	29	26	
Patient treated at a Private Hospital	8	26	
Patient treated at another NHS Trust	3	4	
Patient treated at this Trust	15	58	
Referred to GP - LHB ruling		1	
Refusal of reasonable offer	5		
Removed - INNU		30	

Removed - Insufficient referral information	18		
Removed - Lifestyle	1		
Removed after validation - Consultant request		10	
Removed discharged back to care of GP	3		
Removed unavailable ref to other consultant	1		
schedule	2	1	
Seen at other hospital	8	164	
Seen at treatment centre		10	
Seen via emergency admission	9	3	
Seen via other treatment	145	170	
Telephone Contact	2		
Transferred to Inpatient/Daycase waiting list	19	2	
Treatment no longer required	145	569	1
Grand Total	**1565**	**2349**	**47**

AREA	**In-Patients**

Row Labels	**Urology**	**Trauma & Orthopaedics**	**Dermatology**
Appointment Inconvenient	3		
C.N.A & discharge	2	1	
Cancelled by GP		1	
Cancelled by GP or Cons	4	2	
Cancelled by Health Authority	2		
Cancelled by Hospital	189	238	
Cancelled by patient	90	166	
Clerical error	8	5	
Conditioned Resolved	10	4	
Did not attend & Patient Discharged	3	3	
Died (before appointment)	7		
Discharged by Consultant	3	2	
Discharged following consultant decision	1	5	
Domiciliary		1	
Entered in error	43	105	
Inappropriate Referral	1	3	
Moved to Treatment waiting list	13		
NHS Patient seen as Private	15	39	
Not Specified	433	332	
NULL	2	2	
Outpatient Attendance	1	1	
Patient cancelled repeatedly	1	1	
Patient did not attend	14	7	
Patient did not phone	3	20	
Patient died	115	53	1
Patient failed to opt-in	79	46	

Patient moved away from area	2	12	
Patient no longer requires treatment	52	102	
Patient no longer traceable	2	8	
Patient no longer wants treatment	86	133	
Patient treated at a Private Hospital	5	67	
Patient treated at another NHS Trust	8	14	
Procedure not wanted by patient	1		
Refusal of reasonable offer	10	3	
Rejected - lack of capacity		1	
Removed after validation - Consultant request	3	4	
Removed after validation - no response	5	79	
Removed after validation - patient request	2	97	
Removed discharged back to care of GP	1		
Removed unavailable social	2	9	
Removed unavailable unfit	3	20	
Seen at other hospital	23	90	
Seen at treatment centre		68	
Seen via emergency admission	7	18	
Seen via other treatment	28	114	
Transfered to Inpatient/Daycase waiting list	5		
Treatment no longer required	118	228	
Grand Total	**1405**	**2104**	**1**

Appendix C: 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.

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ
Website: Audit & Assurance Services - NHS Wales Shared Services Partnership