Follow-up: Patient Pathway Appointment Management Process

Final Internal Audit Report

June 2022

Cwm Taf Morgannwg 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 Cwm Taf Morgannwg University Health Board

Contents

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Auditor:	Lucy Jugessur – Audit Manager Emma Samways – Deputy Head of Internal Audit
Executive sign-off:	Gethin Hughes - Chief Operating Officer
Distribution:	Catherine Roberts – Director of Operations, Merthyr Cynon ILG Carl Verrecchia – Director of Operations, Bridgend ILG Rachel Burton – Director of Operations, Rhondda Taf Ely ILG
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 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

The overall objective of this audit was to provide the Health Board with assurance regarding the implementation of and progress against the agreed management responses from the patient pathway review that was reported as part of our 2019/20 programme of work.

Overview of findings

There were five recommendations in our original report. Two have been closed and three actions remain outstanding.

Our remaining high priority recommendations relate to the incorrect closing of patient pathways on the Welsh Patient Administration System (WPAS) and the failure to record outcomes on the WPAS following outpatient appointments. Actions are still needed to address both recommendations to prevent these situations occurring frequently. Better processes are needed to ensure that where errors are made, they are rectified in a timely manner.

Follow-up Report Classification

		Trend
Limited 	**Follow up:** No high priority recommendations implemented but progress on most of the medium and low priority recommendations.	⇔

Progress Summary

Previous Matters Arising		Previous Priority Rating	Direction of Travel	Current Priority Rating
1	Patient Outcomes	High	⇔	High
2	Closed Pathways	High	⇔	High
3	Welsh PAS Training	Medium	⇩	Closed
4	Temporary Medical Secretaries	Medium	⇩	Closed
5	Watch Lists	Medium	⇔	Medium

1. Introduction

1.1 The follow-up review of the Patient Pathway Appointment Management Process was completed in line with the 2021/22 Internal Audit Plan for Cwm Taf Morgannwg University Health Board (the 'Health Board').

1.2 Our original patient pathway audit was finalised in October 2019. We issued a 'limited' assurance report with two high and three medium priority recommendations. The main findings related to ensuring that: following outpatient appointments, the correct outcomes were recorded on the patient administration system; that suitable training was provided to the medical secretaries responsible for inputting this data; and a consistent approach to monitoring patient records, where diagnostic results were needed, was implemented.

1.3 In October 2020 we undertook a follow up review to establish the progress that had been made implementing the agreed management actions. Whilst a significant amount of preparatory work had been undertaken to address the issues identified in our original report, due to the pandemic and the retirement of key officers, there was little progress to address the specific points in our recommendations. The implementation of agreed actions was also affected by changes in the Health Board's operating model and changes in officer responsibility for implementation.

1.4 The Health Board has continued to monitor progress against the agreed management actions, updating the Audit and Risk Committee via the audit tracker. The tracker currently indicates that two recommendations have been implemented and work is in progress for implementing the remaining three, which aligns to our findings below.

1.5 The relevant lead for the review is the Chief Operating Officer.

1.6 The potential risks considered during our original review were:

- Inaccurate reporting of the Referral to Treatment Time (RTT) performance as a result of the Booking Process Pathway not being adhered to.
- RTT targets not achieved if issues are not identified at an early stage, reported and addressed.

2. Findings

2.1 The table below provides an overview of progress implementing the previous internal audit recommendations:

Original Priority Rating	Number of Recommendations	Implemented / Obsolete (Closed - No Further Action Required)	Action Ongoing (Further Action Required)	Not implemented (Further Action Required)
High	2	-	-	2
Medium	3	2	-	1
Low	0	-	-	
Total	**5**	**2**	**-**	**3**

2.2 Full details of recommendations that have not been implemented and require further action are provided in the **Management Action Plan** in **Appendix A**.

2.3 The two recommendations that have been closed relate to:

- WPAS training, which has been provided to the new medical secretaries, and refresher training that has been provided when requested.
- The use of temporary medical secretaries to input data into the WPAS has now stopped.

Appendix A: Management Action Plan

Previous Matter Arising 1: Patient Outcomes (Operation)		
Original Recommendation		Original Priority
1. Clinical Service Group Managers need to: • Remind consultant, medical and nursing staff of the need to complete outcome forms for all patients seen. • Remind outpatient receptionists of the importance of inputting outcome forms on WPAS in a timely manner. • Remind Medical Secretaries to check that outcomes that have been input on WPAS align to outcomes as per dictated letters. All staff need to be made fully aware of the implications of not recording the outcome for a patient and their responsibilities in ensuring the correct process is adhered to. 2. The reports received by the Clinical Service Groups of patients with no outcome recorded, should be analysed to determine if there are certain departments or clinics who are repeatedly failing to record outcomes. Where necessary additional training should be requested. 3. Given the ongoing problem of outcomes not recoded and the apparent success of the use electronic outcome forms within ENT, the use of electronic forms should be reviewed again, for piloting in other areas. 4. If the 'Planned Patient Flow Project' remains a live project, its action plan should be updated to fully incorporate the internal audit findings in relation to patient pathways.		**High**
Management Response	Target Date	Responsible Officer
These recommendations are accepted, though the ownership at ILG level will be through the Hospital Service Managers. Regular performance meetings have been set up in two of the three ILGs, where this will be a regular performance/compliance agenda item. These two ILGs also have a senior Performance & Information lead taking up post in January, a key appointment that will help drive forward this agenda. The equivalent post in the third ILG is out to advert.	February 2021	ILG Acute Service Managers, supported by the Assistant Director of Performance & Information.

No other specialty has been as enthusiastic as ENT in the deployment of JAYEX, with some openly hostile. Whilst attempts will be made to reinvigorate this deployment, the lack of a dedicated resource, but more so given the alternative digital solutions for non-face to face consultation means that this may not be a desirable longer-term objective. The Planned Patient Flow Project stopped in March 2020 and given the turnover of key staff, together with a new operating model, an alternative mechanism is to be found to take this work forward. With bed pressures and mass vaccination the key priorities for January, reinforcing the recording of outcomes, together with providing any refresher training required is targeted for the end of February 2021. With individual ILGs taking on UHB wide responsibility for certain specialties, the ongoing challenge of having to utilise two instances of WPAS becomes even more challenging e.g. for Bridgend ILG, who are continuing to use the Swansea Bay UHB WPAS instance, but will now additionally need to utilise the CTM instance for Ophthalmology and for RTE ILG, who will now need to also utilise the Swansea Bay instance for Urology services. This ongoing risk requires resourcing to ensure that services are transferred over to single instances of core operational systems on an incremental basis during this calendar year and beyond.		

Current findings	**Residual Risk**
We understand that the importance of correctly recording outcome forms has been relayed to staff. We requested data from the Welsh PAS team of the number patients where an outcome had not been recorded on the WPAS following an outpatient appointment. In October 2021, the outcome had not been recorded for 782 patients. However, since then figures have continually increased and by March 2022, the number had increased to 2,287 patients. We met with senior managers from each ILG to establish the processes that have been implemented in their areas following the previous audit recommendations: <u>Rhondda Taf Ely ILG</u> • Electronic outcomes forms have now been rolled out to a number of Clinical Service Groups (CSG).	RTT targets not achieved if issues are not identified at an early stage, reported and addressed. Patients not appropriately moving to the next stage in their pathway in a timely manner or receiving treatment as required if outcomes are incorrectly recorded.

- Monthly reports are received detailing the patients where no outcome has been recorded. We understand there are staff with responsibility for reviewing the reports and correcting the data in WPAS. However, as at end of March data from the WPAS team showed 908 main speciality and 364 nursing speciality records outstanding.

Merthyr and Cynon ILG

- In response to our previous recommendations the Children & Young People and Obstetrics, Gynaecology & ISH CSGs had produced a summary document detailing how the previous recommendations were being addressed.
- The Children & Young People Deputy CSG Manager expressed concerns in relation to lack of any data received for this area. Previously Children & Young People CSG sat under Bridgend ILG and the data is still being sent there. Requests have been made for this to be rectified, but until it is, there is a risk that information is sent to Bridgend ILG and not actioned as they are no longer responsible for it. Our review of the Bridgend data identified approximately 90 paediatric patients.
- Obstetrics, Gynaecology & ISH CSG advised reports are passed onto the secretaries to input the correct outcomes. Medicine CSG also advised that they receive the report, and it is forwarded to service managers or secretaries to action it.
- However, as at end March data from the WPAS team showed 1084 main speciality and 631 nursing speciality records outstanding.

Bridgend ILG

- The reports are sent to the Deputy Service Manager OPD and Appointments who reviews them and updates the outcomes for the main specialities. However as at April 2022 data from the WPAS team showed 311 main speciality records outstanding.

Whilst staff within departments correct the outcome record, the number of patients without a recorded outcome remains high. This would suggest that either action is not being taken to rectify the errors identified on the reports, or high numbers of new errors are occurring every month.

There is no analysis of the data to understand the reasons for the outcomes not being recorded, or to help identify if there are trends in where the errors lie at any of the ILGs.

Furthermore, the monthly 'outcome not recorded' reports issued by WPAS are not always received by the right people for actioning as they are sent to staff that no longer have this responsibility. We note that in recent months the WPAS team have attempted to refresh the distribution list.

Conclusion: We consider this action **not implemented.**

New Recommendations		Priority
1.1	Management should ensure that the correct data detailed within the outcome reports is produced for each of the Clinical Service Groups, especially where services and therefore data was previously the responsibility of a different ILG.	High
1.2	Management should ensure that outcome reports are being sent to the correct staff within each of the Clinical Service Groups to ensure that they action the outcomes recorded. The WPAS team should liaise with senior managers in each ILG to identify who is the most appropriate person in each CSG to receive the monthly reports.	
1.3	On receipt of the outcome reports, management within the CSGs should ensure that they analyse the data to identify trends such as those staff or departments that are continually failing to input outcome data or making the errors. Appropriate action should be taken including the provision of additional training on the WPAS.	
1.4	The Acute Services Manager in each ILG should be provided with the reports for their area to enable them to monitor and have oversight of the errors being made.	
1.5	Given the ongoing problem of outcomes not recorded, management should look to build on the roll out of electronic outcome forms.	

Management Response		Target Date	Responsible Officer
1.1	Discussion will be held with colleagues in Performance to ensure that this data is correct for each Service Group and fits in with the new operating model.	31 August 2022	ILG Directors of Operations / Head of Information
1.2	Each ILG will work with colleagues in the WPAS team to identify the correct staff members.	31 August 2022	ILG Directors of Operations / Head of Information
1.3	ILGs will ensure that they undertake this action.	31 August 2022	ILG Acute Services General Managers

1.4	ILGs will work with colleagues in Performance to ensure that the reports produced are suitable to allow the appropriate monitoring to take place.	31 August 2022	ILG Directors of Operations / Head of Information
1.5	Consideration will be given by ILGs to roll out electronic outcome forms by September 2022.	30 September 2022	ILG Directors of Operations / Head of Information

Previous Matter Arising 2: Closed pathways (Operation)		
Original Recommendation		Original Priority
1. Within each of the Directorates/ Clinical Service Groups, analysis should be undertaken of the cases where the pathway has been incorrectly closed to identify if they are common to one department or person. Further training should be provided within the respective areas. 2. The incorrectly closed pathway reports should be escalated to ensure that Service Group Managers and more senior staff within the Health Board are made aware of the ongoing issue.		**High**
Management Response	Target Date	Responsible Officer
We agree with the recommendations, noting that the draft Data Quality Assurance Framework and the additional training material developed offer an opportunity to ensure staff are accountable for their actions and this will need to be reinforced through the new operating model. The Performance & Information Directorate will regularly carry out analyses to target additional training towards specific Directorates and/or individuals and escalate concerns to the ILG Hospital Service Managers. This will commence in the new year, with a regular process in place by the end of January 2021. The same risk regarding two instances of core operational systems having to be used by all ILGs applies.	January 2021	ILG Acute Service Managers, supported by the Assistant Director of Performance & Information
Current findings		**Residual Risk**
The WPAS team send monthly emails to leads within the CSGs stating the number of patients that have been put onto a closed pathway in error and therefore need correcting. However, this information is only for Rhondda Taf Ely ILG and Merthyr Cynon ILGs. Data for Bridgend ILG is sent separately by the RTT Manager for Bridgend. At the time of our fieldwork in April, we understand that no emails had been sent since January 2022 and we were not provided with		RTT targets not achieved if issues are not identified at an early stage, reported and addressed. Incorrect reporting of RTT figures.

any copies. We understand that the specialities in Bridgend have the ability to generate their own reports, although we have not seen these reports.

Our review of the data for Rhondda Taf Ely and Merthyr Cynon data identified the following:

	No. of patients on incorrectly closed pathway	No. of patients who were also on the previous months report	Merthyr Cynon ILG	Rhondda Taf Ely ILG
January	283	207	64	219
March	357	164	78	279
May	309	194	70	239

We met with each of the above ILGs to understand the process they follow on receipt of the email.

Rhondda Taf Ely ILG

- We were advised by the Acute Services Manager that on receipt of the reports, pivot tables are produced to identify the areas whereby the patients have been put onto a closed pathway and then the reports are sent to the respective staff for them to action.

Merthyr Cynon ILG

- We met staff from a number of CSGs and established reports are disseminated to them for undertaking corrective action and that in some areas dedicated pathway managers are in place who undertake all pathway management work. Furthermore, within Medicine CSG, analysis of the reports is carried out to identify who has made the errors, and if there is a training requirement.
- As per the previous finding, the Children & Young People do not receive the closed pathways report as all the information relating to this CSG is sent to Bridgend ILG. Whilst numbers in this area would always be low, it does mean the values for Merthyr Cynon ILG are likely to be understated.

WPAS management have recently carried out an exercise to check that the closed pathway reports are sent to the correct personnel within each CSG. However there continues to be a high number of patients every month incorrectly on a closed pathway, many of whom were also listed on the previous month's reports, suggesting corrective action is not taking place in a timely manner.

Clinical risk for the patient if further appointments or treatment is not arranged.

Conclusion: Whilst progress appears to have been made in reducing the number of patients appearing on incorrect pathways within Merthyr Cynon ILG, numbers remain high for Rhondda Taf Ely, and we have not data in relation to Bridgend. As such we consider this action **not implemented.**		
New Recommendations		**Priority**
2.1	Management should ensure that the correct data detailed within the closed pathway reports is produced for each of the Clinical Service Groups, especially where services and therefore data was previously the responsibility of a different ILG.	**High**
2.2	Management should ensure that closed pathway reports are being sent to the correct staff within each of the Clinical Service Groups to ensure that the patients are put onto an open pathway. In addition, closed pathways reports should be sent on a regular basis to staff within Bridgend ILG, or checks should be made to ensure managers are accessing this data for themselves.	
2.3	On receipt of the reports, management within the CSGs should ensure that they analyse the data to identify any trends such as those staff or departments that are continually making the errors and closing pathways incorrectly. Appropriate action should be taken including the provision of additional training on the WPAS.	
2.4	The Acute Services Manager in each ILG should be provided with the reports for their area to enable them to monitor and have oversight of the errors being made.	

Management Response		**Target Date**	**Responsible Officer**
2.1	ILGs will work with colleagues in Performance to make sure that this information is available and appropriate.	31 August 2022	ILG Acute Services General Managers / Head of Information
2.2	ILGs will work with colleagues in Performance to ensure that the appropriate staff are identified.	31 August 2022	ILG Acute Services General Managers / Head of Information
2.3	ILGs will ensure that they undertake this action.	31 August 2022	ILG Acute Services General Managers

2.4	ILGs will work with colleagues in Performance to make sure that this information is available and appropriate.	30 September 2022	ILG Acute Services General Managers / Head of Information

Previous Matter Arising 5: Watch lists		
Original Recommendation		Original Priority
A review of the 'watch list' process should be undertaken and following that guidance produced that ensures all Medical Secretaries are using a standard approach that is user friendly and does not restrict access, allowing visibility to other staff members.		**Medium**
Management Response	Target Date	Responsible Officer
A technical assessment on the potential upgrading of watch list functionality to facilitate performance management of Medical Secretaries will be commissioned.	March 2021	Assistant Director of Performance & Information and Assistant Director of ICT
Current findings		**Residual Risk**
We understand that there have no changes in the way medical secretaries use watch lists. We understand that a number of systems, including the watch list function in the WPAS are still being used. As such the current set up in some areas, means that staff are only able to view the watch lists they created in the WPAS system, meaning separate records also have to be maintained to allow effective monitoring. We note that within Bridgend ILG, staff have the ability within the WPAS to create watch lists and allow other members of staff to view them. The lists do not have restricted access to the person that created it, in the same way that Rhondda Taf Ely and Merthyr Cynon ILGs do. **Conclusion:** We consider this action **not implemented.**		Ongoing delays in treating patients awaiting diagnostic test results, if effective monitoring of 'watch lists' cannot take place. Failure to meet targets.
New Recommendation		**Priority**
3.1	Management should establish if staff in the Rhondda Taf Ely and Merthyr Cynon ILGs areas can be provided with the same access to watch lists within WPAS as staff in Bridgend ILG, allowing all staff to be able to view and then monitor each other's watch lists. If this functionality is not available, then our original recommendation should be implemented. A review of the watch list process should be undertaken and following that guidance produced that ensures all Medical	**Medium**

	Secretaries are using a standard approach that is user friendly and does not restrict access, allowing visibility to other staff members.		
Management Response		**Target Date**	**Responsible Officer**
3.1	This will be addressed by the ILG with colleagues from Performance.	30 September 2022	ILG Directors of Operations / Head of Information

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. **Follow up:** All recommendations implemented and operating as expected
 **Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved. **Follow up:** All high priority recommendations implemented and progress on the medium and low priority recommendations.
 **Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved. **Follow up:** No high priority recommendations implemented but progress on most of the medium and low priority recommendations.
 **No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved. **Follow up:** No action taken to implement recommendations

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