Patient Pathways (DESW & WAAASP)

Final Internal Audit Report

2025/26

Public Health Wales NHS Trust

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EXTERNAL • QUALITY • ASSESSMENT

Executive Summary

Purpose

Our audit of patient pathways across Diabetic Eye Screening Wales (DESW) and Wales Abnormal Aortic Aneurysm Screening Programme (WAAASP) was completed as part of our 2025/26 Internal Audit plan for Public Health Wales NHS Trust (PHW or the 'Trust').

DESW and WAAASP screening are national population-based programmes delivered by the Trust. Both play a critical role in the early detection and prevention of serious health conditions, with significant clinical input required across the screening pathway. Ensuring these pathways are safe, consistent, and patient-centred is essential to delivering high-quality public health services.

DESW aims to reduce the risk of avoidable sight loss by detecting diabetic retinopathy early. All individuals aged 12 and over with a diagnosis of diabetes (excluding gestational diabetes) are invited for regular retinal screening. Screening involves retinal photography following pupil dilation, with results graded to determine follow-up or referral pathways. Recent changes mean participants at low risk may now be screened every two years, while those with identified changes are monitored more frequently.

AAA screening seeks to reduce mortality from ruptured abdominal aortic aneurysms by offering a one-time ultrasound scan to men during the year they turn 65, with additional surveillance for those found to have an aneurysm. The programme is based on demographic eligibility rather than referral and provides clear pathways for monitoring and surgical intervention where clinically indicated.

This review considered the end-to-end patient pathways for DESW and WAAASP, assessing whether clinical input, governance structures, and operational processes were robust, consistent, and aligned with best practice.

Overview

We have concluded reasonable assurance on this area. The matters requiring management attention are:

- Both programme's Terms of Reference (ToR) require update with addition of some key subject areas and harmonisation to a consistent format.
- DESW role profiles require review with several roles not able to evidence approval and several more considerably past review date (> five years).
- Screening venue risk assessment management across both programmes requires review. WAAASP were unable to provide a database list of all risk assessments or specific assessments for venues requested during the review. DESW maintain a database list of venue risk assessments but there were inconsistencies with the records.
- The WAAASP Business Continuity Plan (BCP) had not been approved and had omitted the Business Impact Assessment – a key component.
- DESW programme board meeting does not include a standing agenda item for review, discussion and scrutiny of the programme risk register.

Full details of matters arising are detailed within the Findings & Agreed Action Plan. The following opportunities for enhancement have been identified that do not impact the overall opinion and are highlighted for management information:

- Detailed system access records and robust system access controls are in place across both programmes. However, both programmes would benefit from the addition of staff leaving dates to their respective system access databases to provide assurance that when a member of staff leaves the programme, that staff member's system access is revoked in a timely manner.

Scope & Assurance Summary

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

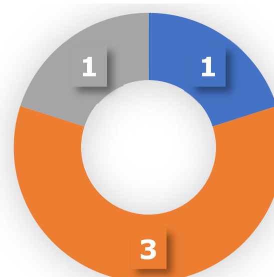
	Objectives	Related Findings	Assurance
1	Evaluate governance and accountability structures supporting the DESW and AAA pathways, ensuring alignment with clinical, regulatory and quality standards and clarity of roles across sites.	1, 2	**Reasonable**
2	Assess the design, documentation and implementation of patient pathways from invitation to outcome, ensuring consistency, safety and compliance with national guidance, including the presence of supporting policies and procedures	3	**Reasonable**
3	Review digital infrastructure and systems used to support pathway delivery, focusing on access, usability and the ability to facilitate safe clinical decision-making and accurate documentation retention across all sites	4	**Substantial**
4	Assess data management and quality controls throughout the patient journey, including identification/notification, vetting decisions, patient communication and the recording of pathway data, ensuring accuracy timeliness and consistency	-	**Substantial**
5	Evaluate performance monitoring and assurance mechanisms, including reporting arrangements and the use of demand data, to ensure effective oversight of pathway delivery and continuous improvement across both programmes	5	**Substantial**

Management Actions

5

Medium Priority

Themes



Governance

Risk Management

Training & Development

Risk Types

Public Perception & Reputational Risk

Quality or Safety Issues

Legal & Regulatory Non-Compliance

Findings & Agreed Action Plan

Objective 1: Evaluate governance and accountability structures supporting the DESW and AAA pathways, ensuring alignment with clinical, regulatory and quality standards and clarity of roles across sites.	**Reasonable**

Overall, the DESW and AAA programmes both demonstrate a mature governance framework, with consistent structural arrangements and quality standards aligned with national screening committee guidance. Programme Boards and management structures are in place for both pathways, providing escalation routes in principle and ensuring that operational and strategic oversight is maintained by divisional, senior and executive groups (DMT, SMT, BET). Our review of minutes for each group confirmed that reporting cycles and decision-making flows operate effectively in practice.

Comprehensive quality manuals exist for both programmes, which use a common template and clearly define patient eligibility, pathways and programme reporting requirements. These documents are reviewed by quality groups that report to programme boards, with evidence of clear ownership, periodic update, version control and alignment with national standards. Internal and external assurance mechanisms are also in place, although WAAASP has not received an external peer review to date.

The Terms of Reference (ToR) documentation for DESW is current and includes detailed member responsibilities and meeting documentation requirements. However, the WAAASP ToR does not appear to have been reviewed for several years. Across both programmes, neither ToR defines escalation criteria or provides a visual or narrative description of how Programme Boards fit within the wider organisational governance structure. Reporting lines above Programme Boards also differ between programmes without a clear rationale.

WAAASP maintains an up-to-date staffing structure, approved job descriptions and a training compliance process, including mandatory Level 3 and 4 screening qualifications. DESW, however, holds a role database in which 53% of job descriptions are overdue review.

In summary, while operational governance and quality assurance processes are strong, improvements are required to ensure consistency, clarity and completeness of governance documentation and to strengthen workforce assurance—particularly within DESW.

	Key Findings	Risk & Impact	Suggested Management Action
1	**Programme Terms of Reference (ToR)** Both programmes have established and approved ToRs, however several gaps reduce the clarity and consistency of governance arrangements. The WAAASP ToR is 4.5 years overdue for review, and omits essential content such as member responsibilities, required meeting documentation and expected outputs. It also lacks a description of sub-groups reporting into the Programme Board. The DESW ToR is current and more comprehensive but does not specify the escalation destination for risks and issues. Across both programmes, neither ToR defines decision/risk escalation criteria or the process for managing escalations, nor do they illustrate how Programme Boards fit within the wider governance structure (Programme Board → SMT → BET). Reporting lines above Programme Board also differ between programmes without clear rationale, creating potential ambiguity in accountability. Updating and harmonising both ToRs into a standard format would strengthen assurance and support consistent governance across both screening programmes.	Inadequate oversight results in improperly approved programme decisions and lack of awareness of programme performance	Both programmes will review their programme Terms of Reference. This review will include a side-by-side comparison of both programme ToRs with a view to identifying best practice inclusions. The review will include (but will not be limited to): • Programme member roles and responsibilities • Meeting documentation and expected outputs • Programme Board escalation routes • Programme risk, change and decision escalation criteria and process • Programme Board reporting lines • Documentation, definition and illustration of Programme Board sub-groups/committees • High level programme governance illustrating fit with wider Trust governance groups and processes **Expected Evidence of Implementation:** Updated Terms of Reference with a clear consistency in ToR documentation across programmes
		Medium Priority	**Officer: DESW - Kate Morgan** **WAAASP – Jeremy Surcombe** **Target Implementation Date: June 2026**
	Theme: Governance	Control Design	

<table>
<tr><th colspan="2">Key Findings</th><th>Risk & Impact</th><th>Suggested Management Action</th></tr>
<tr><td rowspan="3">2</td><td rowspan="2">Role and Job Description Management

Our review of DESW’s role database highlighted several job descriptions that were unapproved or out of date. Of the 19 DESW job descriptions listed in the database, 53% are overdue for review, and for 32% there was no evidence of formal approval. As such, it was unclear if roles, responsibilities and reporting lines remain accurate and aligned to current operational needs.

Strengthening role review and ensuring job description approvals would improve workforce governance.</td><td>Personnel involved with managing or delivering the screening programmes are unaware of their responsibilities</td><td>A review will be undertaken across the role database maintained by the DESW programme to ensure that:
All roles associated with the programme are approved and that approval is documented
All roles associated with the programme are reviewed at required review points and that these reviews are documented
Expected Evidence of Implementation:

DESW staff role database is cleansed and includes points as listed by action</td></tr>
<tr><td>Medium Priority</td><td rowspan="2">Officer: DESW - Kathryn Hughes

Target Implementation Date: July 2026

Not applicable to WAAASP</td></tr>
<tr><td>Theme: Resourcing</td><td>Control Operation</td></tr>
</table>

Objective 2: Assess the design, documentation and implementation of patient pathways from invitation to outcome, ensuring consistency, safety and compliance with national guidance, including the presence of supporting policies and procedures	**Reasonable**

Our review assessed the design, documentation and implementation of patient pathways across the DESW and AAA screening programmes. Overall, we saw pathway designs with comprehensive documentation and clear mapping of all key stages from eligibility through to outcome. Documentation is approved, version-controlled, securely stored and subject to defined ownership arrangements with documents stored in a centrally accessible, secure location on dedicated SharePoint sites.

Our walkthrough testing confirmed that DESW screening processes are consistently implemented in practice by screening staff who were polite, helpful and supportive of patients throughout. Our observations of the pathways of eight patients in two different clinics showed the patient journey to be consistent and that all stages from security checks to retinal imaging and result communication aligned with documented pathways. Our sample testing of DESW patient records demonstrated correct application of grading, recall intervals, failsafe procedures and pregnancy-specific pathways, all of which were comprehensively documented for all patient records that we sampled in the Optomise system (core patient management system in use by DESW).

Similarly, our sample testing of AAA confirmed adherence to surveillance intervals and escalation criteria. Records showed appropriate movement between annual and quarterly surveillance where aneurysm size increased, consistent with programme guidance. Processes for non-visualised aortas were also well defined and evidenced in patient records which were similarly comprehensive in detail recorded in aSIMS (core patient management system in use by WAAASP).

Both programmes maintain venue databases and have developed capacity-versus-demand forecasting models. These models demonstrate clear consideration of population distribution and enable scenario-based planning. However, venue risk-assessment governance, essential for ensuring patient Health & safety, is inconsistent. DESW maintains a central database, but it contains outdated, duplicate and incomplete entries. WAAASP was unable to provide either a master database or the requested sample of venue risk assessments.

In conclusion, pathway design, documentation and operational adherence are strong across both programmes. Capacity planning is well developed and responsive to demand pressures. The primary weaknesses relate to venue risk-assessment governance, where both completeness (WAAASP) and data quality (DESW) require improvement.

<table>
<tr><th colspan="2">Key Findings</th><th>Risk & Impact</th><th>Suggested Management Action</th></tr>
<tr><td rowspan="3">3</td><td rowspan="2">Screening Venue Risk Assessments (RA)

The WAAASP programme were unable to provide either a master RA database or specific venue RAs requested for our sample testing. We understand that these documents likely exist and are held by the premises team. However, the programme should at minimum have access to these documents or, take responsibility over managing them and associated activities so assurance can be provided over venue safety and suitability.

The DESW risk-assessment documents that we reviewed during our site visits were complete, accurate and covered relevant areas such as privacy, accessibility and health and safety. However, we identified some data quality issues with its venue risk-assessment database:

• 47/79 RAs (59%) exceeded five years in age without evidence of review.
• 5 RAs were held for venues not recorded on the venue database.
• 6 RAs were held for venues marked as 'no longer in use'.
• 12 currently used venues had no recorded RA.

These issues indicate that the database does not fully align with the current venue list and that review cycles have not been consistently applied.</td><td>Inadequate venue facilities, overcrowding or inconvenient facility location results in poor patient experience</td><td>WAAASP will create a risk assessment database ensuring that:

• All venue risk assessments are recorded
• The date of risk assessment completion is recorded
• All venues have been risk assessed
• Date of risk assessment review is recorded

DESW will review the risk assessment database including:

• Comparison against the master venue database to ensure that all venues have been risk assessed
• Any risk assessment recorded for either an unrecorded venue or a venue no longer in use is removed.
• Implement a risk assessment review schedule

Expected Evidence of Implementation:

Updated risk assessment databases for both programmes</td></tr>
<tr><td>Medium Priority</td><td rowspan="2">Officer: DESW – Victoria Jones and Stephen Williams

WAAASP – Jeremy Surcombe

Target Implementation Date: DESW - May 2026

WAAASP – June 2026</td></tr>
<tr><td>Theme: Risk Management</td><td>Control Design</td></tr>
</table>

Objective 3: Review digital infrastructure and systems used to support pathway delivery, focusing on access, usability and the ability to facilitate safe clinical decision-making and accurate documentation retention across all sites	**Substantial**

We confirmed that both services operate well-established digital systems that support safe pathway delivery, accurate documentation and effective clinical decision-making. Each programme uses a system specifically designed for its screening context: Optomise for DESW, and aSIMS for WAAASP. Both systems are widely used, incorporate hard-coded grading or measurement parameters, and provide structured workflows that minimise manual error and support consistent patient outcomes.

The controls relating to access were robust for both systems. Both programmes maintain detailed documentation of role profiles, access rights, access requests and approvals, and changes to user profiles. Access is granted only following formal approval processes, and system administrators manage assignments and amendments. Quarterly reviews of user activity provide an additional layer of assurance. However, neither programme records the date a staff member leaves within their master access databases, limiting the ability to evidence timely revocation of access.

Automated processes within both systems support data accuracy and operational efficiency. Both programmes operate daily referral file checks, exception reporting and DESW additionally operate weekly failsafe reconciliations – a process specific to DESW as patients re-enter the screening programme following any secondary care provision which is not an available pathway for patients in the WAAASP programme. Both systems also benefit from automated demographic updates via the Wales Demographic Service (WDS) feed, ensuring patient data remains current and accurate where changes are communicated through primary care providers.

We spoke to staff about how usable the systems are. DESW staff note some inefficiencies in report generation, while WAAASP highlighted delays in implementing system changes due to external development dependencies, although feedback was generally positive. Both programmes maintain business continuity arrangements, although the WAAASP Business Continuity Plan (BCP) requires strengthening to ensure completeness and formal approval.

Key Findings		Risk & Impact	Suggested Management Action
4	**Business Continuity Planning Documentation** Our review of business continuity arrangements identified two issues specific to the WAAASP Business Continuity Plan (BCP). First, the BCP did not contain evidence of approval and further, did not include and approval date. Second, although the BCP includes a section specifically for the Business Impact Assessment (BIA), this section had not been populated and could not be located by the programme lead. The BIA is a critical component, as it identifies essential functions, recovery priorities and the potential impact of system downtime on service delivery.	The absence of an approved business continuity plan could result in prolonged operational downtime, inability to service patients and loss of key staff	WAAASP will locate the Business Impact Assessment document and add this to the BCP. The BCP will be approved, and the date of approval will be added to the BCP document.
			Expected Evidence of Implementation: Business Impact Assessment will be appended with the BCP and SMT meeting minutes will confirm approval of the BCP.
		Medium Priority	**Officer: Jeremy Surcombe WAAASP** **Target Implementation Date: June 2026**
	Theme: Risk Management	Control Operation	

Objective 4: Assess data management and quality controls throughout the patient journey, including identification/notification, vetting decisions, patient communication and the recording of pathway data, ensuring accuracy timeliness and consistency	**Substantial**

We reviewed data management and quality controls across the full patient pathway for both DESW and WAAASP, focusing on data integrity, timeliness of activity, communication processes, and the accuracy of pathway documentation. Our sample testing demonstrated that both programmes operate structured, well-established systems that support accurate patient identification, timely screening, and consistent clinical decision making.

For DESW, demographic information for the patients in our sample was accurately recorded, supported by automated updates from the Wales Demographic Service (WDS) – the most accurate and up to date patient data available in NHS Wales. WAAASP relies entirely on automated WDS feeds, meaning demographic data is synchronised without manual intervention.

We looked at the timeliness of screening activity and communication. DESW met the 90-day appointment target in all but one case, where the delay resulted from patient deferral. WAAASP met the 12-month target in four of five cases that we tested, with the exception attributable to COVID pandemic related service disruption. Letters and notifications to patients, GPs and secondary care were consistently issued promptly, and both programme records clearly evidenced confirmation of receipt from secondary care providers. Both programmes demonstrated appropriate follow up for patients who initially declined screening, with re-engagement occurring within expected timeframes, facilitated via the local council SURGE team.

Our testing also confirmed that system parameters for grading and measurement are correctly configured, with automated determination of outcomes reducing potential for manual processing error or assessment. DESW operates a comprehensive QA model, including 100% review of trainee grader outputs, blind reassessments, and escalation to senior optometrists where consensus is not reached. WAAASP applies QA to all complex, ambiguous or clinically significant screens, with most reviews completed within 28 days and priority given appropriately to specific patient groups (e.g. pregnant women – DESW). These processes ensure that onward referral decisions and surveillance intervals are based on validated assessments.

We confirmed image retention for both programmes, with DESW retaining all images and WAAASP storing images within patient files ensuring full auditability of all patient files. Across all our sample testing, required process steps were completed within defined tolerances, and any exceptions are surfaced through routine Screening Programme Activity Reports (SPARs).

Objective 5: Evaluate performance monitoring and assurance mechanisms, including reporting arrangements and the use of demand data, to ensure effective oversight of pathway delivery and continuous improvement across both programmes	**Substantial**

We assessed the effectiveness of performance monitoring and assurance mechanisms across screening programmes with an objective of determining whether accurate, timely and relevant management information is produced and used to support oversight, escalation and continuous improvement.

Across both programmes, reporting arrangements are well established and consistently applied. Screening Performance Activity Reports (SPARs) are produced monthly by the Trust's informatics team using automated scripts that extract KPI data directly from Optimise (DESW) and aSIMS (WAAASP). This independence provides confidence in the integrity of reported data. Our sample testing confirmed that KPI calculations for both programmes reconciled accurately to underlying system data.

Both programmes supplement statistical reporting with narrative update reports prepared by programme managers. These are routinely submitted to Programme Boards, where they are discussed and used to support scrutiny of performance trends, operational pressures and improvement activity. Reporting is also escalated appropriately through the Screening Management Team (SMT), Divisional Management Team (DMT) and relevant committees of the Board, including the Quality Safety and Improvement Committee (QSIC). We saw evidence that reports are aligned with governance cycles, ensuring that the most recent data is available for review.

SPARs produced by the two programmes are consistent in format and structure, with a core set of comparable measures covering uptake, surveillance, timeliness and referral. Variations in metrics reflect legitimate differences in pathway design and clinical requirements.

The main differences relate to the treatment of programme risks at Programme Board level. WAAASP Programme Board agendas and minutes include a standing item for review of the programme risk register, with evidence of discussion and scrutiny. In contrast, DESW Programme Board papers have not included a dedicated risk register item since July 2025, and meeting minutes, subsequent to that point in time, do not reflect equivalent scrutiny. While risks may be discussed through narrative reporting, the absence of a structured and visible risk review process reduces assurance that risks are consistently monitored, challenged and escalated.

	Key Findings	Risk & Impact	Suggested Management Action
5	**Programme Board Risk Register Scrutiny** Our review identified an inconsistency in the treatment of programme risks within Programme Board governance. The DESW Programme Board agendas have not included a dedicated risk register item since July 2025 and meeting minutes from that time do not reflect structured discussion of programme risks. While elements of risk may be referenced within narrative update reports, the absence of a formalised risk review process reduces transparency and limits assurance that risks are being consistently monitored and escalated.	The Trust are not aware of issues or trends that indicate poor patient experience or ineffective screening	**Agreed Action:** Programme Board meetings for the DESW screening programme will include as a standing agenda item discussion around and scrutiny of the programme's risk register. This discussion should include (but may not be limited to): • New risks added or forecast • Change in risk profile/rating to existing risks • Risks suggested for removal **Expected Evidence of Implementation:** Programme Board meeting agenda includes risk register and discussion of programme risk register is recorded in meeting minutes
		Medium Priority	**Officer: Kate Morgan** **Target Implementation Date: June 2026** **Not applicable to WAAASP**
	Theme: Risk Management	Control Operation	

Appendix A

Assurance Opinion

	Substantial	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	Reasonable	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	Limited	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	Unsatisfactory	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	Advisory	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 Findings

Priority	Explanation
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

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