Archwilydd Cyffredinol Cymru
Auditor General for Wales

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Handling of Historic Waiting List Anomalies

Cwm Taf University Health Board

Audit year: 2013-14

Issued: May 2015

Document reference: 454A2014

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The team who delivered the work comprised Alun Griffiths and Mandy Townsend, under the direction of David Thomas.

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Summary report

Background

1. During 2011, work at Cwm Taf Health Board (the Health Board) by the Welsh Government's Delivery and Support Unit (DSU) identified anomalies between planned elective activity and the actual numbers of patients on the waiting list. Further examinations by the DSU revealed that in March 2011 the Health Board had undertaken a validation exercise that looked specifically at a cohort of 1,900 patients who would have waited in excess of 36 weeks by the end of March 2011. The DSU examined details of a significant proportion of this cohort and found that their waiting times were inappropriately adjusted or stopped. The patients were ultimately placed on a holding list prior to year-end, which had the consequence of removing them from the reported Referral to Treatment Time (RTT) figures. These patients were subsequently returned to the waiting list in the early months of the next operational year.

2. The Health Board established an internal Root Cause Analysis review to examine the reported anomalies. That internal review concluded in December 2011 and pointed to a number of weaknesses in the Health Board's processes for the management of waiting lists but concluded that there was no evidence of deliberate malpractice. However, following further investigation work, the DSU issued a report in March 2012 raising concerns that the anomalies were strongly indicative of systematic and deliberate waiting list manipulation. The DSU reported that, on the basis of its analysis, it could not conclude if the alleged manipulation had occurred as a result of actions of individuals or if it constituted an organisation strategy to report an improved performance picture beyond that which reflected reality.

3. Following the DSU's findings, the Health Board suspended several members of staff and appointed Disciplinary and Investigating Officers to examine the concerns in detail. These investigations concluded in late 2012 finding no case to answer in respect of the individuals that were suspended. The Investigating Officer's final report did, however, conclude that there was an organisation strategy at the time to improve the performance picture, which was achieved by creatively interpreting RTT rules. This gave a false picture in relation to the organisation's performance that was reported to the Welsh Government at the end of March 2011.

4. By the end of 2013, the Health Board had used the findings from the various investigations into the waiting list anomalies to identify and implement a number of remedial actions to strengthen its management of waiting lists.

5. It should be noted that the Chief Executive of the Health Board changed in the early part of 2011. The previous Chief Executive officially retired at the end of March 2011. The current Chief Executive took up post in early 2011, taking on Accountable Officer status from January 2011. The outgoing Chief Executive retained responsibility for managing the 2010-11 year-end position.

Focus of our audit work

6. Given the seriousness of the issues identified, the Auditor General decided that audit work was needed to assess if the Health Board demonstrated due diligence in investigating the anomalies and whether appropriate action has been taken to prevent similar problems recurring.

Key findings

7. Our overall conclusion is that whilst the Health Board responded appropriately to concerns about waiting list data anomalies, and subsequently strengthened processes, several aspects of its investigation were unsatisfactory. Notably the investigations failed to attribute any individual accountability for the problems that were acknowledged. More positively, the Health Board has subsequently strengthened its waiting list management processes to prevent similar problems recurring.

8. The factors that have led us to these conclusions are considered further in the sections that follow.

The Health Board's immediate response to concerns was appropriate and it crucially sought assurance that no patient had come to harm as a result of being placed on a holding list

9. On learning of the initial anomalies identified by the Welsh Government's DSU, the Health Board set up an internal Root Cause Analysis review in 2011. It took this decision after close dialogue with Welsh Government, which was maintained throughout the investigation process. The Chief Executive also ensured the Chair of the Board was fully briefed on the emerging position.

10. Crucially, following the discovery that 1,900 patients had been placed on a holding list at the end of March 2011, the Health Board worked with the DSU to obtain assurance that these patients did not come to any harm as a result of their 'suspension' from the waiting list. Our reviewers were told that this exercise did not identify any patient safety issues: all affected patients were quickly reinstated to the waiting list, in correct order, with no adverse impact on the timing of their treatment. These actions provide positive assurances that patient care was not compromised. However, we have not done any audit work to validate if these assurances were correct.

11. The Chief Executive swiftly informed the Board when further DSU investigations uncovered issues that were strongly indicative that waiting lists had been deliberately manipulated. The Board approved a series of recommendations including invoking disciplinary procedures and suspending four members of staff pending an investigation led by an external investigating officer. The process of identifying an investigating officer was undertaken in close liaison with the Welsh Government. This was an important step in ensuring that the officer was genuinely independent of the Health Board.

12. Collectively, these actions constitute an appropriate and timely set of responses to the concerns that were being reported. However, as set out in the following section, there were a number of aspects of the investigatory work that were not satisfactory.

Several aspects of the Health Board's investigations into the waiting anomalies were unsatisfactory and ultimately it failed to identify any individual accountability for the problems that were acknowledged

The Root Cause Analysis review identified several problems with waiting list management processes but ultimately failed in its core purpose

13. The Terms of Reference for the Root Cause Analysis review commissioned by the Chief Executive were appropriately wide ranging in relation to the concerns that had been identified. It concluded in December 2011 and identified several weaknesses and inconsistencies in the Health Board's waiting list management processes and associated lines of accountabilities. The review recommended urgent action to simplify and centralise waiting list management arrangements; to formalise monitoring and reporting arrangements; and to establish more explicit roles and responsibilities in terms of the ownership of RTT targets and supporting procedures.

14. The Root Cause Analysis review concluded that there was no evidence of deliberate malpractice or endemic mismanagement of waiting lists. However, while it identified the existence of a flawed waiting list validation exercise at the end of the final quarter of 2010-11, it failed to identify this as the root cause of the anomalies. Subsequent investigations would go on to highlight this issue as being at the heart of the problems reported.

15. The failure to recognise the importance of the validation exercise meant that opportunities were missed to probe issues around the governance and decision making associated with the validation exercise. Instead, the Root Cause Analysis review focussed on the actions of those with responsibility for co-ordinating the waiting list management information at the end of 2010-11.

16. The extent of problems identified by the Root Cause Analysis work made it difficult for the review team to pin point the actual root cause of the problems. This problem might have been avoided if the review had been under the direction of a more senior individual with relevant knowledge and experience. Members of the Health Board's executive team were deliberately not involved in the RCA because of uncertainty over whether any executives were implicated in the problems that had been identified. However, the Health Board did not identify a senior external lead with waiting list expertise from another organisation, nor involve an Independent Member(s) who might have brought valuable scrutiny skills to the process.

Several issues affected the robustness of the initial investigation process that followed the Delivery and Support Unit's second report in 2012

17. Following the decision to suspend staff and set up an externally led investigation, the Health Board encountered an immediate problem in identifying a suitable Investigating Officer. Its preferred candidates could not be released from their existing roles in a neighbouring health board to undertake the investigation. The Health Board worked with the Welsh Government to eventually identify and appointed an alternative Investigating Officer with appropriate seniority and human resources experience, although he was not able to start work until some six weeks after the staff suspensions began.

18. The Investigating Officer's background meant that he did not have detailed technical knowledge of the issues surrounding the reporting of RTT figures and associated rules and information systems. This was stated as a caveat within his report. A senior member of staff from another health board in Wales with the appropriate knowledge was identified to provide technical expertise and advice but the Investigating Officer did not use his services.

19. A further problem arose in relation to the engagement of DSU in the investigation process. We understand that the Investigating Officer wanted to formally interview DSU staff involved in the identification of waiting list anomalies and alleged manipulation of data. However, on the advice of the HR Department in their hosting organisation, the DSU did not participate in the process. It was concerned that the Unit was being inappropriately drawn into what should have been an internal investigation when they had already provided the necessary evidence in the form of their reports and through a briefing with the Health Board's Chief Executive.

20. This unhelpful sequence of events ultimately meant that the Investigating Officer was not able to have first-hand contact with the DSU to fully explore the issues identified by their reviews. This, along with the fact that the Investigating Officer did not make use the technical expert that had been made available, meant that he was not able to fully understand the details which were at the heart of the DSU's concerns.

21. More broadly, the Terms of Reference provided to the Investigating Officer were limited in scope. They necessarily prompted the investigation to consider the actions of the staff that had been suspended in relation to manipulation of waiting list data, but stopped short of seeking to explicitly establish where the instruction to undertake such actions may have come from.

22. The Investigating Officer reported his findings to the Health Board in September 2012. He concluded that there was no evidence to suggest that the suspended staff had manipulated waiting list data or inappropriately accessed supporting patient records. His report did not go into any details of how the waiting anomalies occurred.

Subsequent investigations attributed the reported concerns to waiting list validation exercises undertaken during early 2011 but crucially failed to identify any individual accountabilities for the acknowledged problems

23. The initial Investigating Officer's report was made available to the internal disciplinary officer appointed to consider if any disciplinary action was merited against the suspended staff. However, the disciplinary officer felt that additional detail was needed before any decisions could be made. As the original Investigating Officer could not do any further work and the investigation needed to be completed urgently, the Chief Executive appointed a senior HR manager from within the Health Board to undertake further investigations and produce a second report.

24. These further investigations focussed on the waiting list validation exercise that occurred in the final quarter of 2010-11. The Health Board's Acute Care Productivity and Efficiency Board, chaired by the previous Chief Executive identified the need to validate waiting lists. Validation of waiting lists is a necessary activity to ensure that they represent a fair and accurate picture of the number of patients waiting. There are clear rules around the RTT targets that support fair and accurate validation of waiting lists. The suspended staff undertook the validation exercises which resulted in patients being removed from the main waiting list and placed on a holding list, contrary to RTT rules and guidelines. We note that validation was not part of their normal duties, and happened in the last quarter 2010-11 as a one off exercise.

25. No minutes of the Acute Care Productivity and Efficiency Board meetings were kept. Action notes from the meeting were recorded but it was not possible to verify from these what discussions took place or what the Acute Care Productivity and Efficiency Board's precise instructions were in relation to the validation exercise.

26. The senior HR manager reported the findings of the second investigation at the end of November 2012. That report contained the following conclusion:

'It is the opinion of the Investigating Officer that there was an organisational strategy at that time to improve the performance picture [of the Health Board] and that this was achieved by creatively interpreting the rules of RTT, which did give a false picture in relation to the organisation's performance which was reported to Welsh Government on 25 March 2011.'

27. These findings were interpreted as ones of 'organisational failure'. However, there was deemed to be insufficient evidence to state categorically if the inappropriate handling of the validation exercise was due to mis-management or deliberate intent. The suspended staff were allowed to return to work, although their return was subject to formal management through the capability policy and they ultimately returned to different roles as a result of changes to the organisational structure that had been implemented in the interim.

28. The absence of clear evidence about the decision-making processes that took place surrounding the validation exercise in the last quarter of 2010-11 means that no culpability or accountability has been attributed to any individuals. We consider this to be a highly unsatisfactory outcome in the context of an investigation which concluded that there had been organisational failure in relation to waiting list management processes and creative interpretation of RTT rules to falsely present the waiting list performance of the Health Board.

The Health Board has taken positive action to address weaknesses in its waiting list management processes and prevent the identified problems recurring

29. This audit has also reviewed the actions that the Health Board has subsequently taken to strengthen its waiting list management processes and prevent the problems experienced in 2010-11 from happening again. We can report that a number of key initiatives have been implemented to strengthen the Health Board's arrangements, and that waiting list management systems now are very different to those that existed in 2010-11.

30. Improvements include:

- regular (weekly) validation of patients on waiting lists;
- continuous monitoring of waiting list information at an operational and executive level to help identify and address any potential anomalies in the reported data;
- new structures, information system improvements and staff training, supported by a revised Waiting List Management Procedure;
- revised responsibilities for maintaining and validating waiting lists, with medical secretaries now being responsible for maintaining waiting list information for their specialty;
- clear separation of duties between the Chief Operating Officer, who is responsible for RTT performance and the staff who are responsible for reporting the waiting list position; and
- key management meetings and forums are routinely minuted.

31. The Health Board is confident that the actions it has taken have considerably strengthened its arrangements for the management and reporting of waiting lists. We would concur with this view based on the information we have been given. However, we must state that we have not undertaken any detailed testing of the new arrangements.

32. It is also positive that the Health Board is not complacent and is aware that it needs to keep its arrangements under review. This should be supported by building appropriate and periodic independent checks into its waiting list management processes.

Recommendations

Standardising waiting list management, processes and reporting

R1 The Health Board must ensure that its new processes, management and training for waiting list management are fully embedded in operational practice, by for example inviting a Delivery Unit or Internal Audit spot check audit, and considering the findings openly and transparently at a public Board meeting.

Capturing learning from Root Cause Analysis and disciplinary investigations

R2 If it has not already done so, the Health Board needs to formally capture the key learning points from the Root Cause Analysis and disciplinary investigations it undertook in response to the 2010-11 waiting list anomalies. The aim must be to ensure that weaknesses and difficulties encountered in these investigations are not repeated in future.

Formal recording of key management decisions

R3 The Health Board must ensure that adequate minutes and audit trails are maintained for all key forums where important management decisions are taken.

Appendix 1

Methodology of review

The Wales Audit Office reviewed the relevant documentation and reports from the various investigations. We reviewed the information and records held at the Health Board that demonstrate the management response. Wales Audit Office staff interviewed officers, management and Independent Board members of Cwm Taf Health Board as well as key individuals representing the Welsh Government's Delivery and Support Unit (now called Delivery Unit), Welsh Government and individuals that were available to provide technical support for the Health Board at the time of the investigations. We reviewed annonomised interview transcripts from the disciplinary investigation.

We also reviewed a self-assessment provided by the Health Board for our National Study on NHS Waiting Times, which included revised policies and procedures for managing waiting lists at Cwm Taf Health Board. Our fieldwork concluded in the latter part of 2014.

Appendix 2

Timeline of key events

Table showing key events of timeline

Event		Timeline
1.	Acute Care Productivity and Efficiency Board identify the need to undertake a waiting list validation exercise.	Around November 2010
2.	Waiting List Validation Exercise occurs.	February/March 2011
3.	DSU, WG and Health Board identify irregular movement in waiting list numbers at HB and agree approach for resolution.	April 2011 to June 2011
4.	RCA Review (commissioned by new Chief Executive Officer).	June 2011 to November 2011
5.	DSU undertake additional work to review waiting lists analysis at Cwm Taf.	June 2011 to March 2012
6.	DSU provide verbal update of findings to Chief Executive Officer.	October 2011
7.	RCA Review is completed and WG and Board briefed.	December 2011 to January 2012
8.	HB agreed actions including the commencement of a Capability Process.	January 2012
9.	DSU issue report and findings from their work.	March 2012
10.	HB updated of DSU findings and Disciplinary Process commenced with staff suspended from duty.	April 2012
11.	HB experience difficulty in identifying suitable Investigating Officer.	April 2012
12.	Independent Investigation Officer commences review with HR support and access to a Waiting List technical expert.	May 2012
13.	A parallel ‘due diligence’ review is undertaken by an independent person.	May 2012
14.	The Finance and Performance Committee monitor the progress and completion of the action plan developed by the HB in response to the identified waiting list issue.	May 2012 – present
15.	The new Chief Executive Officer commences the process of re-building the structure, processes and systems led by a new team.	Summer 2012
16.	Investigating Officer provides Disciplinary Officer with report of Disciplinary Investigation findings.	September 2012

Event	Timeline
17. Disciplinary Officer requests that additional aspects are considered to complete investigation. Chief Executive requests that the HR officer completes investigation as Investigating Officer informs HB that he is unable to undertake additional work.	September 2012 to November 2012
18. Investigating Officer provides Disciplinary Officer with report of additional work.	November 2012
19. Disciplinary Officer concluded that there was insufficient evidence against suspended staff and that organisational failure had occurred during 2010-11. Staff return to work at HB.	November 2012
20. The HB engages with the Technical Expert and undertakes a comparative system review.	Early 2013
21. Updated Action Plan is reviewed on a quarterly basis by the FPC and Data Quality Steering Group commences.	Early 2013 to present

Wales Audit Office
24 Cathedral Road
Cardiff CF11 9LJ

Tel: 029 2032 0500
Fax: 029 2032 0600
Textphone: 029 2032 0660

E-mail: info@wao.gov.uk
Website: www.wao.gov.uk

Swyddfa Archwilio Cymru
24 Heol y Gadeirlan
Caerdydd CF11 9LJ

Ffôn: 029 2032 0500
Ffacs: 029 2032 0600
Ffôn Testun: 029 2032 0660

E-bost: info@wao.gov.uk
Gwefan: www.wao.gov.uk