Follow-up: Single Cancer Pathway Data Quality & Integrity

Final Internal Audit Report

August 2022

Cwm Taf Morgannwg University Health Board

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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.

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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 September 2021 Single Cancer Pathway (SCP) Data Quality and Integrity audit report.

Overview of findings

Action has been taken by management against all of our previous recommendations, resulting in three recommendations being completely closed and two reassessed with either the same or a lower priority rating.

Management have implemented robust validation and quality assurance checks to ensure the integrity and reliability of SCP data that is reported to the Board and Welsh Government.

Testing showed that key documentation to support point of suspicion and first definitive treatment dates are now in place.

The main area where further action is needed is in relation to improving attendance at the Cancer Steering Group meetings.

Follow-up Report Classification

		Trend
Reasonable	**Follow up:** All high priority recommendations implemented and progress on the medium priority recommendations.	⇧

Progress Summary

	Previous Matters Arising	Previous Priority Rating	Direction of Travel	Current Priority Rating
1	Accuracy of reported SCP data	High	⇧	Closed
2	Integrity of the SCP data	High	⇧	Closed
3	Quality assurance monitoring	High	⇧	Closed
4	Policy and procedures	Medium	⇧	Low
5	Cancer Steering Group	Medium	⇔	Medium

1. Introduction

1.1 The follow-up review of the Single Cancer Pathway (SCP) Data Quality and Integrity recommendations was completed in line with the 2022/23 Internal Audit plan for Cwm Taf Morgannwg University Health Board (the 'Health Board').

1.2 Our original SCP Data Quality and Integrity review was finalised in September 2021. At that time a limited assurance opinion was issued based on the high and medium priority recommendations.

1.3 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 three recommendations have been fully implemented with the remining two partially complete. Work is in progress for the remaining two and revised completion dates of June 2022 have been set.

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

1.5 Potential risks considered in our original review were:

- The service does not meet performance measures due to ineffective monitoring and governance arrangements.
- There is a lack of trust in the data due to weaknesses in the accuracy and completeness of the patient management system.
- Exposure to reputational issues for the Health Board, should reported data be found to be inaccurate or incomplete.
- Patients suffer avoidable harm through inefficiency and delays caused by data issues not being managed correctly and expediently.

2. Findings

2.1 The table below provides an overview of progress in 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	3	3	0	0
Medium	2	0	2	0
Low	0	0	0	0
Total	**5**	**3**	**2**	**0**

2.2 Full details of recommendations requiring further action are provided in the **Management Action Plan** in **Appendix A**.

2.3 For the three recommendations that have been fully closed, management have taken sufficient actions to address the matters arising in our original report. These include:

- Correcting the data script errors to ensure all data is properly captured and putting new processes in place at an all-Wales level to ensure the correct reporting of patients whose test results are obtained after data extraction.
- Implementing robust weekly and monthly validation checks, in-line with an approved Data Validation Standard Operating Procedure (SOP), to ensure the integrity and reliability of SCP data prior to its Welsh Government submission.
- Implementing robust monthly and ad-hoc quality assurance checks by senior management to ensure the on-going accuracy of SCP data. This includes a three-monthly report to rectify discrepancies in data caused by delays in pathology reporting. The maintaining of issues logs as means to report back to staff and aid training.

2.4 Whilst two recommendations remain open, we have seen that action has been taken to start to address these findings. The priority rating of one of these recommendations has reduced as a result, whilst the other remained the same.

Appendix A: Management Action Plan

<table>
<tr><th colspan="3">Previous Matter Arising 4: Policy and procedures (Control design)</th></tr>
<tr><td colspan="2">Original Recommendation</td><td>Original Priority</td></tr>
<tr><td colspan="2">1. A corporate policy in relation to data quality should be developed that sets out the Health Board’s strategic direction and its commitment to have robust data quality processes in place.
2. All draft Standard Operating Procedures in relation to the recording and validation of SCP data should be appropriately approved and implemented as soon as practically possible.</td><td>Medium</td></tr>
<tr><td>Management Response</td><td>Target Date</td><td>Responsible Officer</td></tr>
<tr><td>1. The UHB’s Medical records and Information Governance policies both incorporate Data Quality requirements and describe where accountabilities rest.
2. Some procedures have been introduced – upgrade / downgrade 1st June, breach reporting procedure.</td><td>Q2 2021/22</td><td>Senior Cancer Manager</td></tr>
<tr><th colspan="2">Current findings</th><th>Residual Risk</th></tr>
<tr><td colspan="2">1. The need for a standalone corporate policy in relation to data quality was discussed with the Chief Information Officer. They re-iterated their original management response that both the Medical Records and Information Governance policies incorporate sufficient information. Our review of these policies confirmed that both policies provide succinct but sufficient information pertaining to data quality, particularly when read alongside the SCP Validation SOP. As such this finding is closed.
2. The majority of SOPs identified during our original audit have been finalised. However, when we reviewed them, we noted some gaps in information and some discrepancies between what was set out in the SOP and what was actually taking place. For example, validation reviews are happening more frequently than set out in the SOP.
Furthermore, whilst all SOPs contained details of their review cycle, none were dated when originally approved, therefore it was unclear when they needed to be reviewed.</td><td>The service does not meet performance measures due to ineffective monitoring and governance arrangements.</td></tr>
</table>

We also identified that the Escalation Policy is still in draft form, although an overview of the escalation procedure is detailed in the finalised SOP for Delivering Cancer Waiting Times. As such this finding is **partially implemented.**

Conclusion: Progress has been made against our previous recommendations including the completion and approval of several SCP SOP's. However, further review and some amendments are required and so we consider this recommendation to be **partially implemented.**

New Recommendations		Priority
1.1	a) Management should ensure all relevant key data is included in the Single Cancer Pathway SOPs and checks undertaken to identify where variations are between the SOP and current practices, with amendments made as necessary. b) The Escalation Policy should be finalised.	**Low**

Management Response		Target Date	Responsible Officer
1.1	a) Review and amendments of validation SOPs commenced, with plans to approve them at cancer steering group which is scheduled for the 14th September 2022. b) The escalation policy has been reviewed and amendments being updated. Plans to approve this is planned at Cancer programme Board on 7th September 2022.	14/09/2022 07/09/22	Senior Cancer Manager HB Clinical Lead for Cancer

<table>
<tr><th colspan="3">Previous Matter Arising 5: Cancer Steering Group (Operating effectiveness)</th></tr>
<tr><td colspan="2">Original Recommendations</td><td>Original Priority</td></tr>
<tr><td colspan="2">1. The terms of reference for the Cancer Steering Group should be reviewed and approved.
2. Management should either include an escalation process for dealing with frequent non-attendance by individuals or provide clarity in relation to key officers and quoracy within the terms of reference.</td><td>Medium</td></tr>
<tr><td>Management Response</td><td>Target Date</td><td>Responsible Officer</td></tr>
<tr><td>1. The terms of reference have been reviewed, re-drafted and approved via the cancer steering group, which takes into account attendance.
The revised Cancer Operating Model also clarifies roles and responsibilities, underlining the requirement for all key members of the group to contribute proactively to the CSG.
2. Unfortunately, competing priorities such as covid response, vaccination and covid recovery meant that meetings could not be supported from all departments.
The UHB is investing is an additional cancer analyst post which to support the Cancer Business Unit and ILG's improve data quality and integrity. This post is in the process of recruitment and will be appointed to in Q3 2021/22.</td><td>Q2 2021/22</td><td>Cancer Services Director
Head of Information</td></tr>
<tr><th colspan="2">Current findings</th><th>Residual Risk</th></tr>
<tr><td colspan="2">1. The Cancer Steering Group's Terms of Reference (TOR) has been approved and finalised, though we note that they were due for review at time of our follow-up audit being undertaken. However, we deem this finding is closed.
2. Whilst the TORs do not incorporate an escalation process for non-attendance, they do clearly set out the purpose of the group, membership, reporting lines and frequency of meetings. Quoracy requirements are also set out.
Our review of the minutes from the last four meetings held (between January and May 2022) identified that attendance by some key members remains low.</td><td>The service does not meet performance measures due to ineffective monitoring and governance arrangements.</td></tr>
</table>

- The Cancer Services Director, who is the Chair of the Group, the Senior Cancer Manager, and the Head of Information, only attended 50% of the meetings.
- All four meetings failed to have full representation from the ILG Cancer Leads, the ILG Acute Service General Managers and the ILG Senior Nurse. Some ILG representatives have failed to attend any of the meetings.
- Clinical Lead for Primary Care, the Public Health Lead, and the Delivery Unit Representative did not attend any of the four meetings.

As a result of the low attendance levels, we have identified that only two of the last four meetings achieved the quoracy level as outlined in the TOR. As such this finding is **partially implemented.**

Conclusion: Progress has been made in updating and approving the revised TORs for the Cancer Steering Group, that clearly set out the quoracy requirement. However, attendance at meetings remains poor meaning that quoracy requirement is often not being achieved. We consider this recommendation to be **partially implemented.**

New Recommendation		Priority
2.1	a) A further review of the Terms of Reference of the Cancer Steering Group should be undertaken with consideration given to the current membership and quoracy levels given on-going poor attendance. b) Where members are unable to attend meetings, consideration should be given to representatives attending on their behalf.	**Medium**

Management Response		Target Date	Responsible Officer
2.1	a) TOR for cancer steering group is planned to be reviewed and updated with approval for revised version at next cancer steering group on 14th September 2022. b) Representatives for attendance on behalf of core members that are unable to attend will be included in the updated cancer steering group TOR.	14/09/22	HB Clinical Lead for Cancer

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.

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