Access to Cancer Services
Final Internal Audit Report

June 2023

Swansea Bay 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 Bae Abertawe
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Acknowledgement

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Executive Summary

Report Classification

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	N/a

Assurance summary [1]

Assurance objectives		Assurance
1	Structure, roles and responsibilities	Limited
2	Plans to address recovery and performance	Limited
3	Delivery, monitoring and reporting	Reasonable
4	Accuracy and reliability of data	Reasonable

Purpose

To review the health board's approach to manage the waiting list backlog within cancer services in order to ensure timely access to services for patients.

Overview

We have issued reasonable assurance on this area.

Improvement and recovery plans have been developed to support the performance of key tumour sites. Whilst performance against the Single Cancer Pathway target measure, and backlog waiting list are below Health Board targets, a range of actions are in progress with intention to improve against both.

The matters requiring management attention include:

- Recovery plan structures should be standardised to offer consistency.
- Tumour site recovery meetings lack formal records.
- Committee reporting does not include updates on previously reported actions.
- Outcomes from breach reports not regularly shared with services.

Key matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	Cancer Delivery Structure	1	Design	High
2	Gynaecology recovery actions	2	Operation	Medium
3	Recovery Plan format	2, 3	Design	High
4	National Optimal Pathway assessment	2	Design	Low
5	Recovery plan monitoring arrangements	3	Design	Medium
6	Cancer Performance progress of actions	3	Design	Medium
7	Waiting time and escalation trigger review	4	Design	Medium
8	Breach reports sharing and themes	4	Operation	Medium

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

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 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 Swansea Bay University Health Board ('the health board'), has included actions to support the recovery of cancer services following the COVID-19 pandemic, which impacted cancer referral rates and service provision, within its Recovery and Sustainability plan. Outcomes within the plan include both reducing the backlog of patients waiting over 63 days for treatment, and improved performance with the SCP national target of 75% of patients starting treatment within 62 days.

1.3 Cancer service performance has been subject to escalation within the health board's performance management framework since August 2021. Progress in addressing the backlog waiting list, reducing it from over 700 to 408 patients in early 2022, had been reported to the Performance and Finance Committee in August 2022. However further improvement trajectories shared at that meeting have yet to be realised, with a recent increase to the overall backlog figure of 574 reported in December 2022, and a backlog figure of 394 at the date of reporting (reported within the Integrated Performance Report, Board, May 2023).

1.4 At its January 2023 Board meeting, current performance was highlighted as a continuing concern, with only 53% of patients treated, in the previous month, meeting the 62-day SCP target. Actions outlined to address this included further recovery plans aligned to tumour site being developed, and meetings to be scheduled between the Chief Executive Officer and service Clinical Directors, leads and management teams.

1.5 It is acknowledged that the concerns regarding the performance of cancer waiting times is an issue across the whole of NHS Wales. Welsh Government have stated that there is an urgent need to improve cancer services in Wales and a three-year improvement plan was published by the Wales Cancer Network, in January 2023, outlining the plan to deliver cancer care that will improve cancer patient outcomes and reduce health inequalities.

1.6 Following review of in month and backlog performance figures reported to the January Board, we selected Lower Gastroenterology, Urology and Gynaecology as our sample sites for review. These comprised high percentages of the backlog (25%, 9.5%, and 20% respectively), and provided scope to include arrangements at both Morriston, and Neath Port Talbot – Singleton Service Groups.

1.7 The risks considered during the review were:

i. Unclear structures or responsibilities resulting in a lack of assurance to the Board on service delivery;

ii. Failure to deliver services potentially resulting in patient harm, and associated financial and reputational implications.

2. Detailed Audit Findings

2.1 The table below summarises the recommendations raised by priority rating:

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	2	3	1	6
Operating Effectiveness	-	2	-	2
Total	2	5	1	8

2.2 Our detailed audit findings are set out below. All matters arising and the related recommendations and management actions are detailed in Appendix A.

Audit objective 1: The health board has a structure to support the delivery of Cancer services, which includes clearly defined roles and responsibilities.

2.3 A Cancer Programme Board (CPB) was established in May 2022 as part of the health board's approach to the delivery of its Recovery and Sustainability Plan (RS Plan). It is chaired by the Executive Medical Director and membership includes Service Group Directors for Morriston and Neath Port Talbot Singleton Service Groups. CPB terms of reference (ToR) include that the '*CPB will develop the framework for the Cancer programme…and oversight of delivery of the overall programme.*'

2.4 The CPB ToR includes that it will meet on a monthly basis, however review of agendas and minutes for the period May 2022 – March 2023 identified that four meetings had been stood down or cancelled (July & December 2022; and, January & February 2023); and the April 2023 meeting deferred. Review of minutes also confirmed that the August 2022 and March 2023 meetings were not quorate, with the CPB approving two business cases at the August meeting. **See MA1**

2.5 Referenced within the CPB ToR is that each specialty will have an improvement trajectory, to be monitored through a Cancer Performance Group (CPG), a subgroup of the CPB. CPB ToR outlines that trajectories will be reported to the Performance and Finance Committee (PFC) and Quality and Safety Committee (QSC). Performance reporting to PFC is within para 2.14 and we note there have been updates which include tumour site trajectories in August 2022, November 2022 (for three sites only) and March 2023. The QSC has received information on cancer performance through the monthly Integrated Performance Report, but has

not received any specific papers on cancer performance outside of these. **See MA1**

2.6 The CPG ToR state that it will meet on a monthly basis, and group objectives include:

- Oversee the operational delivery of cancer services across the health board;
- Ensure sustainable delivery of the SCP waiting times target and the National Optimal Pathways (NOPs); and
- Review and challenge all cancer improvement plans.

No formal minutes or action logs are retained for the CPG, and we were informed it last met in September 2022. **See MA1**

2.7 Alternative performance management arrangements have been adopted with the Deputy Chief Operating Officer meeting service group management and clinical leads for selected tumour sites on a weekly/biweekly basis. To support a pathway approach, where appropriate, there is inclusion of endoscopy or pathology representatives. As with the CPG, no formal minutes or action notes were available to demonstrate operation of these meetings (see **MA5**). However, feedback received during audit fieldwork indicated that these meetings were regarded positively by service management.

2.8 In the absence of the CPG, we note that the CPB has not received any additional performance reporting, although RS Plan delivery updates include reference to overall SCP performance.

2.9 In May 2023 the CPG was re-established following discussions with Service Group Directors regarding appropriate membership. This was to ensure those in attendance would be of sufficient seniority to represent the service group, whilst also providing knowledge of issues and blockages at tumour site level. As was previously included there will also be representation from endoscopy and pathology management to allow full sight of the patient pathway.

2.10 At the time of fieldwork, the Executive Medical Director remained the lead Executive for Cancer. Minutes of the March 2023 CPB meeting included that following the appointment of a substantive Chief Operating Officer there would be need for discussion on the future of the meeting, and how cancer is managed within the health board. At the end of May 2023, the health board announced the Executive Medical Director would take on role of interim CEO for a 12-month period (wef 1 August 2023), and this could provide an opportunity to further consider the cancer portfolio within the health board. **See MA1**

2.11 Alongside Executive leadership, the health board also has a designated Cancer Lead Manager, and the lead for Cancer performance is the Deputy COO (noting that there has been a recent change of personnel in this role). We note there has been five Cancer Lead Managers or Cancer performance leads since 2020, whilst

some changes are the result of retirements and personnel changes, the number of changes could impact the progress to be made in this area.

Conclusion:

2.12 Whilst we note the health board has established a Cancer Programme Board a number of meetings have been cancelled, and there have been concerns raised relating to its remit by its Chair, and the wider responsibilities relating to management of cancer within the health board. The supporting structure of the Programme Board has also not been taken forward as originally outlined, and whilst alternative arrangements have been made, we've noted a lack formal governance or documentary trail. We do acknowledge, however, that as audit fieldwork was concluding, there had been the re-establishment of the outlined cancer performance group. We assign this objective **limited** assurance.

Audit objective 2: Plans and actions have been developed to support waiting list recovery and address issues in performance.

2.13 As per para 1.2, outcomes included within the RS Plan include:

- *% of patients starting definitive treatment within 62 days from point of suspicion (regardless of the referral route) improved trajectory towards a national target of 75%;*
- *Reduced number of patients waiting over 63 days.*

2.14 Since the escalation of cancer performance within the health board's performance management framework (August 2021), there has been development of improvement and recovery plans for a number of tumour sites of concern. These have been regularly shared with the Performance and Finance Committee (PFC), and, more recently, in March 2023 with the Board. The format of these updates has varied between verbal, presentation, and formal report – see para 2.25.

2.15 We reviewed detail submitted within PFC papers in August 2022, November 2022 for the tumour sites of Gynaecology, Lower Gastroenterology (Lower GI), and Urology; in addition to the March 2023 Board paper.

Gynaecology

2.16 Challenges to this service relate to a Post-menopausal Bleed (PMB) clinic, and theatre capacity. The PMB clinic provides both diagnostic and treatment within its service and it continues to serve both health board residents, and those of the Bridgend area as part of post boundary change arrangements with Cwm Taf Morgannwg University Health Board. Service management outlined that Bridgend patients make up around 35% of capacity. We were also informed that whilst theatre capacity has increased since earlier COVID-19 related restrictions meant all surgical activity had paused, it currently has seven theatre lists against its pre COVID-19 allocation of eight.

2.17 Improvement or recovery actions to address capacity were included within both the August 2022, and March 2023 papers:

- Expansion of current PMB clinics;
- Further outpatient capacity within a Rapid Diagnostic Clinic;
- Insourcing additional non urgent diagnostic support;
- Regional working with Hywel Dda to increase outpatient and theatre activity; and
- Development of a dedicated hysteroscopy suite which would reduce the need for theatre access.

2.18 The actions developed align with the challenges highlighted, to address the identified pathway blockages within the services, considerations of efficiencies to reduce demand; and sustainable solutions to address theatre capacity gaps. Whilst this demonstrates the number of approaches underway, there is no formal action relating to services provided to Bridgend patients which we were informed is being progressed. **See MA2**. We acknowledge this would be a medium-term action, but given the outlined impact on PMB capacity would expect it to feature within the services plans.

Urology

2.19 The service is made up of five cancer sites, Bladder, Prostrate, Kidney, Testicular and Penile, with the first three comprising the majority of patients treated. Diagnostic delays with histology results have been identified as a main factor, but constraints have also been identified due to cancellations as a result of pressures on the Morriston site, and limited access to robotic assisted surgery – which is currently only available through Cardiff and Vale University Health Board.

2.20 Actions were outlined within the August 2022, November 2022, and March 2023 papers including:

- Process refinements to ensure patient movement through the pathway, whilst there is also transfer non-complex cases from Morriston to Neath Port Talbot;
- Escalation arrangements in place for delayed histology results with the pathology service; and
- Development of a business case and associated surgical practitioner for local robotic assisted surgery.

Lower GI

2.21 This tumour site has been consistently identified as a risk area for the health board due to the large number of referrals received, and the subsequent waiting list which developed. Challenges have been identified at both the diagnostic stage, related to pressures within Endoscopy services, and theatre capacity within the Morriston site for complex patients.

2.22 Improvement or recovery actions were outlined within the August 2022, November 2022, and March 2023 papers:

- Straight to test (STT) pathway refinement to agree criteria between specialities resulting in reduced outpatient demand;
- Improve compliance with Faecal Immunochemical Test (FIT), a test available to triage within primary care; and
- Additional recruitment of colorectal consultants with associated clinic and endoscopy capacity as a result.

Endoscopy

2.23 Noting the impact of access to Endoscopy on the delivery of the SCP target for Lower GI, we also reviewed the detail of actions developed to support its role within the pathway. A pre COVID-19 deficit in capacity had been mapped in 2019/20, and lowered levels of activity within the initial stage of the pandemic resulted in a considerable waiting list backlog.

2.24 Service capacity has been a key area to address with insourcing commissioned, whilst also progressing the refinement of STT pathways as referred to above. A regional approach with Hywel Dda University Health Board has been developed which aims to address the workforce constraints and gaps between infrastructure capacity and delivery.

Plan Format

2.25 Paras 2.16 to 2.24 demonstrate the health board has developed detailed actions, for the sampled tumour sites, reflecting a mix of capacity, workforce, and pathway enhancements to support SCP and waiting list recovery. However, we note that whilst these have been detailed within the papers referred to above, for Lower GI and Gynaecology, we have not identified their inclusion within formal plans outside the papers reported. The Urology service manager shared a draft plan used to support the development of actions related to March 2023, but this was not fully populated. **See MA3**

2.26 In reviewing the actions, we noted for some outlined the timescales and ownership of actions were not clearly outlined. A number also included reference to pathway improvements but did not necessarily include a measurable target to support the improvement. **See MA3**

2.27 We were informed that progress against actions is regularly discussed at the performance meetings (see para 2.7), and the frequency of monitoring arrangements, and operational nature of some may have influenced the formalising of proposed actions.

Performance Trajectories

2.28 As the requirement to report against the SCP has been in place since December 2020, the development of performance trajectories for addressing the backlog of patients in 2022/23 was mapped with little trend data available. Trajectories were developed to reflect that services would aim to address the backlog, improvements would not be included for known pressure points (such as school/summer/bank holidays), and, due to the limited ability to 'pause' patient pathways, a consistent backlog of around 70 patients would feature.

2.29 Discussions with the Cancer Information and Performance Manager highlighted that the above principles have continued to be followed in the development of the 2023/24 trajectories, with further analysis of where performance issues were experienced in 2022/23. Improvements for the tumour sites listed above are also factored in to provide time to take effect, and the supporting mapping document used to plot these demonstrated this. We are informed that performance against these will feature within the continuing tumour site performance meetings. Trajectories for 2023/24 were approved by the Board in March 2023. Refer to audit objective 3 (para 2.60) for further detail on Board reporting.

National Optimised Pathways

2.30 National Optimised Pathways (NOPs) are developed to offer consistent pathways, mapping patient routes of entry from point of suspicion to the diagnostic and treatment options available. For some specialties there can be a number of NOPs applicable related to individual tumour sites.

2.31 We reviewed the arrangements for self-assessment against the NOPs for the three services sampled and found the formality of assessment varied. Further, for Gynaecology, whilst we were informed that review against NOPs would have taken place, no formal documentation to evidence this was available. **See MA4**

Conclusion:

2.32 Actions have been developed to support improvements within cancer pathways against both the SCP 62-day target, and backlog positions. Approaches encompass pathway refinement and capacity across diagnostic and treatment stages. These have developed iteratively, and whilst recognising the immediacy of action, we were not able to identify collation into formalised structured plans at service level nor defined timescales or ownership of actions. Mapping against the national optimum pathways was also inconsistently documented across areas reviewed. We assign this objective **limited** assurance.

Audit objective 3: Delivery of plans and actions are regularly monitored and reported, with assurance provided to the Board.

2.33 As referenced within para 2.7, recovery meetings, chaired by the Deputy COO, have been established with service management and clinical leads. Where appropriate these will include representation from wider elements of the SCP pathway, such as Endoscopy for Lower GI, and pathology for Urology.

2.34 Whilst no formal records are retained of the meetings, management confirmed that key actions are regularly discussed, trajectories monitored, and discussion with services indicated they have proven beneficial in highlighting issues.

2.35 As highlighted within para 2.25, reported plans and actions are not structured within the plan format. We requested copies of service performance reports, and divisional reports to identify if they contained detail related to the progressing of recovery and improvement actions reported.

Gynaecology

2.36 As part of the Womens Health and Ophthalmology (WHO) Division within Neath Port Talbot Singleton Service Group, Gynaecological cancer services are reported under the Gynae-oncology service. WHO Divisional meetings are monthly and alternate between business/performance, and quality, safety and risk meetings.

2.37 Gynae-oncology provides a service report which focuses on demand:

- Patient booked and waiting for Outpatients/One stop clinic;
- Number of breached patients; and
- Total patients on pathway.

A SPORT (Successes, Priorities, Risks/Threats) appendix providing summary updates is also reported at each meeting. The WHO Directorate also provide a summary report to the Neath Port Talbot Singleton (NPTS) Operational Management Group (OMG), including key issues from each of its services, although management advised that this group has not met post October 2022 (see para 2.38) due to the transition between Service Group Directors. **See MA5**

2.38 Review of service reports and SPORT summaries for September 2022 – January 2023, and an OMG report submitted for October 2022 noted that there is reference to two of the five actions featured within the recovery and improvement plan provided to the PFC in August 2022: (1) that the service was looking to secure support from Hywel Dda for development of an outreach service, and (2) that it was undertaking a 'deep dive' review of the PMB pathway. We could not identify any incorporation of actions into a formal plan, or evidence of local service monitoring and reporting against the recovery plans presented to Board and Committees. **See MA3 & MA5**

2.39 Noting the above, we discussed progress against actions with the WHO Service Group Manager. Of the nine actions outlined within the recovery plan to PFC (five actions) in August 2022 and Board (four actions) in March 2023, there has been some progress noted with four complete. One is in progress noting the development relating to the 'outreach' role below, three relating to recent enhancements to pathways were queried but we had not been provided with further evidence at the close of fieldwork. **See MA3, MA5 & MA6** We noted:

Closed actions:

- Action in March 2023 for additional insourcing through a private provider progressed with supporting agreement from the Deputy COO evidenced.
- Service Management confirmed additional Rapid Access Clinic slots at the Neath Port Talbot site had been established in 2022.
- Trialling of alternative hysteroscopy equipment had not resulted in a change in approach, but we're informed the equipment sourced has supported the ability to commission the insourcing referred to above.
- Additional theatre capacity was included within the August 2022 paper, noting the service operated seven lists, matching pre-COVID-19 capacity where demand and capacity review suggested an additional two were needed. Whilst there has been no increase, we noted there has been

progress against an action agreed in March 2023 to include an ambulatory gynaecology theatre within the Singleton modular theatre business case. This is being progressed through the Singleton Elective theatre board with indicative timings for summer 2024 handover.

Actions progressing included:

- Hywel Dda University Health Board support for an additional 'outreach' consultant was included in August 2022, noting discussions had begun the previous month. Management confirmed that no funding was agreed, but that service consultants had begun to use Hywel Dda outpatients' clinics and theatres. We were also provided with emails demonstrating a joint health board application for Welsh Cancer Network funding towards the 'outreach' consultant role, although a number of supporting elements were still to be worked through.

Incomplete/outstanding actions:

- Three actions, across August and March, relating to review of PMB pathway, introduction of a patient contact stage relating to PMB clinics, and the expansion of clinic slots were awaiting further evidence at the time of fieldwork closing. As noted above an action to expand theatre capacity for the service has not resulted in additional theatre slots, but is now being progressed through the modular theatre business case.

2.40 Review of performance data highlights that the service is yet to see improvements intended as the health board remains above the All-Wales position in days from suspicion to treatment, and the service backlog remains substantial.

Table 1: Gynaecology

Performance Indicator	March 2022	December 2022	March 2023
Total Patients Treated	18	13	3
Treated within SCP target (%)	11.1	38.5	33.3
Days from Suspicion to Treatment - SBU (Median)	96	69	153
Days from Suspicion to Treatment – All Wales (Median)	90	93	93
Backlog patients (total)	45	116	119

Source - NHS DU SCP Compliance Dashboard – SBUHB
https://www.gov.wales/suspected-cancer-pathway-waiting-times-interactive-dashboard
Integrated Performance Report – Single Cancer Pathway backlog - SBUHB

As reported in the Cancer Information Team weekly report, 17 May 2023, the total backlog position was reported as 115 patients.

Urology

2.41 The Urology service forms a Directorate with the Head & Neck service, within the Specialist Surgical Services Division (SSSD) of the Morriston Service Group. Services report to a SSSD Divisional Board which is scheduled to meet on a monthly basis.

2.42 Services report structure incorporate a SPORT overview, a quality priorities/patient experience section, and workforce indicators (sickness, PADR, training compliance). Performance sections for planned care and cancer performance are also included.

2.43 The SSSD provide a monthly Divisional Performance and Quality review to the Service Group Directors which is in a presentation slide format. It contains detail on SSSD Structure/key issues, Quality, Safety and Patient Experience, Resources: Workforce & Finance, and Performance.

2.44 We reviewed agendas and minutes for the SSSD Board meetings held September 2022, January 2023, and March 2023, noting no Urology service report was submitted to the September meeting. The three sets of recovery and improvement plans provided to the PFC (August & November) and Board (March 2023) include 13 individual actions, although some are similar in nature such as the movement of less complex surgery from Morriston to NPTH, and include actions for the pathology service, and the COO relating to pathway discussions with Hywel Dda. Reporting contained updates or references to six of the actions, but we could not identify formal monitoring of the March plan (para 2.25), or earlier actions. **See MA3 & MA5**

2.45 We sampled nine of the 13 actions to confirm progression or completeness of actions reported. Four actions are complete, four are in progress, and one yet to commence. We noted:

Closed actions:

- Three actions listed across August and November relate to service monitoring of increases in capacity within outpatient and follow up clinics. These were supported through revised booking rules demonstrating new additional slots included through clinic restructures.
- Pathology attendance at the Urology performance meeting has been established alongside escalation arrangements for outstanding histology results which is continuing with evidence provided of recent escalations undertaken in May 2023 provided.

Actions progressing included:

- Progress noted in the establishment of an Enhanced Recovery Unit at the NPT site, minutes of the NPTH Elective Surgery Hub indicate a SOP for the Unit, known as the Higher Level Care Unit, have been developed although minutes also highlight concerns relating to the retention of the theatre scrub teams to support operation. This links to actions raised in August, November and March.

- We note the intention to develop a robotic surgery business case was discussed at the March 2023 Planned Care Board where actions to progress the case were discussed. The Paper highlighted a number of key aspects were still to be worked through, including location, financial impact, and that the Health Board were considering aligning with equipment in use within Cardiff and Vale health board rather than the system put forward by the All-Wales Robotic Programme.

Outstanding action:

- The service has not yet started developing a business case for a surgeon with a robotic surgery interest, we note the need to progress the business case above to support this.

2.46 The March 2023 Board paper on cancer performance outlined that Urology had accounted for the highest number of treated breached patients in addressing its backlog. As noted in table 2, progress within that area has continued, however the service had recently moved above the All-Wales position relating to days from suspicion to treatment, and treatment numbers for March 2023 were 17 below that of March 2022. Whilst this is the case, the service are progressing actions to address the movement of surgical capacity from Morriston and exploring longer term plans to remove reliance on commissioned robotic surgery.

Table 2: Urology

Performance Indicator	March 2022	December 2022	March 2023
Total Patients Treated	49	32	32
Treated within SCP target (%)	32.7	46.9	50.0
Days from Suspicion to Treatment - SBU (Median)	82	83	92
Days from Suspicion to Treatment – All Wales (Median)	91	84	86
Backlog patients (total)	89	59	59

Source – NHS DU SCP Compliance Dashboard – SBUHB
https://www.gov.wales/suspected-cancer-pathway-waiting-times-interactive-dashboard
Integrated Performance Report – Single Cancer Pathway backlog - SBUHB

As reported in the Cancer Information Team weekly report, 17 May 2023, the total backlog position was reported as 54 patients.

Lower GI

2.47 The reporting arrangements of the Lower GI service mirror those as outlined within para 2.41/2.42 as it also sits within the SSSD within Morriston Service Group. Lower GI is managed within a wider General Surgery service, and reports to SSSD through a joint report between General Surgery, Vascular, and the Artificial Limb and Appliance Centre (ALAC).

2.48 Similarly to Urology, we note no paper was submitted to SSSD in September 2022; and we reviewed the January and March reports to identify if progress against the 15 actions reported in committee and board papers featured. We noted papers contained reference to the challenges both within the service, through need for further outpatient and theatre capacity, actions to support this feature within the recovery and improvement plans reported. We could not identify updates against pathway review actions which had been reported, however we were informed some were progressing through clinical lead, or were linked to Endoscopy. As with the other services we have not identified the inclusion of actions within a formal plan structure. **See MA3 & MA5**

2.49 We sampled eight actions to confirm progression or completeness of actions reported, noting as above that some also relate to Endoscopy and so would be progressed by that service. Three are complete, four in progress, for one we did not receive detail from the service on current status. We noted;

Closed actions:

- Following the introduction of a new STT pathway and grading criteria, with continuing work to reduce variation in grading through a monthly meeting between clinical leads.
- Additionally, this has been supported by primary care access to FIT and FCP we note the referral pathway and guidance has been agreed and issued.
- We are informed theatre capacity has also seen an increase in January 2023 with an additional Thursday morning list.

Actions progressing included:

- Recruitment of two Colorectal consultants forecast to start in October 2022 did not progress as planned. Only one appointable candidate who was not JAG accredited and so the forecast gain to the pathway outlined within the August PFC paper would have been impacted. (We have highlighted the need to capture updates related to previously reported actions **See MA6)**
- The Enhanced Recovery Unit opened within Singleton in March 2023 which should allow for further movement of complex surgery from Morriston.
- Further theatre capacity is planned for May and June 2023, but at the time of fieldwork we were informed the anaesthetic cover was still to be job planned and so reliant on availability.

Outstanding actions:

- Review of demand and conversion rates relating to STT pathway is being progressed by the National Colorectal Cancer lead based within Morriston, but we were informed no initial feedback has been received by the service to date.

2.50 The March 2023 Board report highlighted that the Lower GI pathway had seen substantial improvements between October 2022 and March 2023. This represented an overall reduction of patients on the Lower GI pathway of 397 patients, and the reduction in the backlog of 156 patients. Further improvements have been realised as we note (see table 3) the higher number of number of

patients treated in March 2023 and the health board matching the All-Wales figure for days from suspicion to treatment.

Table 3: Lower GI

Performance Indicator	March 2022	December 2022	March 2023
Total Patients Treated	26	21	34
Treated within SCP target (%)	46.2	28.6	29.4
Days from Suspicion to Treatment - SBU (Median)	83	91	83
Days from Suspicion to Treatment – All Wales (Median)	78	83	83
Backlog patients (total)	70	145	81

Source – NHS DU SCP Compliance Dashboard – SBUHB
https://www.gov.wales/suspected-cancer-pathway-waiting-times-interactive-dashboard
Integrated Performance Report – Single Cancer Pathway backlog - SBUHB

As reported in the Cancer Information Team weekly report, 17 May 2023, the total backlog position was reported as 69 patients

Performance Management Framework

2.51 Cancer services performance is escalated within the health board's Performance Management Framework (PMF). Discussion with the Head of Performance outlined that current arrangements include a weekly meeting between the Executive Medical Director, Director of Finance and Performance, Chief Operating Officer, and Service Group Directors for Morriston and Neath Port Talbot-Singleton. Meetings review the current performance position and consider any support required. Current meetings are not formally minuted, but we are informed the next iteration of the PMF will include a change in format with the meetings moving to a bi-weekly basis with actions summarised therefore no recommendation has been raised at this report.

2.52 We were informed that the escalation status of cancer services remains at level 3 within the PMF, which includes '*review recovery plan and monitor progress*'. We note level 4 would include CEO meetings with services, and whilst formal escalation to this stage have not taken place, there have been CEO led meetings with key services, including Gynaecology, Lower GI and Urology, indicating intention to make use of a range of performance mechanisms and oversight at the earliest opportunity.

Cancer Performance Reporting

2.53 The Cancer Information Team (CIT) produce a weekly cancer status report which is shared with Executive Directors who attend the escalation meeting above, Service Group Directors, service managers, and the Cancer lead clinician. The report is accompanied by an update by service against their trajectories for

backlog performance. Refer to **objective 4** (para 2.64) in reference to data quality and reporting.

Management Board

2.54 Management Board has received cancer performance reports in August 2022 and October 2022. These include detail on trajectories, recovery plans and actions. Prior to these, in November 2021 it received initial recovery trajectories for 2021/22 and approved the methodologies for their development.

2.55 A dedicated cancer performance paper was received in August 2022 highlighting that whilst the trajectories approved for 2021/22 had not been achieved there had been significant improvements in the backlog position from 724 to 408. The paper also included a backlog reduction trajectory for 2022/23 to 73 patients, noting that reducing the backlog would continue to be a priority. Performance management arrangements were outlined through the CPB, CPG, weekly escalation meetings, and tumour site recovery meetings. Recovery actions for tumour sites matched those referred to within previous objectives.

2.56 An update followed in October 2022 providing trend information on SCP performance since April 2022. It also provided summary of increases in demand, contributing factors and actions to support pathway analysis. Position updates and improvement plans were listed for Urology, Breast and Lower GI sites. It did not provide updates against actions previously shared in the August paper. Review of the Management Board work programme included that a Cancer paper was scheduled for February 2023, however we could not identify this within agendas and papers. **See MA6**

Performance & Finance Committee (PFC)

2.57 We noted in para 2.14 that the PFC received Cancer presentations in August and November 2022, which included detail on recovery and improvement plans and actions. Additional verbal updates on performance were provided in January 2022, April 2022 and May 2022. A presentation was also received in March 2023 ahead of the Board paper submitted later that month.

2.58 Detail to the PFC replicates that within the papers provided to Management Board. We note that reporting has provided detailed analysis and trends across areas including number of patients at each stage, but due to the change in format this is not always replicated in a consistent format for information provided against tumour sites. We note the November 2022 presentation included detail from the NHS Delivery Unit SCP Compliance Dashboard, which holds a number of indicators aligned to NOPs and continued use of these comparators will be useful for reviewing performance.

2.59 We also note that the November 2022 presentation contained improvement plans for three tumour sites, whereas in August 2022 plans had been outlined for six tumour sites. As noted in para 2.56 updates against previous actions were not included within the paper. **See MA6**

Board

2.60 The Board receives performance figures relating to the 62-day SCP target and backlog performance on a monthly basis through receipt of the Integrated Performance Report, and quarterly through inclusion within the IMTP Delivery Report. Cancer performance is also regularly highlighted through the Chief Executive Officers (CEO) reports to board. The CEO report has also provided updates on current issues within tumour sites, and listing key actions including establishment of Enhanced Recovery Units at Neath Port Talbot and Singleton sites.

2.61 The March 2023 Board meeting received trajectories for 2023/24 alongside the most recent set of recovery plans which had been developed following the 'deep dive' meetings held between the CEO, COO and service management. We note trajectories forecast the SCP performance will improve from 43% initially forecast in April 2023 to gradually improve to 75% by March 2024. The health board's performance over 22/23 is included in table 4, noting its previous highest performance in 2022/23 was 59% in September 2022. Performance, however, remains below the All-Wales Average.

Table 4 - Health Board Performance 2022/23

Performance Indicator	Highest performance	Lowest performance	*SBU 2022/23 Average*	All Wales Average	SBU Ranking within Health Boards
SCP Treatment in target	59% - September 2022	44% - February 2023	*53%*	54%	4th
Number of patients treated	274 – August 2022	195 – February 2023	*243*	296	5th

Source - Suspected cancer pathway waiting times: interactive dashboard | GOV.WALES

Health Board Risks

2.62 There are three risks contained within the Health Board Risk Register in relation to access to cancer services;

- Access to Cancer Services (HBR 50);
- Chemotherapy 'Chair' treatment capacity (HBR 66); and
- Breaches in radiotherapy treatment (HBR 67).

There is evidence of regular review of risk content and Executive oversight of scores. We note risks are presented to assuring committees: PFC for HBR 50, and Quality and Safety Committee for both HBR 66 and HBR 77.

Conclusion:

2.63 Actions are underway across a number of areas to support the health board's SCP performance and to reduce the backlog given the health board is below the All Wales average. Noting the recent nature of some, it is too early to determine if they will have the desired impact. Cancer performance is regularly reported through corporate reports, at service level, and the wider health board structure, although coverage of actions was not as clear within reports reviewed. Trajectories have been approved which include meeting the SCP target by the end

of 2023/24 which will require improvement from current levels. Therefore, we assign this objective **reasonable** assurance.

Audit objective 4: Mechanisms are in place to ensure data used for monitoring and reporting is accurate and reliable.

2.64 Welsh Government has issued *'Guidelines for managing patients on the suspected cancer pathway' ('*the WG guidelines*'),* which also provides guidance for the reporting of performance. Version 4 is the current issue, and we note it is available within the Clinical Online Intelligence Network (COIN) section of the health board's SharePoint site.

2.65 Included within the above is that '*Health boards must ensure that appropriate systems are in place to capture the information necessary to meet the requirements for reporting.*' The Cancer Information Team shared a local procedural document which outlined validation procedures for SCP data. Sampling the January 2023 performance report, we were provided with working documents collated when undertaking validation of cancer tracker data.

2.66 A sample of six patients from the January 2023 SCP data was selected for each tumour sites of Urology, Lower GI, and Gynaecology, 18 in total. Included were patients reported as treated both within target, and those which breached. Data within the cancer tracker module of Patient Administration System for Wales (known as WPAS), alongside associated systems which retained supporting documentation were compared to confirm accuracy of entered fields for:

- Source of referral & Suspicion date;
- Diagnosis date; and
- First definitive treatment date and treatment type.

2.67 Minor discrepancies were noted within three records - one against a date of suspicion, and two for diagnosis dates. However, these did not impact the treatment in target or breach status.

2.68 The Cancer Information Team have also used Microsoft Teams to communicate cancer trackers within the Morriston and Singleton sites, to feedback on trends, issues or direct attention to patient records in need of review. This has included establishing a format for summaries within the WPAS free text box, to ensure standardisation and assist in identifying key dates within a patient's pathway journey.

2.69 A local policy document 'Cancer Waiting Times and Escalation policy' has also been developed by the Cancer Information Team. This references the responsibilities of those involved within pathway reporting, and proposed escalation triggers for relevant stages are outlined. This document is available through the above Microsoft Teams facility. The document was due for review in July 2022, and discussion with the Cancer Information and Performance Manager indicated there is intention to do so, which will include review of escalation triggers as some are currently not deemed feasible. **See MA7**

2.70 In line the WG Guidelines, where a patient is not treated within the target then a breach report should be completed. The Cancer Information Team use an All-Wales template to complete this, and the document maps the individual steps or events, noting time taken for each, alongside the cumulative total. There are fields to record up to three reasons for breach; and there are further fields for any associated actions, Multidisciplinary team review, and outcome of harm panel review. Currently the team are completing in excess of 100 reports per month, and we confirmed a breach report had been completed for the patients within our sample not treated within the SCP target.

2.71 Breach reports are not regularly shared with services, unless specifically requested. We are informed there is intention to develop thematic reporting to aid in the identification of themes. **See MA8**

Conclusion:

2.72 Validation processes are in place to support the quality and accuracy of data used to support the reporting of cancer performance. National and local documents are also available to support those undertaking reporting. Whilst there is sharing of issues with administrative teams, there is currently no formal reporting of breach reports. We assign this objective **reasonable** assurance.

Appendix A: Management Action Plan

Matter arising 1: Cancer Delivery Structure (Design)	Impact
Referenced within the Cancer Programme Board (CPB) Terms of Reference is that each specialty will have an improvement trajectory, to be monitored through a Cancer Performance Group (CPG), a subgroup of the CPB. Review of CPB papers identified that it received only one performance paper in May 2022, no direct reports from the CPG, and whilst it received RS Plan delivery updates which include an overall performance figure, it has not received service level improvement plans or actions. At the June 2022 CPB meeting the ToR were approved noting the need to confirm a therapies representative, review of subsequent minutes and attendance has not confirmed that this representative has been agreed. The CPG ToR state that it is to meet on a monthly basis, but it had not met since September 2022 at the commencing of fieldwork. The ToR also includes reporting to both the Performance and Finance Committee (PFC) and the Quality and Safety Committee (QSC), whilst we have identified regular reporting to the PFC on actions relating to key tumour sites, we could not identify cancer reporting to the QSC outside of the headline performance figures within the monthly Integrated Performance Report. Alternative performance management arrangements were taken forward through direct engagement with tumour site management and Clinical Leads. In May 2023 the CPG was re-introduced alongside the above continuing meetings. At the time of fieldwork, the Executive Medical Director remained the lead Executive for Cancer. Minutes of the March 2023 CPB meeting included that following the appointment of a substantive Chief Operating Officer there would be need for discussion on the future of the meeting, and how cancer is managed within the health board. Review of CPB agendas and minutes for the period May 2022 – March 2023 identified that four meetings had been stood down or cancelled, and the April 2023 meeting deferred. Review of minutes also confirmed that the August 2022 and March 2023 meetings were not quorate, with the CPB approving two business cases at the August meeting.	Potential risk of: • Effectiveness of health board delivery structure impacted by attendance and meeting cancellations.

Recommendations	Priority
1.1 a) Noting that performance arrangements have recently been amended, we recommend terms of reference are refreshed to reflect the roles of each group within the health board's cancer delivery structure and associated reporting needs. b) Meetings should be held in accordance with the terms of reference with decisions made only when there is appropriate representation.	**High**

	Management response	Target Date	Responsible Officer
1.1a	Agreed - The Cancer Performance Group has now been reinstated and meets monthly. Terms of Reference for this Group are currently being amended to reflect the revised membership and relationship with the Cancer Programme Board.	July 2023	Deputy Chief Operating Officer
1.1b	Agreed - The Terms of Reference for the Cancer Performance Group will define its quoracy	September 2023	Executive Medical Director

Matter arising 2: Gynaecology recovery actions (Operation)	Impact
Improvement or recovery actions for Gynaecology were included within both the August 2022, and March 2023 papers. The August 2022 paper included that 201 out of 316 patients on the pathway were awaiting 'one stop' or first outpatients' appointment. The PMB clinic provides the service to the health board population plus the Bridgend locality of Cwm Taf Morgannwg University Health Board, and the August paper noted that current capacity was not sufficient to address the backlog at that point. Discussion with service management outlined that around 35% capacity is allocated to Bridgend patients. A number of supporting actions to expand and enhance the PMB capacity are underway, as is insourcing additional non urgent diagnostic support. Whilst this demonstrates the number of approaches underway, there is no formal action relating to services provided to Bridgend patients, although we were informed is being progressed. At the close of fieldwork Gynaecology held the largest share of the backlog within the health board.	Potential risk of: • Significant improvement action not formally agreed or monitored.

Recommendations	Priority
2.1 Noting the expected impact on PMB capacity the health board should include the disaggregation of the PMB service within future improvement plans, including a forecast target date for implementation.	Medium

Management response	Target Date	Responsible Officer
2.1 Agreed - The current backlog for PMB clinics is largely associated with the provision of hysteroscopies. Arrangements are now in place to outsource over 200 cases to clear the current backlog.	August 2023	Deputy Chief Operating Officer
There is no agreed date as yet for the disaggregation of the service with Cwm Taf Morgannwg but the impact of this change will be factor into future improvement plans	March 2024	Service Group Director, Singleton – Neath Port Talbot

Matter arising 3: Recovery Plan format (Design)	Impact
Review of Cancer performance papers to Performance and Finance Committee and the Board demonstrated that the health board has developed detailed actions reflecting a mix of capacity, workforce, and pathway enhancements to support SCP and waiting list recovery. However, we note that whilst these have been detailed within the papers presented, we have not identified their inclusion within formal plans outside the papers reported for Lower GI and Gynaecology. The Urology service manager shared a draft plan used to support the development of actions related to March 2023, but this was not fully populated. In reviewing the actions, we noted: • Gynaecology – Of the nine actions listed, four did not include a clear timescale for delivery. One action held a review of PMB pathway where benefits were listed, but no measurable target included. No specific action owners were listed. • Urology – Of the 13 actions listed eight did not include a clear timescale for delivery. Seven contained improvements to pathways but no specific target set. Only 1 action had a specific lead. • Lower GI – Of the 15 actions listed 11 held no timescale for action. Eight contained forecast benefits but not a target measure. The Urology cancer plan format included mapping actions against NOP targets, average and longest waits, action outline, forecast impact in days, owner, timescale and RAG status. It also included a column outlining resource or associated	Potential risk of: • Lack of clarity of action timescale and ownership.

Recommendations	Priority
3.1 The health board should agree a format for the development of cancer recovery plans to ensure clarity of timescale and ownership, and consistency of approach.	High

Management response	Target Date	Responsible Officer
3.1 Agreed - Formal action plans in a standard format will be introduced and monitored through the monthly Cancer Performance Group meeting.	July 2023	Deputy Chief Operating Officer

Matter arising 4: National Optimal Pathway assessment (Design)	Impact
National Optimised Pathways (NOPs) are developed to offer consistent pathways, mapping patient routes of entry from point of suspicion to the diagnostic and treatment options available. For some specialties there can be a number of NOPs applicable related to individual tumour sites. We noted the formality of mapping varied across sites reviewed. Within Urology, to support the development of the March 2023 improvement actions, there was comparison undertaken for the three largest tumour sites (which make up 93% of demand). Discussion with Gynaecology service management outlined that whilst the service Clinical Director was the NOP Clinical Lead, no formal documentation to evidence mapping could be provided.	Potential risk of: • Missed opportunities to map health board pathways against national guidance.

Recommendations	Priority
4.1 The health board should consider establishing a standardised format to assist services in mapping services against relevant NOP to capture variances and identify potential areas of further compliance.	Low

Management response	Target Date	Responsible Officer
4.1 Agreed - All cancer sites will be mapped against the National Optimised Pathways (NOPs) and variance to be reported through the Cancer Performance Group. The Welsh Cancer Network and the NHS Executive lead for Cancer are supporting this work across Wales	December 2023	Cancer Performance and Information Manager

Matter arising 5: Monitoring arrangements for recovery plans (Design)	Impact
We are informed that review of performance against trajectories and progress against recovery and improvement actions are regularly discussed at service level at meetings chaired by the COO and now by the Deputy COO. Attendance at these meetings include associated diagnostics colleagues where appropriate, such as Endoscopy service management within the Colorectal (Lower GI) meeting, pathology within the Urology meeting. We were provided with evidence of meetings taking place, but these are not minuted or otherwise documented. In some cases the meetings have not met i.e. NPTS OMG, but we do acknowledge this has been due to the transition between Service Group Directors. It has been highlighted that the above meetings have provided a mechanism for focused discussions, and feedback received during fieldwork from a number of members of service management included positive reflections on the meetings usefulness and impact in addressing issues. We have noted within the previous matter arising that there could be enhancements to the format and formalising of recovery plans and actions, in progressing this the health board should ensure monitoring arrangement are also considered. Review of local service reporting arrangements identified regular reporting of cancer performance but content relating to actions within recovery and improvement plans was inconsistent.	Potential risk of: • Informal monitoring arrangements could impact on the completeness and timeliness of delivery.

Recommendations	Priority
5.1 The health board should consider the formality of current monitoring arrangements, both within cancer performance groups or meetings, but also outline expectations related to service group monitoring and reporting.	Medium

Management response	Target Date	Responsible Officer
5.1 Agreed - The Cancer Performance Groups now receives update for each cancer site through the Service Group. In addition, there are fortnightly meeting with those cancer sites with the lowest compliance against the Single Cancer Pathway. Formal highlight reports will be established as the means of reporting to the Cancer Performance Group and where not already in place action plans developed for individual cancer sites.	September 2023	Deputy Chief Operating Officer

Matter arising 6: Cancer Performance progress of actions (Design)	Impact
We reviewed the frequency and content of cancer performance reports provided to Management Board, Performance and Finance Committee, and the Board. Management Board papers received included the development of trajectories in November 2021, the 22/23 trajectories and improvement and recovery plans in August 2022, and the next round of improvement actions in October 2022. We note that the Management Board work programme indicated a following paper was scheduled for February 2023, but we could not identify this within the papers. The Performance and Finance Committee (PFC) has received a number of verbal updates, presentations, and detailed papers across the period September 2021 – March 2023. These included outline of improvement and recovery actions. We note that whilst detail is provided on current actions, papers do not include detail of the status of previous actions, their completeness or whether outlined gains were realised. Our request for evidence of action progress or completion highlighted a number where evidence of actions was not provided by the service.	Potential to: • Enhance assurance provided through updates on action completeness.

Recommendations		Priority
6.1	Cancer performance reports should include updates on progress or completeness of previously reported actions.	Medium

Management response		Target Date	Responsible Officer
6.1	Agreed - The format of reports presented to the Management Board and Performance and Finance Committee will be reviewed to ensure they include progress and completeness of previously reported actions.	September 2023	Deputy Chief Operating Officer

Matter arising 7: Waiting times and escalation triggers (Design)	Impact
Cancer Waiting Times – Standards and Escalation Policy has been developed by the Cancer Information Team to reference the responsibilities of those involved within pathway reporting. Following review of National Optimal Pathways, a number of timescales have been identified relating to diagnostics and pathology results. This document is available through the above Teams facility for tracker teams in Morriston and NPTS. The document was due for review in July 2022, and discussion with the Cancer Information and Performance Manager indicated intention is to undertake a review of escalation triggers as some are currently not feasible within current pressures.	Potential risk of: • Opportunities to refresh guidance and clarify escalation triggers

Recommendations	Priority
7.1 While recognising the initial targets for escalation reflect good practice, noting current pressures and the need for consistency of approach, we would support the review of the current document, and follow up review at an appropriate period.	Medium

Management response	Target Date	Responsible Officer
7.1 Agreed - A review of the Cancer Waiting Times – Standards and Escalation Policy will be undertaken and presented to the Cancer Performance Group for ratification with an identified review period.	September 2023	Cancer Performance and Information Manager

Matter arising 8: Breach reports sharing and themes (Operation)	Impact
In line the WG Guidelines, where a patient is not treated within the target then a breach report should be completed. The Cancer Information Team use an all-Wales template to complete this, and the document maps the individual steps or events, noting time taken for each, alongside the cumulative total. The report allows for recording up to three reasons for an individual breach. There are further fields for any associated actions, Multidisciplinary team review, and outcome of harm panel review. Breach reports are not regularly shared with services, unless specifically requested. We are informed there is intention to develop thematic reporting to aid in the identification of themes, and whilst recognising the value of 'deep dive' approaches, there could be opportunity to provide regular outlines of monthly themes and issues.	Potential risk of: • Opportunities to identify themes and issues may be missed.

Recommendations	Priority
8.1 The health board should consider breach reporting arrangements to ensure that services receive regular information on breach themes, whilst also developing longer timescale comparisons of the underlying causes of breaches.	Medium

Management response	Target Date	Responsible Officer
8.1 Agreed - A review of breach reports to identify themes has commenced, initially in two specialties and reported to the Cancer Performance Group. This will be expanded to all specialties in the next two months. Breach reports are also now being shared with the MDT Leads for each cancer site.	September 2023	Cancer Performance and Information Manager

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

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

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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

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

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

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