NHS FIFE
INTERNAL AUDIT SERVICE

NHS FIFE WAITING TIMES ARRANGEMENTS
REPORT NO. B39A/13

Issued To: J Wilson, Chief Executive
           C Bowring, Director of Finance
           G Cunningham, Acting Director of Acute Services
           B Montgomery, Medical Director
           A Wilson, Director of Clinical Delivery
           I Elder, Head of Information Services
           V Anderson, Head of Health Records
           J Greenlees, Head of Performance

           M Porter, Acting General Manager, Kirkcaldy & Levenmouth CHP
           S Manion, General Manager, Dunfermline & West Fife CHP
           V Irons, General Manager, Glenrothes & North East Fife CHP
           A McCreadie, Assistant Director of Finance (Management Accounting)

Follow-Up Coordinator

Audit Committee
External Audit

Date: 29 November 2012
INTRODUCTION & SCOPE

1. Following the Price Waterhouse Coopers (PwC) review into aspects of NHS Lothian’s waiting times management and practice, the Cabinet Secretary outlined the Scottish Government’s response to the findings in a statement to Parliament on 21 March 2012.

2. The overall findings of the NHS Lothian review related in particular to the use of social unavailability coding and waiting times reporting to the Board and also included more general findings relating to culture and governance within NHS Lothian.

3. In a letter to all NHS Board Chief Executives on 21 March 2012, the Director General of Health and Social Care and the Chief Executive of NHS Scotland requested that Boards provide an absolute reassurance that appropriate management control and observance of good practice continues within their areas. The letter stated that the Cabinet Secretary had asked that the rigour of a specific and detailed audit was carried out into local waiting times management and processes, including reporting mechanisms, as part of each Board’s own internal audit programme over 2012/13 and that these findings be made publicly available in each Board’s meeting papers.

4. NHS Fife submitted a letter to the Scottish Government on 27 April 2012 providing the assurances requested in the letter of 21 March 2012, that NHS Fife has and will continue to have, systems and processes in place to ensure compliance with best practice guidance.

5. In June 2012, Audit Scotland published the terms of reference for their review of waiting times, which would cover the period April-December 2011, which is being undertaken under the direction of their Portfolio Manager, Health and Sport.

6. The Terms of Reference for the Internal Audit Review of NHS Waiting Times Arrangements states that the time period to be covered by the internal audit review will be as a minimum the two quarters January to March 2012 and April to June 2012. Each Board was required, through their Audit Committee, to confirm the local approach to the Internal Audit and ensure the findings are reviewed by the Audit Committee in reserved business prior to submission of the report to the SGHSCD by 17 December 2012.

7. PwC were engaged to collect data relating to waiting times from NHS Board electronic waiting times systems and to perform a number of ‘core’ analytical queries to support Audit Scotland and NHS Boards’ Internal Auditors.

Timeline

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<tr>
<th>Event</th>
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<tr>
<td>Lothian report issued</td>
<td>19 March 2012</td>
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<tr>
<td>Letter to Boards seeking assurance</td>
<td>21 March 2012</td>
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<tr>
<td>Letter from Board providing assurance</td>
<td>27 April 2012</td>
</tr>
<tr>
<td>Assurance provided to Board</td>
<td>24 April 2012</td>
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<tr>
<td>SGHSCD requires all Internal Audit departments to include ‘Review of NHS Waiting Times Arrangements’ in 2012/13</td>
<td>3 May 2012</td>
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OBJECTIVES

8. The full terms of reference, as set out by the SGHSCD, are shown in Appendix 1.

9. The objectives of the review, as stated in the terms of reference, were to ensure that:

   - Individual patient records are accurate and that systems are in place to ensure that the patient administration system cannot be inappropriately changed
   - Reporting on waiting is accurate and consistent at every level in the organisation up to and including the Board
   - The local guidance is consistent with national guidance and its implementation is both valid and reliable (i.e. not open to different interpretation in use)

10. In order to report on these, we undertook work in the following areas:

    - Governance and Reporting
    - Policies and Guidance
    - System Management
    - Transaction Testing

LIMITATION OF SCOPE

11. We were subject to limitations in scope as follows:

    - As noted above, our testing is limited to the period January to June 2012. Audit Scotland will report on the period April to December 2011.
    - As with all internal auditors in NHS Scotland, we have placed reliance on data provided by PwC, with limitations on available data being dependent on the relevant patient administration system. We have also had to place reliance on the integrity of these patient administration systems.
    - During our testing, documentary evidence in some areas did not allow us to come to a definitive conclusion on the appropriateness of a number of waiting times entries and we have had to place reliance on information provided by staff.
EXECUTIVE SUMMARY

12. The reporting process to ISD and Scottish Government was in line with guidance issued, and waiting times reports from OASIS were reported consistently to Scottish Government, and the Board/Operational Division Committee and Management.

13. For the period under review, each Board meeting received a high-level report on waiting times, containing an appropriate level of detail for a strategic Board of governance. The Operational Division Committee provided more detailed scrutiny of this key area and discussions on Waiting Times took place in various meetings within the Operational Division and CHPs. However, formal escalation processes for waiting times issues including triggers and pressure points have not been clearly defined.

14. During January-June 2012, there was no overarching Patient Access Policy in place and the two general policies in this area did not fully meet the requirements of New Ways Guidance, although all staff did have access to New Ways booklets. Omissions have now been rectified in the new Patient Access Policy approved by the Board in August 2012, although this policy will require further amendment once clarification has been received from the SGHSCD on certain aspects of the national guidance.

15. New Ways rules had been incorporated into OASIS as far as practicable and data quality checking allowed errors to be identified, investigated and corrected. User access controls limit user access to the functions they require and an appropriate level of security is applied over authorising access to the system. Audit trail functionality allows transactions to be traced to the users creating them.

16. We identified a number of transactions where there was insufficient evidence for audit to form a definitive conclusion. However, the majority of transactions appeared to be reasonable within the context of patient circumstances and explanations provided by staff. For those transactions which were not fully in line with New Ways guidance, our view is that these were based on misunderstandings rather than any deliberate manipulation. All staff consulted were now aware that use of unavailability as described above was not correct, confirmed that unavailability is no longer applied in this way and highlighted the supervisory controls now applied by NHS Fife to identify any anomalous transactions.

17. Internal Audit did not identify any instances of inappropriate behaviour or pressure on staff to hide breaches or manipulate data and our review found no critical matters of concern.

18. Good Practice during the period reviewed included:
   a. Both the Board and Operational Division Committee received reports with an appropriate level of detail
   b. An 18 Week Referral To Treatment (RTT) Project Board was in place to project manage the change programme and to oversee and give direction for service improvements to ensure delivery of the 18 Week RTT target and related stage of treatment targets
   c. Performance reporting and review of patients who Could Not Attend (CNA) and Did Not Attend (DNA).
19. Further good practice put in place from July 2012 prior to the commencement of our audit, included:

a. Performance reports presented to the NHS Fife Board and Operational Division Committee provide patient unavailability data.

b. The establishment of an Elective Flow Project Board to oversee and give direction for service improvements that help sustain performance of the 18 Week RTT target. The Project Board provides an escalation route for the inpatient and daycase, diagnostic and outpatient and detect cancer early work streams.

c. An operational process has been developed for managing inpatients and daycase patients with no allocated treatment date within the 84 day legally binding guarantee. The process includes escalation through the Waiting Times Officers to Business Managers and on to General Managers and is currently being tested.

d. Draft NHS Fife procedures have been produced for dealing with ISD Warehouse Issues in the patient administration system and validation of quarterly waiting times breaches prior to publication of the ISD quarterly report.

e. Evidence of data quality checks of information input to the patient administration system. A Standard Operating Procedure is in place for weekly checking of the accuracy of the number of Patients with Unavailability. We noted good practice in the regular checks undertaken by the waiting times officers in ensuring letters to patients and GPs are produced and in checking appropriateness of unavailability.

20. Potential areas for improvement include:

a. Formal documentation of governance, assurance, reporting and escalation arrangements for management of waiting times and reporting of waiting times performance, in particular the way in which the Operational Division Committee receives and provides assurance to the Board on this key area.

b. Members and officers should be asked to approve the format of reports, in order to ensure the comprehensiveness and user-friendliness of waiting times reports presented to Board and Operational Division Committee, taking into account the recommendations set out in the action plan to this report.

c. The Patient Access Policy should be further updated in accordance with CEL33(2012) once clarification has been received from the Scottish Government on key issues. Further Standard Operating Procedures may be required to comply fully with the CEL.

21. In our view, changes instigated by the Board since the period reviewed should be sufficient to provide a robust control environment, when combined with the recommendations included within the action plan to this report.

GOVERNANCE AND REPORTING

22. At each meeting, Fife NHS Board considers performance against waiting times targets through an Activity Report within the Board Executive Performance Report. Responsibility for detailed monitoring of waiting times is delegated to the Operational Division Committee as a Standing Committee of the Board. The Operational Division Committee considers a detailed Activity & Waiting Times Report at each meeting and minutes of the Operational Division Committee are also presented to the Board. The CHPs also consider Waiting Lists which are relevant to their areas of responsibility.
23. On 24 April 2012, the Chief Executive provided a verbal briefing to the Board on the application of the availability status code. The NHS Fife response to the Scottish Government on 27 April 2012 did not provide any description of the Board’s governance and reporting arrangements but did state that ‘regular reports on the use of unavailability codes will be provided to both our Operational Division Committee and the Board as part of our normal waiting times performance reports’.

24. NHS Fife has not formally defined its governance and reporting structures for waiting times performance management and there is no formal, clearly defined updated escalation protocol. An escalation procedure including trigger points to facilitate timely identification and report of pressure areas is recommended as well as consideration of how the Operational Division Committee reports to the full Board on strategic waiting list issues including capacity, finance, workforce, and performance management as necessary.

25. The Board undertook a review of Board reporting in June 2010 as part of its 2009-14 Performance Management Strategy and Framework. However, whilst the level of detail and comprehensibility in relation to waiting times in activity reports provided was broadly appropriate, changes to the style of reporting could more clearly set out performance against the legally binding waiting times performance targets and will need to be reconsidered once committees have specified the level of information they require to fulfil their role.

26. The level of scrutiny evidenced by the minutes did not appear to be proportionate to the importance of these targets to the Board and the Scottish Government. For example, whilst we have been informed that there was considerable discussion around achievement of waiting times targets for key diagnostic procedures on this area at the Operational Division Committee, this was not fully reflected in its minutes.

27. The Board does not have defined processes for identifying, recording and reporting data quality issues in relation to waiting list information. We recommend that the Operational Division Committee develops KPIs which could include levels of unavailability analysed by speciality and patient type, and (unvalidated) in-month breaches as well as at month end census point and reports from the Board’s own testing of unavailability.

28. For the period under review, committees and groups concerned with the management of waiting times included the Operational Division Executive Team which reviewed waiting times performance through the Operational Division Statistics Highlight report. There were three Directorate Waiting Times Groups - Planned, Emergency and Ambulatory Care, which met on a six-weekly basis, as well as less formal waiting times meetings with CHPs which dealt with the management of consultant led outpatient waiting times. In addition, the Senior Management Team (SMT) considered waiting times issues through the Performance Highlight Report, which identified any areas of underachievement; corrective actions required and identified performance management team actions.

29. Whilst General Managers attended the Directorate Waiting Times meetings and the weekly Operational Division Executive Team, where waiting times were a standard item, there appeared to be no clear method of escalation of pressures or trigger points between these meetings. This escalation process requires to be formalised to ensure there is a system for identification of risk areas rather than escalation being reliant on individuals. Directorate Waiting Time meetings were relatively infrequent (every 6 weeks) but would have benefited from more formal structure and minuting.
30. In addition, our testing confirmed that:

- The Board had appropriately considered corporate risks relating to waiting times.
- The reporting process to ISD and Scottish Government was in line with guidance issued and waiting times reports from OASIS were reported consistently to Scottish Government, and the Board/Operational Division Committee and Management.

Developments from July 2012

31. The Corporate Risks relating to Waiting Times have been updated and consolidated in line with the overall review and update of Corporate Risks.

32. Since the period reviewed, the reporting and governance structures have evolved and continue to be developed and refined. The data within the Activity & Waiting Times Report is under review to ensure it is appropriate and covers all aspects of waiting times and other clinical targets.

33. Reporting arrangements are developing through the Improving Elective Flow Programme. There is an Improving Elective Flow project plan and governance arrangements have been put in place ahead of the formal project launch planned for end November 2012. Prediction of waiting times pressures is now managed through the Improving Elective Flow Project Board and through weekly Core Team meetings.

34. Demand and capacity work is continuing to be developed through a Checklist process and performance monitoring through a management Dashboard; relevant data is maintained within the performance folder. The Dashboard and the performance folder are accessible to management on a shared drive and this information is used for day to day monitoring of waiting times and for performance reporting. All Monthly Management Information (MMI) data is available from both these sources and the performance folder contains all ‘background’ reports i.e. source data for governance reporting from 2008/09.

35. The Acting Director of Acute Services chairs fortnightly waiting times meetings attended by the General Managers and Business Managers with the Director of Clinical Delivery and Assistant Director of Finance in attendance. These have a formal structure, with action notes produced after every meeting.

POLICIES AND GUIDANCE

36. The two general policies entitled ‘Managing Patients who fail to attend and Patient Led Cancellations’ and ‘Policy for Adding Patients to Current True Inpatient/Day Case Waiting Lists’ in place during the period January-June 2012 did not include all the requirements of New Ways Guidance. Staff were provided with a summary of New Ways guidance and various procedures for Health Records staff were available at this time.

37. Although the two policies were available on the NHS Fife Intranet, no input staff interviewed were aware of the policies nor recalled receiving any formal training and we were informed that staff followed local informal processes. We did, however, note that staff interviewed were aware of New Ways guidance and were clear that advice on application of guidance was available from Health Records line management and from the waiting times officers.
Developments from July 2012

38. The new NHS Fife Patient Access Policy was approved by Fife NHS Board on 28 August 2012. It is a comprehensive document which broadly complies with CEL33(2012) and represents a significant improvement in terms of guidance available to staff and addresses omissions in the previous policies. It is intended that the policy will be reviewed by end March 2013 to incorporate the outcomes of ongoing national discussions with Scottish Government on application of guidance and the findings of this report.

39. We noted good practice, beyond the levels required by the CEL, in that the new Patient Access Policy provides clear direction on specific scenarios e.g. patient responsibilities, responsibilities of receiving clinicians (including an additional document summarising basic RTT principles tailored for clinician use), emphasis on the importance of not putting a patient on the waiting list unless available for treatment, a specific section on not using unavailability when a reasonable offer is declined, the process for when a patient wishes a named consultant or specifies their wish to be treated in Fife and not in another Health Board area, and a section on appointments cancelled by hospital after admission.

40. Training sessions on the Treatment Time Guarantee (TTG) have been provided and a process is in place for Medical Records staff which requires them to confirm in writing that they have attended an awareness session; have access to and have read and understood the Patient Access Policy; will comply with the policy; understand the legally binding nature of TTG requirements; and are aware that concerns can be raised with line management.

41. NHS Fife now has numerous Standard Operating Procedures and flowcharts which support the principles in the overarching Patient Access Policy. These useful, high quality documents provide clear guidance for staff and from our interviews with staff we can conclude that they are widely used across the organisation on a day to day basis.

SYSTEM REVIEW

42. NHS Fife uses the Referral Management System (RMS) and the OASIS patient administration system to process outpatient referrals and inpatient and day case referrals from referral receipt to attendance at outpatient clinic and potentially treatment as an inpatient. Processing is mainly undertaken by Health Records staff and Medical Secretaries, with clinician involvement at referral vetting and recording of clinical outcomes following outpatient consultation.

43. Monitoring of the achievement of outpatient, inpatient and referral to treatment targets is undertaken by Directorate and Service Managers, whilst the booking of patients to ensure that they meet these targets is undertaken by Health Records staff and Medical Secretaries.

44. User access to OASIS is controlled by the system administration team in eHealth or by eHealth Administration staff. Access is only setup on receipt of an appropriately authorised system access request form which demands compliance with the NHS Fife eHealth Security Policy and confidentiality requirements. For access to OASIS, this form must be authorised by an authorised signatory before access is granted. The single sign-on system in place in NHS Fife provides additional assurance with the Fair Warning system providing further control.
45. There are 2499 live OASIS user accounts and a review of accounts locked out after a period of 90 days inactivity is undertaken on a monthly basis to determine whether the access is still required. We identified some users who no longer required System Manager access and these have now had their access amended accordingly.

46. Separate authorisation of transactions, where one user inputs and another authorises, is not a function employed by OASIS. The ability to input and process transactions is determined by user access permissions.

47. Control over access to the database is tight, with only the supplier having access as the service provided is a fully managed service.

48. The audit trail on OASIS appeared to provide the required detail to allow queries or instances of misuse to be investigated. This was apparent during the data pack testing undertaken as part of this review.

49. Process controls in OASIS are used to control the flow of information regarding the patient journey and to record relevant dates regarding their stage of treatment.

50. New Ways rules are programmed into OASIS for the processing of outpatient and inpatient referrals as far as is practicable. User acceptance testing was undertaken to confirm that these were functioning correctly in 2007. A configuration manual overview reference document, describing how to configure OASIS for New Ways functionality, was also produced in 2007.

51. There are not separate authorisation functions on OASIS for the application of actions that impact on the patients’ waiting time guarantee dates (e.g. social or medical unavailability, removal from list, resetting of clock) as this would disrupt workflow when staff are attempting to book patients to appointments. There were also not any regular management/supervisory checks on the appropriateness of these actions during the period we examined (1 January to 30 June 2012), although there are now supervisory checks performed on every addition or amendment to periods of unavailability for inpatients.

52. Data quality issues are identified when data is extracted to the ISD National New Ways warehouse and these are investigated and corrected. Local procedures, which have been validated by ISD, have been drafted to record common reasons for errors and methods to investigate and correct these, and the CLOVE system is used to validate inpatient data for compliance with SMR coding rules.

53. Assurance regarding the completeness and accuracy of data extracted from OASIS is not absolute as there are no system control totals built into the system to confirm that all records have been processed and extracted.

**DATA TESTING**

54. Following analytical review of data received from PwC, we requested detailed samples from which we tested 217 transactions. These were reviewed and analysed and as a result, we sought further information from 7 input staff. We also conducted discussions with other key staff.

55. Explanation for application of unavailability provided either in the patient administration system or in medical records reviewed was variable, resulting in the limitation in scope referred to above in that we did not always have sufficient information to conclude
unequivocally on all transactions. We also noted that letters were not often sent to the patient or GP informing them when unavailability was applied or where a patient was removed from the list as a result of DNA or CNA.

56. In considering the following, we would also highlight that much of our sampling was specifically designed to identify potentially inappropriate transactions. Overall we considered that 67% of transactions tested were reasonable in the light of patient circumstances and explanations provided and/or the transactions did not impact on waiting times performance. For 13% we were still unable to form a definitive conclusion after interviews with input staff, reviewing medical records and information recorded on the patient administration system. 20% of transactions did not appear to be in line with New Ways guidance as follows, albeit many issues were of a minor nature which did not impact on overall journey time.

57. The following transactions did not appear to be fully in line with New Ways guidance, albeit we would highlight that the guidance itself was not always prescriptive nor comprehensive:

a. There were a number of patients reviewed who should not have been added to the waiting list. These patients most commonly required a diagnostic test prior to the decision to treat and it appears that consultants were adding these patients to the waiting lists in a bid to ensure that they ‘were not forgotten’. Technically, the periods of unavailability applied for these patients were not in accordance with New Ways guidance, however the end position was correct.

b. Medical unavailability has been inappropriately applied to cover periods where a patient was to undergo a pre-assessment.

c. For a small number of patients, social unavailability was not applied for the exact dates as notified by patient, so that whilst the total length of unavailability was correct, the patient would have been wrongly identified as being available when they were not and vice-versa.

d. 5 patients were categorised as cancelled by patient no further appointment, which resets their clock, when they should have been treated as could not attend.

58. Whilst these transactions were not fully in line with New Ways guidance, our view is that these were based on misunderstandings rather than any deliberate manipulation. All staff consulted were now aware that use of unavailability as described above was not correct, confirmed that unavailability is no longer applied in this way and highlighted the supervisory controls now applied by NHS Fife to identify any anomalous transactions.

59. Our meetings with input staff highlighted an increased awareness of Waiting Times regulations and guidance since training on the new polices was introduced, albeit two community based staff stated they had not been made aware of new guidance and procedures. No staff reported instances of inappropriate behaviour or pressure on staff to hide breaches or manipulate data and the culture within NHS Fife was considered to be supportive and open.

60. In our view, changes since the period tested including revised guidance and associated training, increased staff awareness evidenced and the communication with patients introduced by the latest national guidance should be sufficient to prevent reoccurrence when combined with the enhanced supervisory checks recommended in the action plan to this report.
ACKNOWLEDGEMENT

We would like to thank all members of staff for the invaluable help and co-operation received during the course of the audit, without which we would not have been able to complete this complex audit within the agreed timescales. We would particularly like to thank the management team for their exceptionally helpful contribution in providing timely information and responses.

ACTION

61. An action plan has been agreed with management to address the identified weaknesses. A follow-up of implementation of the agreed actions will be undertaken in accordance with the audit reporting protocol.

A Gaskin
Chief Internal Auditor
**Governance & Reporting**

1. Since the period reviewed, the reporting and governance structures for management of Waiting Times have evolved and continue to develop.

   The Board has not formally considered the need to document governance and reporting arrangements for management of waiting times and reporting of waiting times performance.

   In order to strategically assess the robustness of these governance and reporting arrangements, NHS Fife should formally review and document arrangements taking consideration of any clarification received from the Scottish Government on key issues and the recommendations contained in this report.

   Specific consideration should be given to the way in which the Operational Division Committee receives and provides assurance to the Board on this key area.

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<td></td>
<td></td>
<td>In order to strategically assess the robustness of these governance and reporting</td>
<td>2</td>
<td>Any new guidance received from Scottish Government will be included in future arrangements</td>
<td>Acting Director of Acute Services 31 March 2013</td>
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<td>arrangements, NHS Fife should formally review and document arrangements taking</td>
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<td>Robust reports are provided and discussions take place at the Board but the need for any</td>
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<td>consideration of any clarification received from the Scottish Government on key issues</td>
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<td>changes will be discussed when the final Internal Audit report is presented to the Board.</td>
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<td>and the recommendations contained in this report.</td>
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<td>2.</td>
<td>There are no formal escalation processes for waiting times issues, triggers and pressure points have not been clearly defined.</td>
<td>An escalation procedure including trigger points to facilitate timely identification and report of pressure areas is recommended as well as consideration of how the Operational Division Committee reports to the full Board on strategic waiting list issues including capacity, finance, workforce, and performance management as necessary. The Operational Division Committee should develop KPIs which could include levels of unavailability analysed by speciality and type, and (unvalidated) in-month breaches as well as at month end census point and reports from the Board’s own testing of unavailability.</td>
<td>2</td>
<td>The existing escalation process is being modified to reflect the new guidance.</td>
<td>Acting Director of Acute Services 31 March 2013</td>
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<td>The feedback from the Division to the Board on these issues will be discussed and agreed as part of the discussion of the KPIs.</td>
<td>Acting Director of Acute Services 31 March 2013</td>
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<td>Revised KPIs will be presented and agreed with the Operational Division Committee reflecting the recommendations.</td>
<td>Acting Director of Acute Services 31 March 2013</td>
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NHS Fife

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<td>3.</td>
<td>Whilst NHS Fife Board did undertake a review of Board reporting in June 2010 as part of its 2009-14 Performance Management Strategy and Framework, members and officers have not approved the format of Activity reports including Waiting Times data.</td>
<td>In order to ensure the comprehensiveness and user friendliness of waiting times reports presented to Board and Operational Division Committee, members should be asked to approve the format of reports. We have discussed a number of focused amendments which might enhance members’ understanding of key areas.</td>
<td>2</td>
<td>Board members will be asked if they require any changes to the current format to aid understanding.</td>
<td>Acting Director of Acute Services 31 March 2013</td>
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<td>4</td>
<td>The level of scrutiny evidenced by the Board and Operational Division Committee minutes did not appear to be proportionate to the importance of Waiting Times targets to the Board and the Scottish Government. For example, whilst we have been informed that there was considerable discussion around achievement of waiting times targets for key diagnostic procedures on this area at the ODC, this was not fully reflected in its minutes.</td>
<td>Recording of debate and the presentation of findings should be considered as part of the process described above.</td>
<td>3</td>
<td>This will be considered as part of the overall exercise currently underway to review the format and content of governance committee minutes through the Board.</td>
<td>31 March 2013</td>
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5. Whilst the Patient Access Policy is a comprehensive document, it requires further development to ensure it reflects all available guidance and in any event will need to be updated once clarification is received from the SGHSCD on a number of issues which are still to be resolved nationally.

Review and update of the Patient Access Policy should include:

- Reference to the requirement for compliance with CEL33(2012)
- Clinical input before DNA removal.
- Cross reference to updated Financial Operating Procedure on Patients’ Travel Costs including patients’ right to travel costs when being treated outwith Board area
- Clarification that declining a short notice offer would not result in any detriment to the patient

The need to undertake this has already been recognised in the review date set for the current policy.

Director of Clinical Delivery
31 March 2013
### Action Plan

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<td>6</td>
<td>Two staff, outwith Medical Records reported that they had not received training on the new guidance and policies and these staff were not recorded on the training database.</td>
<td>The training database should be reviewed to ensure it covers all staff.</td>
<td>2</td>
<td>This will be reviewed to look at the most appropriate way of ensuring that all staff who required to be trained undertake the relevant training.</td>
<td>Head of Health Records 31 March 2013</td>
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<td>7</td>
<td>Whilst NHS Fife has various Standard Operating Procedures and flowcharts in place Internal Audit has identified the requirement for further guidance.</td>
<td>The following Standard Operating Procedures should be developed:</td>
<td>3</td>
<td>The requirements of the CEL will be reviewed to ensure that all aspects are captured in NHS Fife procedures.</td>
<td>Director of Clinical Delivery 31 March 2013</td>
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### System Review

8. **In order to discharge their duties, staff managing the booking of patients to appointments need the flexibility to be able to apply new ways rules by adding periods of unavailability, removing patients from the waiting list and to reset patient’s waiting time clocks without separate authorisation by a supervisor.**

   Coverage of these supervisory checks should be considered on the basis of results to date so that they are proportionate to risk and should be extended to outpatients.

   Risk factors could include:
   - known capacity issues
   - levels of unavailability and findings from previous supervisory checks
   - results of Internal Audit testing undertaken as part of this review.

   **Management will consider this risk approach to ensure that checks are undertaken as appropriate.**

   **Head of Medical Records**

   **31 March 2013**
DEFINITION OF ASSURANCE CATEGORIES AND RECOMMENDATION PRIORITIES

The priorities relating to Internal Audit recommendations are defined as follows:

**Priority 1 recommendations** relate to critical issues, which will feature in our evaluation of the Governance Statement. These are significant matters relating to factors critical to the success of the organisation. The weakness may also give rise to material loss or error or seriously impact on the reputation of the organisation and require urgent attention by a Director.

**Priority 2 recommendations** relate to important issues that require the attention of senior management and may also give rise to material financial loss or error.

**Priority 1 and 2 recommendations are highlighted to the Audit Committee and included in the main body of the report within the Audit Opinion and Findings**

**Priority 3 recommendations** are usually matters that can be corrected through line management action or improvements to the efficiency and effectiveness of controls.

**Priority 4 recommendations** these are recommendations that improve the efficiency and effectiveness of controls operated mainly at supervisory level. The weaknesses highlighted do not affect the ability of the controls to meet their objectives in any significant way.